Health & Wellbeing Board

Date: **Tuesday 6 May 2014**

Time: **9:30am to 1pm (*Note earlier start time)***

Venue: **Room 16, Abbey Conference Centre, Norwich**

Membership	Substitute	Representing
William Armstrong	Alex Stewart	Chair, Healthwatch Norfolk
Cllr Brenda Arthur		Norwich City Council
Cllr Yvonne Bendle (Vice-Chairman)	Cllr Lisa Neal	South Norfolk Council
Stephen Bett	Jenny McKibben	Norfolk's Police and Crime Commissioner
Harold Bodmer	Catherine Underwood	Director Community Services
Dr Jon Bryson	Ann Donkin	South Norfolk Clinical Commissioning Group
Pip Coker	Dan Mobbs	Voluntary Sector Representative
T/ACC Nick Dean	C/Sup Jo Shiner	Norfolk Constabulary
Dr Anoop Dhesi	Mark Taylor	North Norfolk Clinical Commissioning Group
Tracy Dowling		Director of Operations & Delivery, NHS England, East Anglia Team
Richard Draper	Dan Mobbs	Voluntary Sector Representative
Andy Evans	Kate Gill	Great Yarmouth & Waveney Clinical Commissioning Group
Cllr John Lee		North Norfolk District Council
Anne Gibson		Acting Managing Director, Norfolk County Council
Joyce Hopwood	Dan Mobbs	Voluntary Sector Representative
Cllr James Joyce		Cabinet Member, Safeguarding Children, Norfolk County Council
Cllr Penny Linden	Cllr Marlene Fairhead	Great Yarmouth Borough Council
Sheila Lock	Michael Rosen	Director Children's Services
Dr Ian Mack (Vice-Chairman)	Sue Crossman	West Norfolk Clinical Commissioning Group
Lucy Macleod		Interim Director of Public Health
Cllr Elizabeth Nockolds		King's Lynn and West Norfolk Borough Council
Dr Chris Price	Jonathon Fagge	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Cllr Roger Foulger	Broadland District Council
Cllr Daniel Roper **(Chairman)**		Cabinet Member, Public Protection, Public Health, Trading Standards, Fire & Rescue, Norfolk County Council
Cllr Lynda Turner	Rhianna Rudland	Breckland District Council
Cllr Sue Whitaker		Cabinet Member, Adult Social Services, Norfolk County Council

Persons attending the meeting are requested to turn off mobile phones.

For further details and general enquiries about this Agenda please contact the Committee Administrator:

Nicola Tuck on 01603 223053
or email committees@norfolk.gov.uk

1	**Apologies**	Chair	
2	**Minutes** To confirm the minutes of the meeting held on 1 April 2014	Chair	**Page 5**
3	**Members to Declare any Interests** If you have a Disclosable Pecuniary Interest in a matter to be considered at the meeting and that interest is on your Register of Interests you must not speak or vote on the matter. If you have a Disclosable Pecuniary Interest in a matter to be considered at the meeting and that interest is not on your Register of Interests you must declare that interest at the meeting and not speak or vote on the matter. In either case you may remain in the room where the meeting is taking place. If you consider that it would be inappropriate in the circumstances to remain in the room, you may leave the room while the matter is dealt with. If you do not have a Disclosable Pecuniary Interest you may nevertheless have an Other Interest in a matter to be discussed if it affects: - your well-being or financial position - that of your family or close friends - that of a club or society in which you have a management role - that of another public body of which you are a member to a greater extent than others (in your ward). If that is the case then you must declare such an interest but can speak and vote on the matter.	Chair	
4	**To receive any items of business which the Chairman decides should be considered as a matter of urgency**	Chair	
	Items for Business		
5	**Joint Health and Wellbeing Strategy 2014-17**	Lucy Macleod	**Page 8**
6	**Clinical Commissioning Groups: 2 year operational plans 2014-16**	Representatives of the 5 x CCGs	**Page 24**
	Break - at the Chairman's discretion		
7	**Clinical Commissioning Groups: Extracts from Draft Annual Reports 2013-14** Appendix A: North Norfolk Appendix B: South Norfolk Appendix C: Great Yarmouth and Waveney Appendix D: West Norfolk Appendix E: Norwich	Representatives of the 5 x CCGs	**Page 418**

8	**Healthwatch Norfolk – update on current activities** (Presentation)	William Armstrong/ Alex Stewart	
9	**Children's Services improvement update** (Presentation)	Sheila Lock	
10	**Health & Wellbeing Board - Budget Report**	Debbie Bartlett	**Page 429**
11	**Voluntary Sector Engagement Project – End of year update report 2013/14**	Linda Rogers	**Page 434**
12	**Norfolk County Council budget 2014/15 – Implications for the Health & Wellbeing Board**	Debbie Bartlett	**Page 461**
13	**Joint Health & Wellbeing Board Strategy 2013-14 end of year report**	Debbie Bartlett	**Page 470**
14	**Annual Review of Membership, Terms of Reference & Forward Plan**	Debbie Bartlett	**Page 484**
	Standing items		
15	**Healthwatch Norfolk minutes** • Minutes of the meetings held on 11 November 2013 and 20 January 2014	William Armstrong	**Page 494**
16	**NHS England verbal update**	Tracy Dowling, NHS England	
17	**Norfolk Health & Overview Scrutiny Committee minutes** • Minutes of the meetings held on 16 January and 27 February 2014	Chair	**Page 502**
	Items previously circulated for information		
18	• **NHS England Primary Care Strategy**	Tracy Dowling, NHS England	
	Close		
	Future Board meetings dates: • 16 July 2014 • 22 October 2014	Chair	
	Venues to be confirmed		

Norfolk County Council
at your service

Health and Wellbeing Board
Minutes of the meeting held on Tuesday 1st April 2014
at 9.30am in Room 16, Abbey Conference Centre, Norwich

Present:
Mr D Roper, Norfolk County Council – Chairman

Alex Stewart	Healthwatch Norfolk
Brenda Arthur	Norwich City Council
Cllr Yvonne Bendle	South Norfolk Council
Harold Bodmer	Director of Community Services, NCC
Dr Jon Bryson	South Norfolk Clinical Commissioning Group
Pip Coker	Voluntary Sector representative
Dr Anoop Dhesi	North Norfolk Clinical Commissioning Group
Tracy Dowling	Director of Operations & Delivery, NHS England, East Anglia Team
Richard Draper	Voluntary Sector Representative
Joyce Hopwood	Voluntary Sector Representative
Steve James	Breckland District Council
Cllr James Joyce	Cabinet Member Safeguarding, NCC
Cllr Penny Linden	Great Yarmouth Borough Council
Dr Ian Mack	West Norfolk Clinical Commissioning Group
Lucy Macleod	Acting Director of Public Health
Elizabeth Nockolds	Kings Lynn & West Norfolk Borough Council
Dr Chris Price	Norwich Clinical Commissioning Group
Cllr Andrew Proctor	Broadland District Council
Kate Gill	Great Yarmouth & Waveney Clinical Commissioning Group
Sue Whitaker	Cabinet Member Adult Social Services, NCC
Catherine Underwood	Community Services, NCC

Others present:
Debbie Bartlett, Head of Planning, Performance and Partnerships, NCC

1. Apologies

Apologies were received from T/ACC Nick Dean, Norfolk Constabulary, Lynda Turner (substituted by Steve James), Sheila Lock and Yvonne Bendle.

2. Minutes
The minutes were agreed as a true and accurate record and signed by the Chair.

3. Interests
There were no interests declared.

4. Urgent Business
There were no items of urgent business.

5. Norfolk Better Care Fund Plan – final submission
The Board received the final paper from Harold Bodmer and the Chief Officers of Norfolk's Clinical Commissioning Groups (CCGs) setting out the final version of the Norfolk Better Care Fund (BCF) which would be delivered to NHS England. During the discussion, the following points were made;

- The paper had been drawn up by the five CCGs and Norfolk County Council. It was a countywide plan which outlined the way in which the health services would be commissioned in future. The plan underpinned integration in Norfolk and would be the mechanism for driving forward integrated working and transformation of services.

- The document had followed the national template to ensure it included key elements. There were areas of the plan which would require further development.

- Development had been made with funding and the performance matrix. This included schemes which would make improvements to services such as the reduction of acute admissions into hospital and residential care.

- Since the first draft of the plan there had been continuing engagement with stakeholders. It was recognised that the County Council and the CCGs had worked hard on the plan and had an ambition to increase the pool of funds and move towards further integrated working.

- One of the components of the fund is dependent on the targets set locally. These targets had to be proposed against the key performance indicators – there are four national indicators and Norfolk has two locally-defined indicators, one of which is around dementia. Once the interventions had been implemented, it would be possible to see how much of a difference they would make and if the plan had set realistic suitable targets for that area.

- It was noted that the transformations funds would be ring-fenced It was also noted that there was clear commitment to drive the transformation of services this year and that there would be a need to work together to identify community-based alternatives. The CCG's would look at sharing resources which would help with practical issues such as travel to reach services.

- Housing was an important element and it was noted that the Disabled Facilities Grant (DFG) was protected in the Fund. Each of the areas were setting out a vision for the broader aspects of what keeps people well and a strengthened network of services to ensure people stayed independent and well would be beneficial.

- Existing commitments had to be met and the required transformation had to be undertaken - all with the same pool of money. Therefore all stakeholders involved in the plan had to work together to meet the collective responsibility.

- Once the plan had been agreed, it would be reviewed by NHS England who would then provide a feedback report. A benchmark against other similar demographic areas would also be completed. The deadline for submitting the plan to NHS England was 4 April and the assessment would be completed by 17th April 2014. Feedback from NHS England would be received within a month and if anything needed to be addressed in the plan there would be a rapid response.

- There were clear implications for acute hospitals from the shift from acute to community. This had been the subject of discussions and further detail would develop as we progressed.

- The voluntary sector representatives welcomed the plan, were committed to the agenda the plan outlined and looked forward to being active partners.

- This was a plan for Norfolk as a whole and had been built in a way that reflected local needs and the local population. There were a lot of similarities in the plans as within

Norfolk the CCG's were working collectively. There were common approaches, including services around primary care, but delivered differently in order to achieve the outcomes. Cultural boundaries were likely to be more of a challenge than geographical boundaries and it would be a function of the Board to pick up any such issues during implementation.

- The risks identified in the plan were brief outlines. There was considerable underlying work taking place even though the detail of this was not noted in the plan. All risks were being considered with a sense of urgency.
- Service users would need reassurance that it was a well-thought out managed approach that was being implemented. Collective messages from all of the partners involved should be given.
- The involvement in the plan from all partners had enabled District Councils engagement with health professionals much more but it was important to realise that it the plan now needed to be put into action.
- The fund was a part of considerable changes taking place nationally, driven by NHS England, for example in acute primary care. There was a need for a coherent approach locally, as this was limited nationally.

The next meeting would take place on **Tuesday 6th May 2014** at 9.30am at the Abbey Conference Centre.

The meeting closed at 11.35am

Chairman

Report to Norfolk Health and Wellbeing Board

6 May 2014

Item 5

Joint Health and Wellbeing Strategy 2014 -17

Cover Sheet

What is the role of the HWB in relation to this paper?

The role of the Health and Wellbeing Board is to approve the content of the 2014 -17 Joint Health and Wellbeing Strategy and so endorse the development and implementation of the actions plans that will support the delivery of the priorities in the strategy.

Key questions for discussion

Q.1 Is the H&WB content that the final draft of the 2014 -17 JH&WBS takes into account comments made and actions identified at the last meeting of the Board?

Q.2 Are the actions that have been identified clear, reasonable and achievable and a good basis from which action plans for the implementation of the strategy can be developed?

Q. Is there a role for Board level sponsors or champions for each of the priorities and, if so, what should be the nature of that role?

Action required

The Health and Wellbeing Board is asked to:

- Approve the content of the 2014/17 Joint Health and Wellbeing Strategy and so endorse the development and implementation of the actions plans that will support the delivery of the priorities in the strategy.
- To approve the Strategy Group as a Steering Group for implementation
- To consider whether there is a role for Board level champions for each of the three priorities in the implementation of the strategy.

Report to Norfolk Health and Wellbeing Board

6 May 2014

Item 5

Joint Health and Wellbeing Strategy 2014 -17

Report of the Director of Public Health

Summary

At the last meeting of the Health and Wellbeing Board on 8 January 2014, an early draft of the Joint Health and Wellbeing Strategy 2014 -17 was discussed. A number of points for clarification and/or further development were identified. The H&WB Strategy Group has responded to these and the final draft of the strategy is appended to this paper for approval.

The Health and Wellbeing Board is asked to:

- Approve the content of the 2014/17 Joint Health and Wellbeing Strategy and so endorse the development and implementation of the actions plans that will support the delivery of the priorities in the strategy.
- To approve the Strategy Group as a Steering Group for implementation
- To consider whether there is a role for Board level champions for each of the three priorities in the implementation of the strategy.

1. Background

1.1 The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board (H&WB), including a duty to prepare a Joint Health and Wellbeing Strategy (JH&WS). The strategy is based upon a process of continuous assessment and so not a static document that sits unchanged for 3 years but something that will evolve over time to meet new areas of identified need, where the H&WB can make a difference and add value. The Joint Strategic Needs Assessment (JSNA) has a key role to play in this process.

2. Strategy development

2.1 A series of evidence-led, multi-agency workshops were held in the first 6 months of 2013 to identify the priorities for the 2014 -17 JH&WS. These were agreed by the Board at the July 2013 meeting as being:

- Promoting the social and emotional wellbeing of pre-school children
- Reducing obesity
- Making Norfolk a better place for people with dementia and their carers.

2.2 In responding to these priorities, three overarching goals were also identified:

- Prevention – providing help and support at an earlier stage before problems become acute

- Reducing inequalities in health and wellbeing
- Integration – partners working together to provide effective, joined up services.

2.3 At the meeting of the Health and Wellbeing Board on 8 January 2014, an early draft of the Joint Health and Wellbeing Strategy 2014 -17 was discussed and areas for further clarification and refinement identified. The Board then resolved to agree that the H&WB Strategy Group should further develop the draft strategy, taking on board the Board's comments and views, and bring a final draft strategy to the next meeting of the Board. Since then the H&WB Strategy Group has met twice and the strategy has been finalised. The final draft version of the strategy is in Appendix 1.

3. Implementation

3.1 The approval of the JH&WS 2014 -17 by the Board does not mark the end of the work that is being done on it. Instead, it will signify the start of the development and implementation of the action plans that will enable the three priorities and cross cutting goals to be achieved.

3.2 Further work will be done to identify and engage with named individuals as the lead officers for each of the actions that have been identified. The ongoing role of the H&WB Strategy Group will also need to be revisited as the focus moves from the creation of the strategy to its refinement and operational implementation.

3.3 There may be a role for some Board members to champion work on the three priorities. This would help raise the profile of the work being done, drive local delivery and ensure that strategic links and connections were made and exploited. If this is an approach that the Board is interested in adopting, then further work would need to be done to understand what the role would entail.

3.4 Early work is underway with NCC Customer Service and Communications to explore what ICT solutions may be available to enable progress on the strategy and action plans to be updated on an ongoing basis by those people who are leading on key aspects of the work. This could also involve various fora, notice boards, virtual working groups and a library of resources and toolkits.

3.5 The means by which progress with the implementation of the action plans, and so the strategy itself, will be monitored is being explored. As is the process for understanding the overall impact that the work upon the three priorities has upon the overarching goals or prevention, reducing inequality and promoting integration has started. This will build upon the accountability framework that was agreed by the Board at the meeting of July 2013.

3.6 The intention is to conduct a formal, annual review of the 2014 -17 Joint Health and Wellbeing Strategy in April of each year to coincide with the publication of the annual Director of Public Health for Norfolk Report and the annual refresh of the JSNA. However, it is proposed that the current Strategy group with amended membership would be responsible for steering and

monitoring the Strategy and would provide progress reports to the Board on a more regular basis.

4. Action

4.1 The Board is asked to:

- Approve the content of the 2014/17 Joint Health and Wellbeing Strategy and so endorse the development and implementation of the actions plans that will support the delivery of the priorities in the strategy.
- To approve the Strategy Group as a Steering Group for implementation
- To consider whether there is a role for Board level champions for each of the three priorities in the implementation of the strategy.

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Name	Tel	Email
Lucy Macleod	01603 638407	lucy.macleod@norfolk.gov.uk

IN TRAN communication for all

If you need this Agenda in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Appendix 1

Final draft of the 2014/17 Joint Health and Wellbeing Strategy

Norfolk Joint Health and Wellbeing Strategy

2014 – 2017

The Norfolk Health and Wellbeing Board
Norfolk's Health and Wellbeing Board brings together local organisations – including local councils, clinical commissioning groups (CCGs), voluntary groups and charities – to work in partnership to improve the health of people in Norfolk.

'Working together for a healthier, happier Norfolk'

The Health and Wellbeing Board is responsible for producing the county's **Joint Strategic Needs Assessment** (JSNA – www.norfolkinsight.org.uk/jsna) which describes our current and future health and wellbeing needs.

Findings from the JSNA have helped the Board identify the health priorities it wants to focus on in this **Health and Wellbeing Strategy**. This strategy outlines an agreed way of doing things so that all our partners' work, added together, creates a bigger impact and better outcomes for the people of Norfolk. We believe that by doing this we will see greater improvements in health and wellbeing in the county.

Our strategy
The Norfolk Health and Wellbeing Strategy aims to reduce inequalities in health and wellbeing across Norfolk while improving outcomes for all.

'Everyone in Norfolk living healthy, happier lives for longer'

Our priorities are focused on issues where we think the maximum impact can only be achieved by working together – using practical action to bring about sustainable change.

Our priorities are:

- Promoting the social and emotional wellbeing of pre-school children
- Reducing obesity
- Making Norfolk a better place for people with dementia and their carers

Activity in each of our priorities must also meet the cross-cutting goals of:

- Prevention – providing help and support at an earlier stage before problems become acute
- Reducing inequalities in health and wellbeing

And the best way of addressing these priorities is through:

- Integration – partners working together to provide effective, joined up services

How we agreed our priorities
In identifying and agreeing our priorities, we took account of data from the JSNA http://www.norfolkinsight.org.uk/jsna and the key messages of the Director of Public Health's Annual Report 2013 which were that:

- The impact of an ageing population is a huge challenge to all forms of care, including palliative and end-of-life care.
- Deprivation and inequality are not only a challenge for future services to individuals, they also have a significant impact on service costs

- Finding a way to break the cycle of deprivation is key to health improvement
- More – and coordinated – prevention services are needed to reduce demand for more intensive and costly interventions later on

In developing this Strategy, we are clear that it is not the role of Health and Wellbeing Boards to duplicate work already being carried out by partners. Our Strategy is intended to fit with and complement other major plans, such as the Children's Services' Improvement Plans.

By focusing on a small number of priorities, our aim is for partner organisations to align their own planning and spend to the joint priorities to drive sustainable change. In this way, as the health and wellbeing of Norfolk is reviewed and new priority areas are introduced, the actions which address the current priorities will have become part of the day-to-day activity of partners.

We want to see major change in the county of Norfolk. We are all agreed that rhetoric is not enough and that measurable change must be delivered for which partners – and the Board as a whole – can be held accountable.

More about our priorities

Priority 1 – Promoting the social and emotional wellbeing of pre-school children

Social and emotional wellbeing is important in its own right, but it also provides the basis for future health and life chances. The first years of a child's life are a key influence on their future health, school performance and ultimate employability. Poor social and emotional skills increase the likelihood of anti-social behaviour and mental health problems, substance misuse, teenage pregnancy, poor educational attainment and involvement in criminal activity.

In the most recent Public Health Outcomes Framework, Norfolk is performing significantly worse than the national average for many of the indicators relating to young people including:

- Breastfeeding initiation
- Mothers smoking during pregnancy
- Childhood obesity
- Pupil absence
- First time entrants to the youth justice system
- MMR (Measles, Mumps and Rubella) vaccination

School attainment at all stages is also poorer than the national average. All of these factors are relatively worse in Norfolk's most deprived areas.

Priority 2 – Reducing Obesity

The most recent Active People survey data, presented as part of the Public Health Outcomes Framework, showed that adult obesity rates in Norfolk are higher than the East of England average and the same applies to excess weight in children aged 4-5 and 10-11.

Projections in the 2013 Director of Public Health's Annual Report for Norfolk http://www.norfolkinsight.org.uk/jsna suggest that over the next 25 years in Norfolk, if

trends continue, there will be an additional 50,000 people with diabetes and an additional 9,000 people who will have a stroke due to obesity.
Evidence has shown that obesity is a common risk factor for diabetes, other metabolic diseases, heart disease, stroke, liver disease, many cancers, injuries, arthritis, and depression – causing death and disability, and posing a huge burden to health and social care services.

Severely obese individuals are likely to die on average 11 years earlier than those with a healthy weight, comparable to the reduction in life expectancy caused by smoking.

Obesity is associated with an increased risk of a number of health conditions:

- 10% of all cancer deaths among non-smokers are related to obesity
- The risk of Coronary Artery Disease in obese people increases 3.6 times for each unit increase in BMI (Body Mass Index)
- 85% of high blood pressure is associated with a BMI greater than 25
- The risk of developing type 2 diabetes is about 20 times greater for people who are very obese (BMI over 35), compared to individuals with a BMI of between 18 and 25
- Up to 90% of people who are obese have fatty liver. Non-alcoholic fatty liver disease is projected to be the leading cause of cirrhosis in the next generation.
- The health effects of excess weight are increasingly apparent even in children; the incidence of both type 2 diabetes and non-alcoholic fatty liver disease used to be rare in children, but is now increasing
- Obesity in pregnancy is associated with increased risks of complications for both mother and baby, such as miscarriage, gestational diabetes, thromboembolism, birth defects and stillbirth

With obesity, social stigma and bullying are common and can, in some cases, lead to depression and other mental health conditions.

Priority 3 – Making Norfolk a better place for people with dementia and their carers

Dementia is an isolating, disabling and frequently misunderstood condition. A recent survey of people with dementia carried out by the Alzheimer's Society found that less than half of respondents felt part of their community and they listed a number of activities which they had to give up, often because of a loss of confidence or a fear of becoming lost or confused. Many felt unable to go out or try new things and most felt unable to contribute to their community. Dementia Friends campaign has cited that many people with dementia end up losing their friends, because of ignorance/lack of awareness/understanding. This means their networks of support are diminished, or disappear completely, which adds to their isolation and lack of confidence.

The prevalence of dementia is rising both nationally and in Norfolk. Dementia is principally a disease of older people and Norfolk has a higher proportion of people over 65 than the England average. It is estimated that nearly two thirds of people with dementia in Norfolk have not had a formal diagnosis of their condition and that over the next ten years the number of people with dementia will increase by about 5,000.

On average, people currently wait up to three years before reporting symptoms of dementia to their doctor and most carers report that they are unaware of the symptoms

before diagnosis. It is recognised that many carers are in denial about their relative having the illness and over half believe the symptoms to be just part of ageing.

Nationally it is estimated that:

- Four in five people in residential care have dementia
- Two in three people with dementia live in the community
- One in three acute in-patients have dementia
- One in four Home Care Staff lack knowledge or skills on dementia
- Only a third of GPs believe they have received sufficient basic and post qualification training to diagnose and manage dementia.

There is no certain way to prevent all types of dementia. However, a healthy lifestyle can help lower the risk of developing dementia when people are older.

To reduce the risk of developing dementia, it is recommended to:

- eat a healthy diet
- maintain a healthy weight
- exercise regularly
- not drink too much alcohol
- stop smoking (if you smoke)
- make sure you keep blood pressure at a healthy level
- reduce salt in the diet

Developing the Strategy

In a county the size of Norfolk, with a complexity of administrative structures, one approach to delivering positive health and wellbeing outcomes clearly cannot be adopted by all partners. As a result, this Strategy does not start from a 'zero base' and the ways in which partners contribute to the overall outcomes will vary according to local circumstances, local need and what is already in place. The aim is, however, that outcomes will be measured in the same way across the county and that any variation in outcome should be solely on the basis of need – not through lack of services or support.

Some issues such as mental health and support for carers and their health and wellbeing, thread through the three priorities and these cross-cutting issues will be picked up under each priority.

The actions in the Strategy are drawn, in the case of the priorities relating to children and obesity, from the national evidence base – the Marmot Review, the National Obesity Observatory and the NICE Guidelines and in the case of dementia, from extensive consultation with service users, families and carers. In most cases the planned actions are high level and require a level of detail sitting beneath them. Action plans and timetables will be linked to each priority. To make it clear how these actions relate to our cross-cutting goals, we have colour coded them (green for prevention, peach for integration and blue for reducing inequalities).

Equality Impact Assessments will be carried out if there is a likelihood of an adverse impact on people with protected characteristics as defined under the Public Sector Equality Duty, for each of the underpinning action plans.

Sharing Best Practice
Although we are very clear that the Board wishes to deliver change and we do not wish to see existing activity rebadged, there are projects underway throughout the county which are related to the priority areas and which are looking to do things differently. As far as possible these will be monitored and reported to the Board to provide an indication of what works or doesn't work, to inform activity elsewhere.

Monitoring the Strategy
The Strategy will be monitored on two levels: activity and outcomes. Once action plans have been developed, progress will be reported to the Board and will be published online. In addition, a range of key countywide outcome indicators will be developed for each priority which will be reported on at appropriate intervals.

Promoting the social and emotional wellbeing of pre-school children	
Examples of how to measure the impact of the strategy ☐ Foundation Stage Attainment ☐ Child and Adolescent Mental Health Services Referrals ☐ A&E data – accidents – emergency admissions ☐ Domestic Abuse Stats – Police data ☐ Public Health Drug and Alcohol Data ☐ Reception Year Childhood Obesity Data ☐ Breast feeding initiation and prevalence at 6-8 weeks ☐ Mothers smoking during pregnancy ☐ MMR vaccination	
Give every child the best start in life	**Action driven by**
1. Improve the promotion of and opportunities for breastfeeding, healthier diets, physical activity and tooth brushing in preschool children. *Action Plan* 2. Promote programmes which support parents and particularly fathers in vulnerable groups such as young fathers, war veterans and offenders. *Action plan*	**NHS England** **NCC Children's Services**
3. Develop arrangements for integrated commissioning of universal and targeted services for children aged under 5. This includes services offered by general practice, maternity, health visiting, school nursing and all early years providers. The aim is to ensure: • vulnerable children at risk of developing (or who are already showing signs of) social and emotional and behavioural problems are identified as early as possible by universal children and family services • targeted, evidence-based and structured interventions are available to help vulnerable children and their families – these should be monitored against outcomes	**NHS England**

• children and families with multiple needs have access to specialist services, including child safeguarding and mental health services. *Action Plan*	
4. Ensure the social and emotional wellbeing of under-5s is assessed as part of the JSNA. *Action plan* 5. Support and encourage development of parental and child literacy including supporting 'Raising Readers'. *Action plan*	**NCC Public Health** **NCC Children's Services**
Improving mental health 6. Ensure that maternal mental health is assessed and any issues identified are addressed at an early stage. *Action Plan*	**NHS England**
Ending domestic abuse 7. Promote early intervention with potential perpetrators and victims of domestic abuse and coordinate identification of abuse and referral training across partner organisations. *Action Plan* 8. Develop and pilot a single programme which addresses empowerment and self-esteem in relation to domestic abuse, relationships and risk taking behaviour in teenagers *Action Plan*	**DASVB** **NCC Children's services**
Minimising harm caused by substance misuse 9. Improve contact between substance misusing parents and treatment services. *Action Plan*	**NDAP**
Keeping children safe in the home 10. Promote projects addressing child safety in the home. *Action Plan*	**District Councils**
Demonstrator Project: Early Help – Diss and Nelson, Great Yarmouth	

Reducing the Prevalence of Obesity
Examples of how to measure the impact of the strategy
☐ Childhood obesity measures

☐ Access to open spaces ☐ Local authority planning data regarding fast food outlets ☐ Active travel data ☐ Healthy schools registration ☐ Active people survey – self reported weight ☐ Health Trainer records ☐ NHS Healthcheck data ☐ GP data	
Build an integrated approach to obesity	**Action driven by**
1. Develop a comprehensive countywide obesity strategy. *Action Plan* 2. Put in place an individual to co-ordinate activity on obesity *Action Plan*	**NCC Public Health**
3. Undertake engagement activity to better understand perceptions of obesity in high prevalence areas and what messages and services will be effective. *Action Plan* 4. Agree a local "obesity branding" such as Change4Life which enables partners to have shared vision, speak with 'a common voice' and be clearly identifiable to the community. *Action Plan*	**NCC Public Health**
5. Ensure elected members and all management and staff working with local communities, both within and across partner organisations, are aware of the importance of preventing and managing obesity and that they advocate for action on obesity. *Action Plan*	**nomination**
Create a healthier physical environment	
6. Work with local businesses and partners to increase access to healthy food choices *Action Plan* 7. Make the most of the potential for the planning system to create a healthier built environment.	**NCC ETD District Council Housing Leads**

Action Plan	
8. Work with registered social landlords to implement the practical action plan led by the Design Council and the National Housing Federation, which sets out ten priorities for change to provide more opportunities for people of all ages to be more active and enjoy the space outside their homes. *Action Plan*	**District Council Housing Leads**
Promote behaviour change	
9. Make the most of key opportunities to engage with communities and promote behaviour change. *Action Plan*	**NCC Public Health**
10. Provide ongoing training and awareness raising to combat prejudice and discrimination against obese people in the workplace. *Action Plan*	**nomination**

Improved Quality of Life for People with Dementia and their Carers

Key outcomes for this strategic priority are mostly qualitative. Measures identified in the Better Care Fund programme will also be used to demonstrate the impact of this strategy.

People with Dementia:

- ☐ are diagnosed early
- ☐ can enjoy their life
- ☐ get right advice and information
- ☐ can make decisions about their future
- ☐ get the right treatment and support
- ☐ are treated with dignity and respect
- ☐ feel part of the community
- ☐ have carers who are well supported
- ☐ know their end of life wishes are respected

Build an integrated approach to dementia	**Action driven by**
1. Ensure that a comprehensive needs assessment is included in the Joint Strategic Needs Assessment (JSNA) and informs this full strategic plan. *Action Plan* 2. Ensure that the needs of hard to reach groups, such as homeless people, BME groups, people who are socially or geographically isolated, are recognised and addressed. A review of transport will assess how older people and their carers access health and wellbeing services including services within GP practices. *Action Plan*	To follow
3. Encourage and support multi-disciplinary working across clinical and organisational boundaries to ensure people are not inappropriately admitted to acute hospitals and to enable timely discharge from acute hospitals. *Action Plan* 4.Evaluate new services including measures of satisfaction of the older people with dementia and their	

carers who receive the services (monitor outcomes not just outputs) and, if effective, fund long-term. *Action Plan*	
Promote awareness of dementia	
5. Improve the awareness and understanding of dementia. *Action Plan* 6. Promote and support dementia friendly communities. *Action Plan*	To follow
7. Ensure the public, independent and voluntary sector workforce supporting older people are required to have appropriate levels of dementia training. *Action Plan*	
Improve the managed dementia care pathway	
8. People with dementia and their carers must be included from the start and through the whole process to implementation and monitoring (co-production). *Action Plan* 9. Improve the rate of timely diagnosis of dementia and provide information and support in GP practices. The 'family GP' model is the best for patient- centred care. *Action Plan*	To follow
10. Improve post diagnosis support and ensure continuity of care through a care manager approach so that relevant agencies co-ordinate support for older people with dementia and their carers from diagnosis until the end of life. *Action Plan* 11. Ensure appropriate support is available in the community post diagnosis, both professional support e.g. Admiral Nurses and in the community, e.g. Pabulum Cafés, aids and adaptations, assistive technology. *Action Plan* 12. All acute hospitals must have a dementia strategy, a dementia lead and have an holistic view of the care of people with dementia and other long term conditions, and coordinate treatment provided by different specialists. *Action Plan* 13. Develop and agree a specific end of life approach for people with dementia and their carers. *Action Plan*	

Support independent living in the community	
14. Establish sustainable low level generic preventative services which help all older people to remain living independently, including information, advice and advocacy. *Action Plan*	To follow
15. Identify and assess the ongoing health and wellbeing needs of carers of people with dementia and encourage and enable carers, including older carers, to recognise they are carers. *Action Plan*	
16. Identify in local development plans how homes for meeting the aspirations and needs of older people, including those with dementia and their carers, can be provided, and ensure the provision of housing information and advice. *Action Plan* 17. Improve the take-up of attendance allowance and other benefits *Action Plan*	
Improve services for those unable to live independently	
18. Improve quality of care for those unable to maintain independent living. *Action Plan* 19. Ensure residential care and nursing homes have the highest quality of care for their residents *Action Plan*	To follow

Report to Norfolk Health and Wellbeing Board
6 May 2014
Item 6

Clinical Commissioning Groups: 2 year operational plans 2014-16

What is the role of the HWBB in relation to this paper?

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a:

- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it

Key questions for discussion

Q.1 How do the CCGs' 2-year operational plans relate to the overarching goals and priorities in the Joint Health and Wellbeing Strategy 2014-17?

Q.2 What will be the overall contribution towards delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17?

Q.3 What are the risks in delivering these plans and how can they best be mitigated? (Eg failure to achieve ambitions, cutting services rather than transforming, changing public expectations, challenge to difficult decisions, ending up with inequity)

Q.4 What is the Board's role in helping to drive forward improvements identified locally?

Actions/Decisions needed

The Board is asked to:

- Note the CCGs operational plans for 2014 to 2016
- Consider the engagement/alignment with and contribution towards delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17
- Consider its role in helping to drive forward the improvements identified locally

Clinical Commissioning Groups: 2 year operational plans 2014-16

Report by Norfolk's Clinical Commissioning Groups

Summary

This report provides the Norfolk's Clinical Commissioning Groups (CCGs) operational plans for the period 2014 to 2016. It brings together the plans prepared by each of the CCGs and submitted to NHS England as part of this year's annual planning process.

Action

The Board is asked to:

- Note the CCGs Operational Plans for 2014/15 to 2015/16
- Consider the engagement/alignment with and contribution towards delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17
- Consider its role in helping to drive forward the improvements identified

1. Background

1.1 At its meeting in July 2013, the Health & Wellbeing Board received the 2013/14 commissioning plans for each of Norfolk's CCGs. Members considered the extent to which they were aligned with the priorities in the Joint Health and Wellbeing Strategy and how they were contributing to delivery of those priorities.

1.2 In the course of that discussion it was agreed that in future this engagement should take place at an earlier stage in the Board's annual programme of work - ideally before the CCGs' plans were formally approved - and this was noted in the Boards' forward work programme.

1.3 As part of this year's annual planning round, in accordance with national guidance, all CCGs were asked to submit a 2-year operational plan to NHS England by 4 April 2014. In addition, all CCGs were asked to submit a draft 5-year strategic plan and, for the purposes of that plan, to confirm their strategic planning 'unit'.

2. This years' annual planning & CCG's 2 year plans

2.1 At its meeting in January 2014, the Board considered the CCGs' commissioning intentions for 2014/15 and the following points were noted:

- The contribution to addressing health inequalities was being picked up through an emphasis on the prevention agenda
- There were opportunities for integration around children's issues, starting perhaps with mapping GP practices around Children's Services clusters
- End of Life care and Bereavement Care was an important issue and needed a greater focus
- It would be useful for the Board to have a way of arriving at a collective view about the overarching risks in the system and about the challenges that faced
- That the CCGs 2-year plans were being developed and they should be brought to the next meeting of the Board.

2.2 At its January meeting, the Health & Wellbeing Board also received a paper setting out the arrangements for the Better Care Fund (BCF), a new initiative which requires the creation of a pooled budget for the commissioning of health and social care services. The BCF initiative serves to act as a catalyst for whole system improvement and forms part of the wider NHS planning arrangements – ie the 2 year operational plan and a 5 year strategic plan which each CCG is required to produce.

2.3 On 1 April, at an additional meeting set up for the purposes, the Health & Wellbeing Board approved the Norfolk Better Care Fund Plan in time for its submission to NHS England by the 4 April 2014 deadline.

2.4 For the purposes of today's discussion, the CCGs were invited to submit their 2- year Operational Plans for 2014 to 2016 and these are attached in the appendices as follows:

- North Norfolk CCG – Appendix A
- South Norfolk CCG – Appendix B
- Great Yarmouth & Waveney CCG – Appendix C
- West Norfolk CCG - Appendix D
- Norwich CCG – Appendix E

3. Action

3.1 The Board is asked to:

- Note the information provided by the CCGs
- Consider the engagement/alignment with and contribution towards delivering the priorities of the Joint Health and Wellbeing Strategy 2014-17
- Consider its role in helping to drive forward the improvements identified locally

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IN TRAN communication for all

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NHS
North Norfolk
Clinical Commissioning Group

NNCCG Strategic Vision, Operational Plan and Financial Plan

2014/15 to 2015/16

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1. The Vision for Health and Care in North Norfolk by 2019

1.1 The Start Point

People in North Norfolk and rural parts of Broadland, by most published indicators, enjoy better health outcomes and access to health and care services than many other places in England. Residents currently receive good quality primary care in-hours and an adequate community and social care, as evidenced by current unplanned admission rates, patient survey results, and other indicators.

- Life expectancy is higher than the national average (80.4/78.9 males; 85.1/82.9 females);

- Deaths from the most common causes such as cardiovascular disease, and cancer, for people aged under 75, are amongst the lowest 25% in England;

- Overall satisfaction with GP services is high, with 89% reporting that the overall experience of their GP surgery was ‘very / fairly good’

Feedback on services provided by the local hospital, Norfolk and Norwich University Hospitals Foundation Trust (NNUH FT), is generally positive though time pressures in unplanned care cause delays.

The overall Friends and Family Test score was 68 (year to date average) which is higher than the average score of 64 for the whole of England.

Over the past year there have been significant failings in Ambulance Response times in North Norfolk with many people waiting too long for an emergency response or transport to hospital.

Mental Health services in Norfolk are undergoing a significant change. We know that over the past year some people have had to wait too long for an assessment, a small number of patients have to travel outside of Norfolk for inpatient care, and patients and professionals complain of a lack of timely and effective communication from Norfolk and Suffolk Foundation Trust (NSFT).

However, possibly the greatest weakness for services in the CCG area, and one which patients consistently tell us is their main concern, is that services are fundamentally fragmented; between health and social care, between primary and secondary care, between care homes and the NHS, and between public and voluntary sector services. This issue is heightened at weekends and at night.

The CCG recognises the importance of developing a strong clinical quality and safety ethos with a clear focus on clinical leadership and embedding quality and patient insight in the commissioning and contracting process. This is a key focus for the CCG as we strive to further improve the quality of services provided for North Norfolk patients and will remain a key driver in the coming years.

Further public health information on the CCG area is available within the North Norfolk CCG Commissioning Strategy 2012-2016, available at http://www.northnorfolkccg.nhs.uk/public-information

Why does there need to be change?
Despite the many strengths of the current pattern of service, it is unsustainable over the next 5 years.

- Our patients and their carers have told us that some aspects of care needs to change to improve their outcomes.
- North Norfolk has the oldest population of any CCG in England. We know that people's use of NHS and social care services increases markedly in later life and this will overwhelm the current system unless we change it.

- Norfolk is fortunate in having a stable and highly skilled workforce; however a combination of North Norfolk's geography and national trends in recruitment mean that it is highly unlikely that additional numbers of GPs and qualified nurses will be available. It will be a challenge to maintain current levels.

- Drug and other technologies in healthcare are changing rapidly; this can both improve outcomes and access for patients, but also increase cost.

- Unless there is a major shift in national economic outlook and investment in public services, the current pattern of services will prove unaffordable very quickly, possibly within 2 years. The historical pattern of making relatively small incremental savings through efficiency will not be enough. The Local Authority budget, for social care in particular, is facing a significant reduction.

- In the face of making significant changes to meet challenges it is imperative we learn from nationally identified failures around the delivery of safe, high quality care, and ensure that within North Norfolk quality underpins our change management processes. Through clinical leadership and contractual levers we will aim to improve the standards of care currently received by our patients.

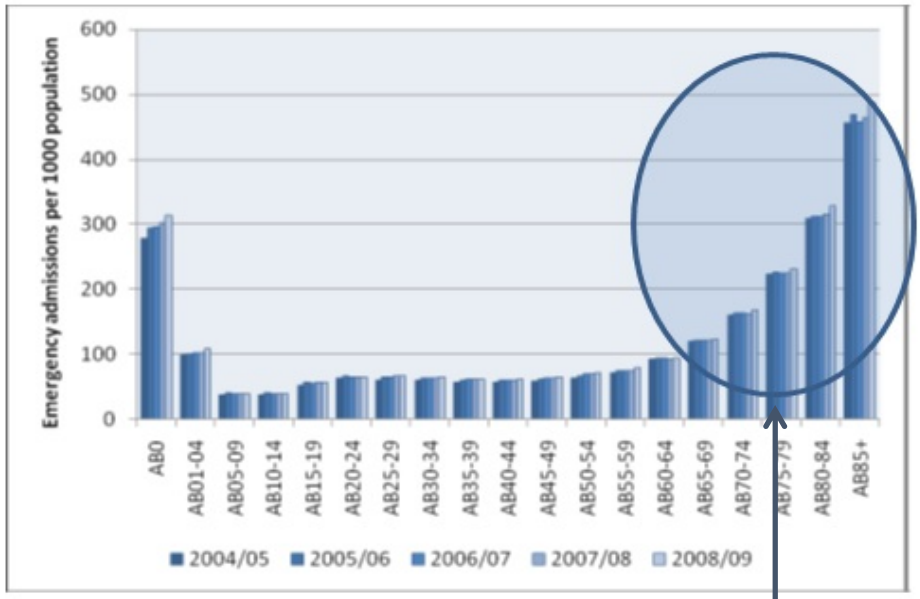
Demographic data: % of Population age 60 - 69 (2012)

Demographic data: % of Population age 70 - 79 (2012)

Demographic data: % of Population age 80+ (2012)

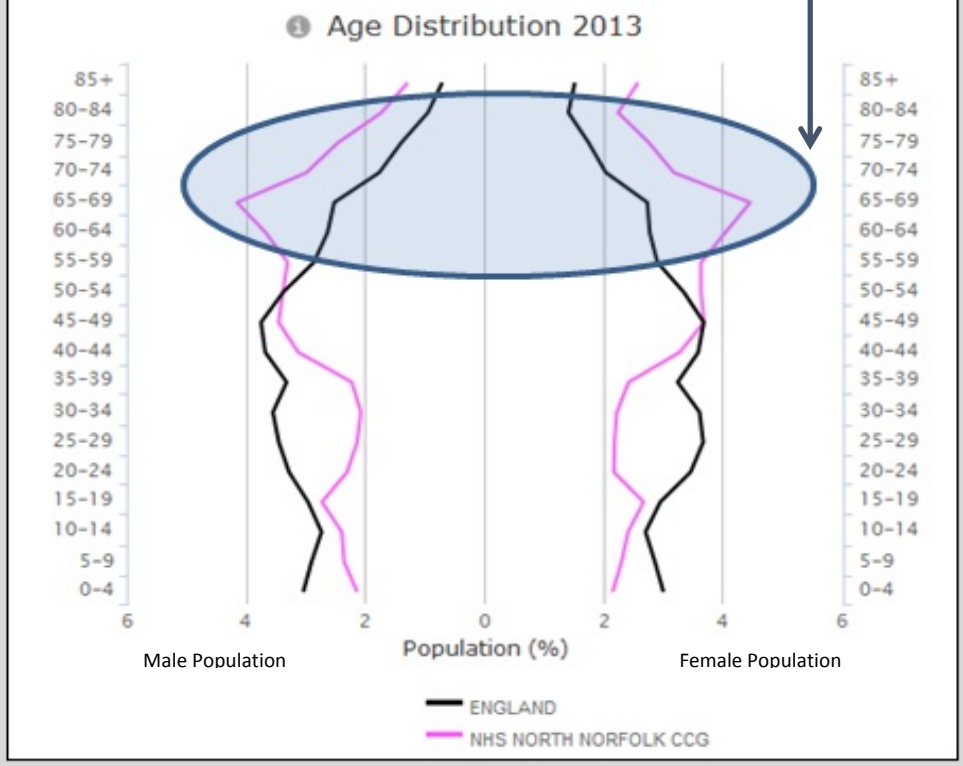
Source: NHS England, CCG Outcomes Tool - http://ccgtools.england.nhs.uk/ccgoutcomes/flash/atlas.html

Rate of emergency admissions by age band (England)



Source: The Nuffield Trust, Trends in Emergency Admissions in England 2004 - 2009

Public Health England, National General Practice Profiles

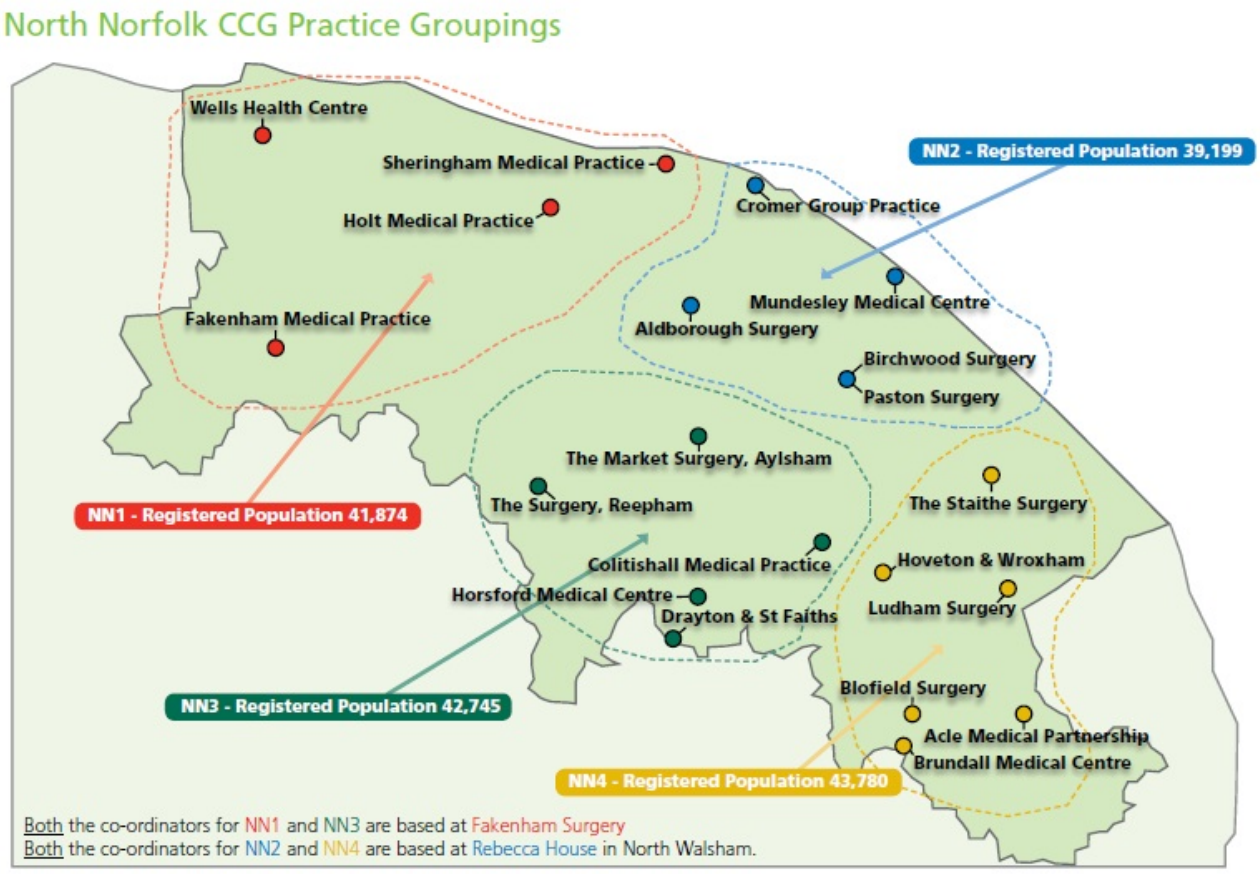


In order to plan for a sustainable model of health and care in North Norfolk, the CCG, local people, and colleagues in Norfolk County Council and North Norfolk and Broadland District Councils have been developing a plan for how services will look by 2019. The "Better Care Fund" which is essentially a pot of joint NHS and Local Authority resources will be used to commission services across agencies for the benefit of local people. This initiative, along with other plans to improve quality, innovation, productivity and prevention (QIPP) will help address the imbalance between resources and need. Much of the plan will be familiar from the CCG's existing Commissioning Strategy 2012-16, published last year.

1.2 The End Point

By 2019 people in North Norfolk will experience:

- The operation of a fully integrated primary, community and care team around 4 hubs comprising community nursing/therapy, mental health professionals with expertise in dementia, social care assessment and case management, reablement and rapid response services (currently known as Norfolk First Response, Swifts/Night Owls). Building on the current strength of in-hours primary care, General Practices will continue as the cornerstone of delivering high quality, locally accessible care for people living in relatively isolated communities at a distance from the many services in Norwich.



The focus for these teams will be people with one or more long term conditions, such as diabetes, obesity, dementia and COPD. The teams will primarily, but not exclusively, support older people who are identified through Risk Stratification tools as being at risk of significant exacerbation of their condition without intervention.

General Practices will be at the core of these teams with patients and professionals having only one dedicated number to call to turn on a package of care, regardless of the time of day or night. The teams will have ready access to GP input, and GPs in turn be able to seek advice where necessary from secondary care specialists, especially Consultants in medicine for the elderly, and psychiatry of old age. Designated GPs will be available in the evenings and at weekends to offer telephone advice/support for patients at risk of an exacerbation of their condition.

All patients deemed to be at risk will have clear care plans for how they would wish to manage their care. These will be owned by the patient and their carers, and be accessible via mobile devices to all relevant professionals, and end of life plans.

The 4 hub teams will have a comprehensive range of interventions available to them, which do not require the permission of anyone beyond the team to authorise:

- Domiciliary care support;
- Integrated rapid response care in the home comprising nursing, therapy and reablement workers;
- Deployment of volunteer support to people with limited or no other social support;
- Integrated post discharge/reablement support in the home;
- A range of housing options including home adaptions through to placement in housing with care and other supported living options;
- On-going medical/nursing/therapy support to people in their homes for people with Long Term Conditions, and at the end of life;
- Readily accessible support for carers;
- A range of high quality placement options available in care homes, and community hospitals which are easily accessible, and offer specialist packages of care including end of life care, on both an admitted and day basis;
- Use of digital technologies to improve access to diagnostic results and specialist opinion from secondary care; and
- Admission to high quality acute assessment and treatment at;
    - Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH);
    - Queen Elizabeth Hospital Kings Lynn (QEH)
    - James Paget University Hospital Foundation Trust (JPUH FT).

By developing our integrated services in this way we believe that we can achieve more effective outcomes, placing patients at the centre of decision making in partnership with their key workers in line with the national guidance on “Transforming Participation in Health and Care”. By building on the capacity and skills of the integrated team we will develop systems to monitor and measure patient experience and quality outcomes that cuts across organisational and professional boundaries,

thereby establishing a more cohesive culture of quality, safety and patient satisfaction. The nature of integration lends itself to provide better, supportive services for the most vulnerable within our community.

When patients have to be admitted into acute care the hub team will continue to track the patients' progress and agree with the hospital clinicians discharge plans which are capable of being actioned 7 days of the week.

- The services will **not just be about treatment and crisis management**. North Norfolk retains a strong sense of community and many people want to support people living in their community in times of need. The CCG will have commissioned the recruitment of an army of volunteers who will support, befriend, and advocate for older people without family and other support. These volunteers will be trained to become experts in how to access the care system effectively and the range of services available to people beyond health and social care. The volunteers will also be able to advise and support the many people who care for people living in the community. These volunteers will glue together the communities in North Norfolk, and build on the growing role of GP Practice based Patient Participation Groups.

- **To identify people with care needs pro-actively** and reduce incidence of acute crises, everyone at the age of 75 will receive a home based health check from a trained volunteer, based on similar arrangements in Scandinavia.

- **The 111 service will continue to be the hub of the care system out of hours**, and increasingly in-hours, for the general population and these people falling into crisis outside of the at risk population known to the Integrated Care teams. It will be fully integrated 7 days a week with 999, Out of Hours (OOH) primary care, mental health, and social care emergency teams, and have strong links with the

local integrated teams to mobilise community and social care responses out of hours. Ready access to real time data about people's care needs will be essential to the effective management of people's care and to allow the at risk population to be fast tracked into appropriate care.

- **A robust and locally sensitive Directory of Services** will enable 111 call handlers to direct people to the right care setting including pharmacies, Walk-in Centres and Minor Injury Units. Everyone will be able to access real-time information on unplanned care services via Apps available on mobile devices. This will protect major hospital emergency departments from presentations which could be dealt with elsewhere. By 2019, our vision is that access to A&E will only be on the basis of either an ambulance transport via a 999 call or having been booked an appointment via the 111 service.

- The area will be supported by a **high quality 999 emergency ambulance service** that delivers the best possible response times in the context of a dispersed population and a poor road network. Where the time taken to transfer to hospital compromises clinical outcomes, we will have explored and implemented alternative pathways for delivering rapid acute interventions where possible.

- Given the constraints on workforce and finance, the CCG believe that the current model of **OOH Primary Care will need to change**. Access to GPs for the general population will be limited to a small number of centres which patients will have to travel to. Increasing use of digital face to face technologies will for some people eliminate the need for travel. The CCG will commission transport for people who cannot travel independently to the OOH Primary Care centre. Nurse Practitioners and Paramedics will play a key role in delivering walk-in services supported by GPs where appropriate. Home visits during out of hours will be limited to those people are truly housebound. GP input out of hours will have shifted in focus to the at risk population, with better and more accessible care plans developed with patients, available 24/7 to reduce the risk of unplanned admissions to hospital.

- **Access to mental health services** will have been made simpler with better stratification between the management of common disorders such as depression and anxiety and more complex mental health disorders. GPs will be able to offer people a choice of services following assessment including access to psychological therapies, in a way which is relevant and acceptable to a largely older population.

- **The diagnosis rate for dementia** will be amongst the best in the country and once diagnosed patients and their families will be able to access timely treatment where relevant, and a range of support and advice from trained staff.

- The standards of **End of Life Care will be of a consistently high quality** whether it is delivered by a GP practice, a care home, hospital or community service. All providers will be expected to have achieved relevant standards of excellence. The CCG is working with partners across the health and social care system to exploit the opportunities to raise public funds to boost NHS and local

authority funding in this area. One of the community hospitals in North Norfolk will be a designated centre of excellence for end of life care, working as a spoke service to the specialist unit at Priscilla Bacon Lodge in Norwich.

- NNCCG will continue to work closely with clinicians across both primary and secondary care to ensure elective patient pathways are appropriate and the care they receive is of a high quality. We will actively target unwarranted variation and we will ensure that, where possible and clinically appropriate, services will be offered locally.

1.3 NHS Constitution

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it. **The NHS Constitution**[1] establishes the **principles** and **values** of the NHS in England. It sets out **rights** to which patients, public and staff are entitled, and **pledges** which the NHS is committed to achieve, together with **responsibilities** which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Under the Constitution patient's rights and privileges include the delivery of:

- Maximum of 18 weeks from referral to treatment;
- Maximum 6 weeks wait for diagnostic tests from referral;
- Cancer waits for referral and treatment;
- Patient admission, transfer or discharge within 4 hours from arrival in A&E;
- Ambulance response times.

NNCCG embraces these rights and pledges within its Operational Plan and sets out its plans to commission sufficient services to ensure it can deliver those rights and pledges for patients on access to treatment.

Mandated in the Standard NHS Contract[2] is the requirement for the provider to comply with the NHS Constitution. This is set out in Service Condition No 1, and stipulates that the Parties must abide by and promote awareness of the NHS Constitution, including the rights and pledges set out in it. The Provider must ensure that all Sub-Contractors and all Staff abide by the NHS Constitution.
Specifically, set out in the Particulars, within the Quality Requirements (QR) is:

- The requirement for patients to start consultant-led non- emergency treatment within a maximum of 18 weeks of a GP referral. The provider is also required to take all reasonable steps to offer a range of alternatives if this is not possible
- The requirement for patients to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected;

[1] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

[2] http://www.england.nhs.uk/nhs-standard-contract/

As well as the lever to apply financial consequence for failing to meet the mandated Operational Thresholds, there are supportive local Thresholds to hold Providers to account. These include sanctions that can be applied if planned operations are cancelled if escalation is required under General Condition 9 of the Contract, the Provider is required to agree a Remedial Action Plan, and actions will be set out to ensure remedy accommodating demand and peaks in activity.

2. Improving outcomes for local people

NHS England's publication "Everyone Counts: Planning for Patients 2014/15 to 2018/19" sets out the better outcomes for people as defined in the NHS Operating Framework. This focusses on:

- **preventing people from dying prematurely**, with an increase in life expectancy for all sections of society;
- making sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**;
- ensuring patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury;
- ensuring patients have a **greater experience** of all their care; and
- ensuring that patients in our care are **kept safe** and protected from all avoidable harm

These outcomes have been translated into **seven specific, measurable ambitions**, or critical indicators of success, against which the CCG will aim to achieve significant improvement.

- Securing additional years of life for people with treatable mental and physical health conditions;
- Improving health-related quality of life for people with Long Term Conditions, including Mental Health;
- Reducing the amount of time people spend in hospital by having better more integrated care in community;
- Increasing proportion of older people living at home independently following discharge from hospital;
- Increasing the number of people with physical and Mental Health conditions who have a positive experience of hospital care;
- Increasing the number of people with a positive experience of care outside of hospital, in General Practice and in the community; and
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

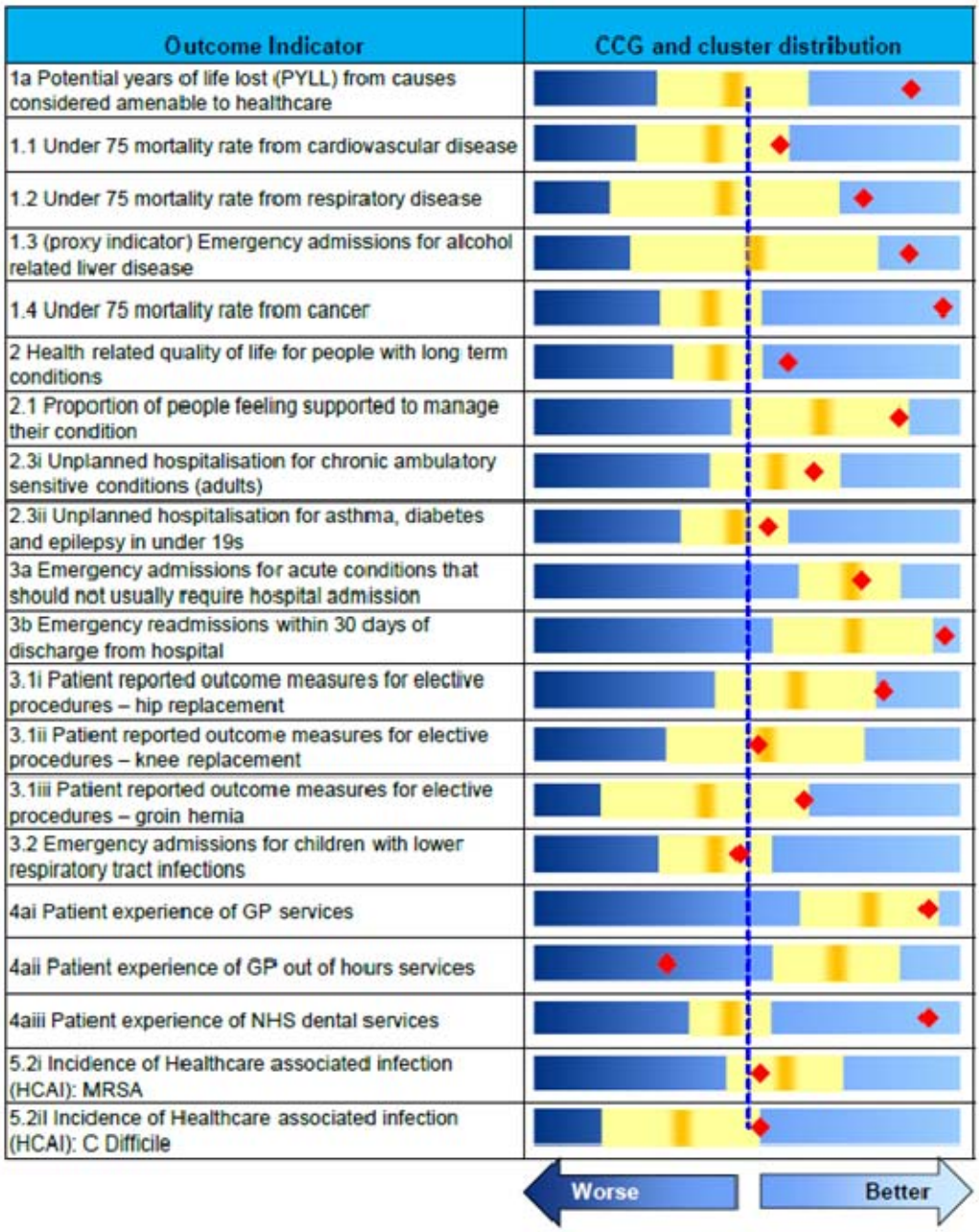
Additionally, NHS England has identified **three more key measures** where there is an expectation of significant focus and rapid improvement:

- Improving health - through promoting healthy environment and lifestyles;
- Reducing health inequalities - between communities and within communities; and
- Moving towards parity of esteem, ensuring an equal focus of improving mental health and physical health.

2.1 Delivering the NHS Outcomes Framework

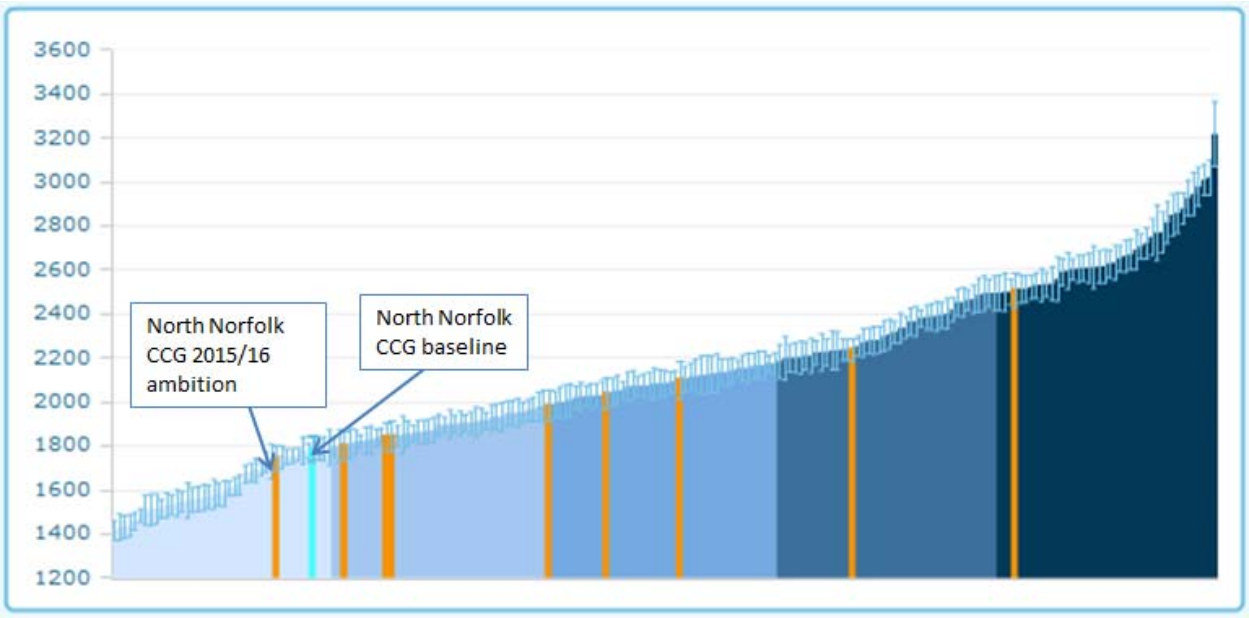
The North Norfolk CCG's current position across the domains of the NHS Outcomes Framework is shown below. Whilst the CCG performs better than the national average in all but two of the measures, we will continue to strive for improvements in all areas.

Having conducted an in depth review of current performance against the key outcome measures, which included a comparative assessment of the CCG's performance at a national level as well a direct comparison with our 10 most similar CCGs, we have set ourselves ambitious targets for improvement. Further detail of how we will achieve this level of improvement is given in the 'Operational Plans for 2014-2016' section.



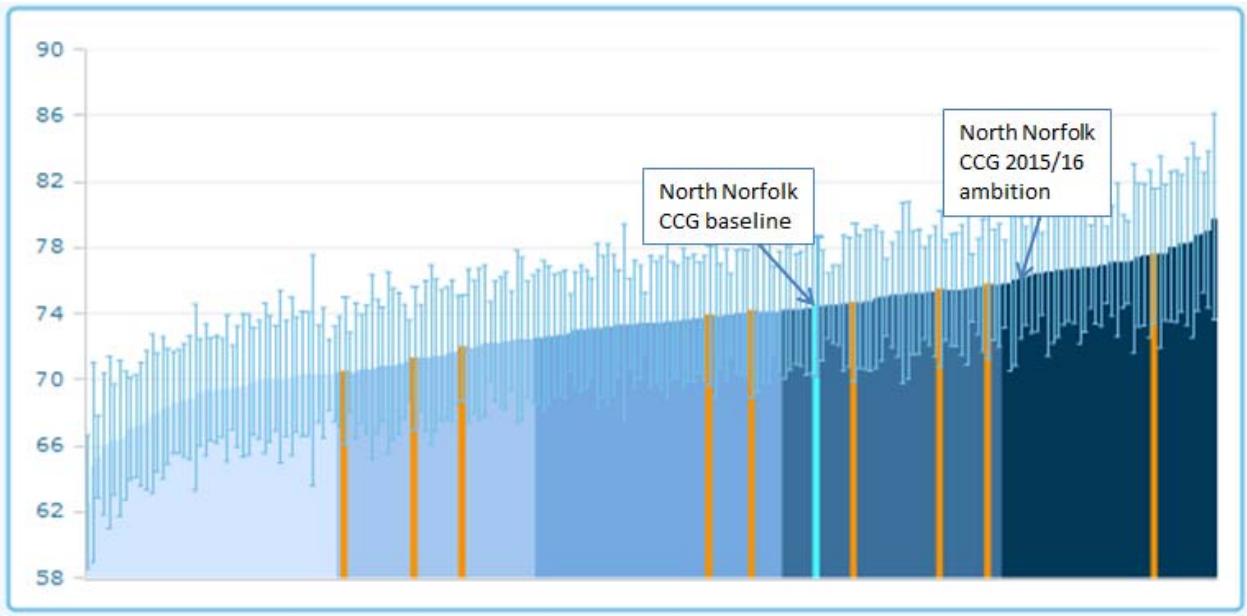
When setting our level of ambition the CCG paid particular attention to local demographic changes and forecast financial pressures on NHS budgets. The following charts indicate our current position when compared to other CCGs, with the yellow lines indicating the 10 CCGs most similar to us.

***Outcome 1*:** Secure additional years of life for people with treatable mental and physical health conditions:



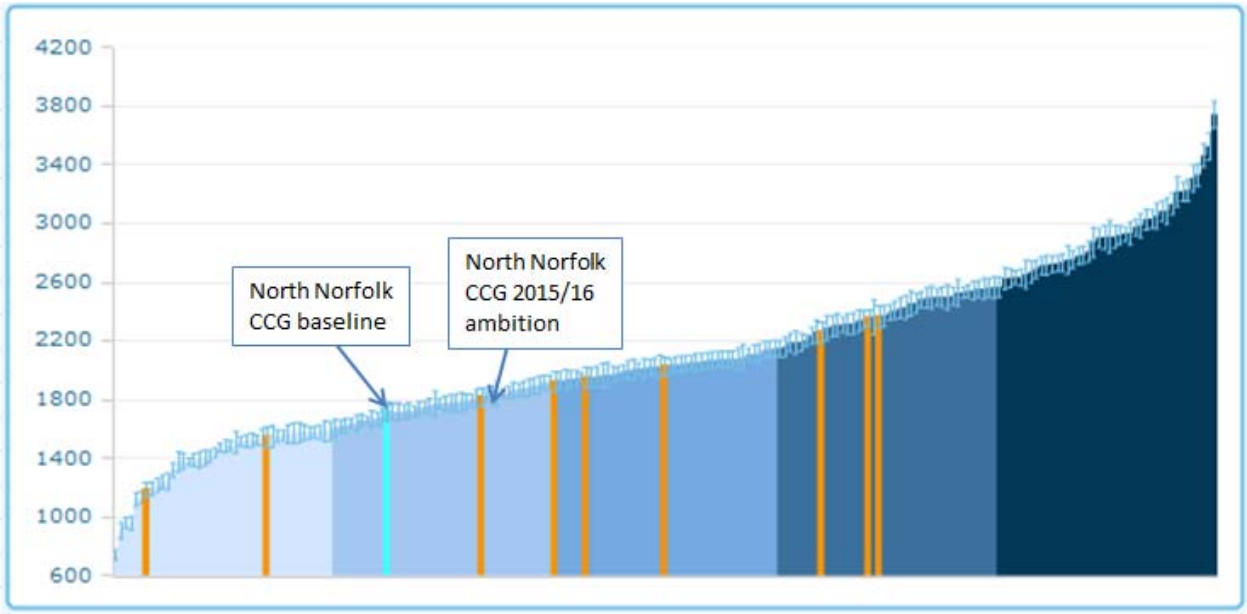
The CCG is committed to increasing additional years of life for local people. This will be measured through a reduction in potential years of life lost from causes considered amenable to healthcare i.e. those causes from which premature death should not occur in the presence of timely and effective healthcare (generally relating to deaths in those aged under 75). The CCG already performs significantly better than the majority of CCGs in England, however we have committed to increase this still further.

***Outcome 2*:** Improving health-related quality of life for people with Long Term Conditions, including Mental Health:



Increasing the quality of life for those people with long-term conditions is a top priority for the CCG and is at the heart of our Integrated Care work. Performance is measured through the national GP Patient Survey, based on the numbers of patients reporting that they have a long term condition, together with indicators around the quality of life for such patients. Whilst the CCG performance in this area is above the England average, we are striving to make significant improvements in this area.

***Outcome 3*:** Reducing the amount of time that people spend in hospital by having better more integrated care in community:



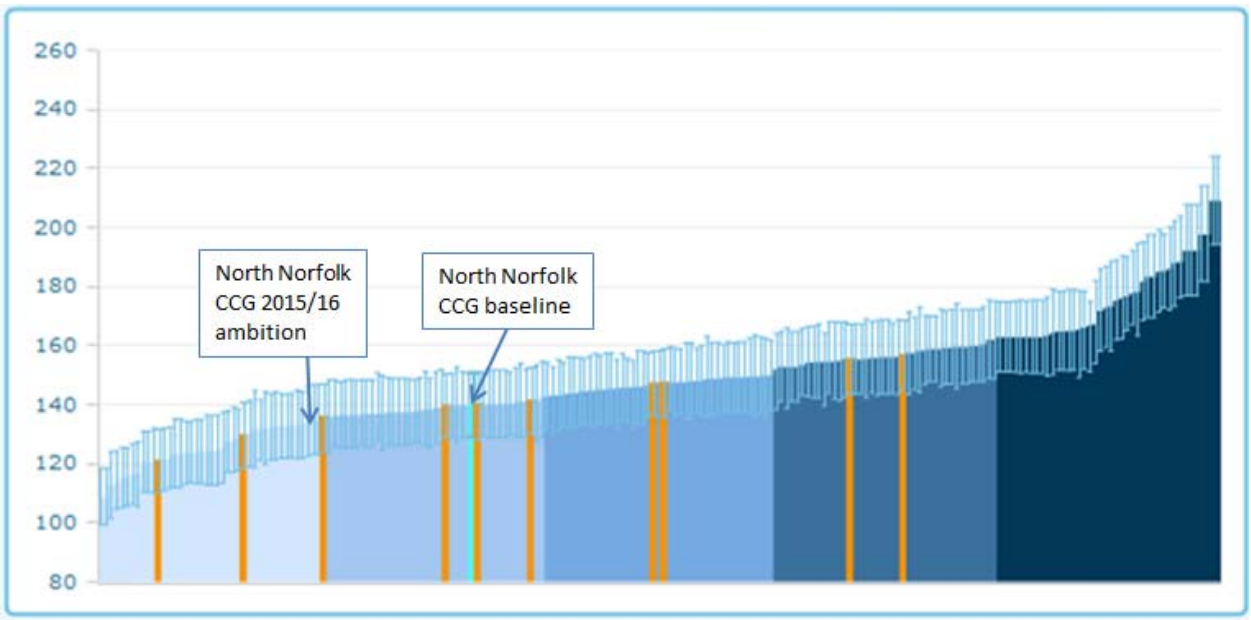
The CCG recognises that in order to help reducing the amount of time people spend in hospital, a comprehensive system wide approach across health and care should be in place in order to tackle this issue. This links to our Integrated Care work and focusses on both physical and mental health. The CCG believe that if we are to make a significant impact in this area we must be bold and innovative and we must work closely with providers to ensure that the level of change required in order to deliver the level of performance identified.

It should be noted that the avoidable emergency admissions indicator (E.A.4) requires a baseline figure from the Levels of Ambition Atlas to be entered. However, the baseline figure from the Levels of Ambition Atlas is generated from 2012/13 data and analysis of emergency admissions for North Norfolk CCG has shown that admissions have increased by approximately 7% during 2013/14. North Norfolk CCG's ambition for this indicator is to reduce the rate of avoidable admissions by 1% per annum from 2014/15, although this means there is an initial increase from the baseline figure to take into account the forecast growth in 2013/14.

***Outcome 4*:** Increasing proportion of older people living at home independently following discharge from hospital:

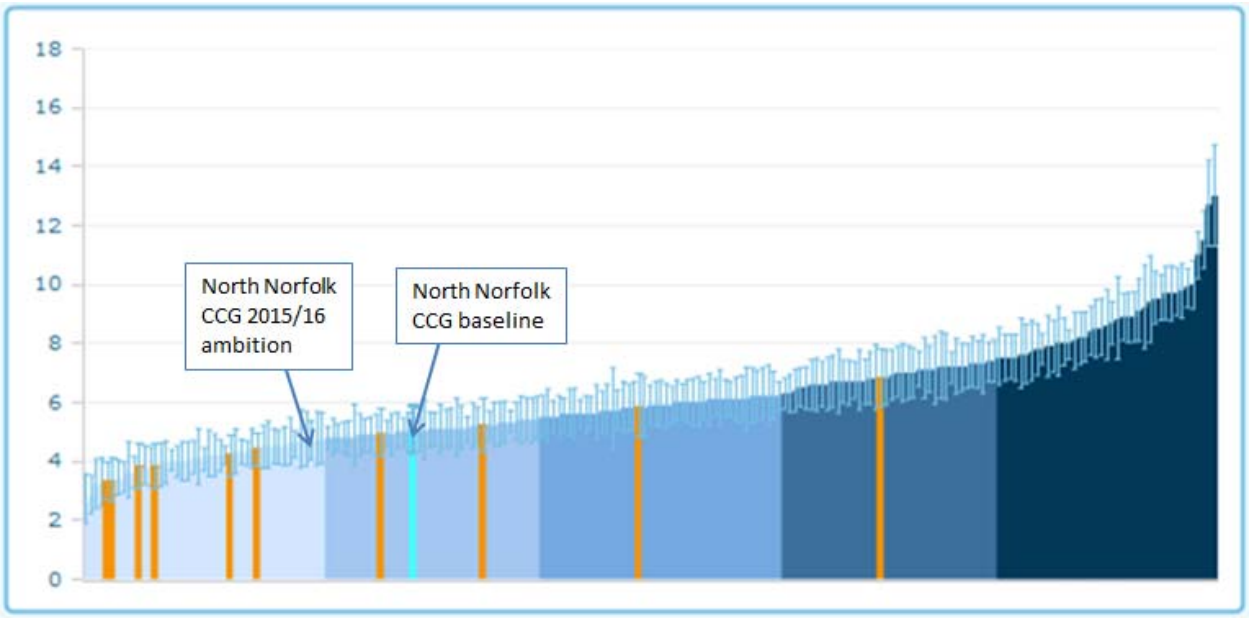
Following discussion and agreement with Norfolk County Council and linked to the Better Care Fund work, the metric we will use to monitor performance in this area will be ASCOF 2B – Proportion of older people (65+) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. For North Norfolk patients the baseline figure is currently 85.52% and we aspire to raise this to 90% by October 2015.

***Outcome 5*:** Increasing the number of people with physical and mental health conditions who have a positive experience of hospital care:



The CCG are committed to working with providers to improve the experience of patients who receive hospital care. The Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH) review patient experience feedback of the services they provide through the Friends and Family Test, the 'Patient Opinion' & NHS Choices websites, national & local surveys, complaints and through the Patient Advice and Liaison Service. The Friends and Family Test results are displayed on the Clinical Quality and Patient Safety, and Performance Dashboards which are reported at the Quality and Safety Committee, the Governing Body and Council of Members meetings. During 2014 North Norfolk CCG will continue to work with the NNUH to develop ways of using all the patient experience information gathered by the hospital to inform its patient quality monitoring in a more coherent and proactive way.

***Outcome 6*:** Increase the number of people with a positive experience of care outside of hospital, in general practice and in the community:



The CCG's comparative performance shown above is currently above the national average, but when compared to the 10 most similar CCGs it suggests that there is opportunity to improve. We believe that by providing more seamless and joined up care as a result of our integrated care work we will be able to improve outcomes for our patients in this area. We will measure performance in this area by seeking to reduce the number of people reporting very bad primary care (GP, out of hours and community service)

***Outcome Ambition 7**: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care*

The baseline data for the outcome indicator underlying this ambition is not yet available. However, North Norfolk CCG is fully committed to working with our

providers to monitor a number of key performance indicators relating to clinical quality and patient safety.

We produce a monthly clinical quality and patient safety dashboard, which consists of a main indicator summary dashboard, as well as a separate provider document to allow visual triangulation of data for individual providers. Indicators routinely monitored relating to patient safety and avoidable deaths within our providers include:

- Quality Issues, Serious Incidents and Never Events;
- Healthcare Associated Infections – incidence of MRSA, C.Diff, E-coli and MSSA;
- Mortality – Hospital Standardised Mortality Ratios;
- Provider staff sickness / absence rates;
- Ambulance response rates; and
- Other key provider performance metrics including monitoring of A&E 4 hour target, cancer treatment wait times, 18 week referral to treatment wait times.

These reports are presented and discussed at our monthly Governing Body and Quality and Patient Safety Committee. Any unacceptable levels of performance or abnormal trends / spikes within the data can be quickly investigated to identify any areas of concern at our main providers to ensure patients are receiving the highest standards of quality and patient safety.

2.2 Improving the health of local people

In November 2013, NHS England published "A Call to Action: Commissioning for Prevention" which suggests prevention programmes can be important enablers for reducing acute activity and capacity. It set out a five step framework intended to support CCGs in commissioning for effective prevention:

1. Analyse key health problems
2. Prioritise and set common goals
3. Identify high-impact programmes
4. Plan resources
5. Measure and experiment

North Norfolk CCG will continue to work with Health and Wellbeing partners utilising the above framework to help deliver the Norfolk Health and Wellbeing Strategy (http://www.norfolk.gov.uk/view/NCC122775). Having worked closely with the Norfolk Health and Wellbeing Board, and following feedback from other local partners, patients and carers at CCG engagement events, three areas for action which amalgamate six of the Health and Wellbeing Board's emergent priorities have been agreed. These are:

Physical Activity, Healthy Eating and Weight Management - Nearly 94,000 adults in the CCG area (67%) are estimated to be overweight or obese and adult participation in sport is lower than in other CCG areas. There are considerable differences in National Child Measurement Programme outcomes between the best

and the worst MSOA in the CCG area. This is an issue which is important in both the North Norfolk and the Broadland District Council areas and therefore we are committed to working with partners to tackle the problem.

Supporting independence at home, better supporting people with long term conditions, and addressing the needs of adult and young carers - This encompasses four areas from the emergent priorities:

- Unplanned/emergency care and admissions and preventing re-admission of people to hospital and/or health and social care services, post-intervention
- Supporting Frail People Living Independently
- Carers of older people and people with long term conditions
- Young carers – identify and support young carers and their families.

The North Norfolk and Rural Broadland area has the highest proportion of older people in the County with high levels of fuel poverty in parts and a relatively high level of excess winter deaths, all of which are associated with unplanned or emergency admissions. Levels of age related conditions such as dementia are projected to rise and there is considerable geographical variability in people over 65 admitted to hospital with fractures. The role of carers, young and old is therefore a key one in improving outcomes for older people and those with long term conditions and their needs are therefore a priority. This area of work was agreed to be one where cross agency working would be beneficial and add value to the efforts of individual partners.

Creation of good developmental and learning outcomes for children and young people - Child poverty has worsened in both of the Districts since 2011 and roughly one in ten children in the CCG area now lives in poverty. GSCE attainment has worsened in North Norfolk, but improved in Broadland. At foundation stage, there is considerable variation across the area with parts of North Norfolk having the worst attainment in the County. Children's' development and achievement relates closely to their future health and life outcomes and this area has therefore been agreed as a partnership priority.

In order to deliver the improvements in the above areas we have established the North Norfolk and Rural Broadland Strategic Partnership Group which includes members from the CCG, Public Health, Norfolk County Council and both North Norfolk and Broadland District Councils. This group has been tasked with overseeing the many initiatives across all organisations to help deliver improvements in the areas identified above.

2.3 Reducing health inequalities

A report from the *Institute of Health Equity* points out that eight people a second are seen by the NHS, yet not enough attention is given to social and economic problems underlying poor health. It highlights examples of best practice, which include social

referral schemes to employment and housing advice and helping elderly patients to build social networks after a stay in hospital.

The Marmot Review 2010 (p.17) used *disability free life expectancy* (DFLE) as an indicator to quantify the years lived free of limiting long term illness. The social gradient of DFLE is even steeper than for life expectancy. More affluent groups live on average 17 years longer without disability than the poorest groups.

The demographic and socio-economic data for North Norfolk can be accessed via:

http://fingertips.phe.org.uk/profile/general-practice/data#mod,1,pyr,2013,pat,19,par,E38000124,are,-,sid1,2000005,ind1,-,sid2,-,ind2,-

Key figures which support our approach to improving integrated care, and risk profiling patients are below:

	NNCCG	England Average
% aged 65+ years 2013	27.9%	16.7%
% aged 75+ years 2013	13.1%	7.7%
% aged 85+ years 2013	3.9%	2.2%
IDAOPI (Income Deprivation Affecting Older People)		
2012	14.0%	18.1%
Disability allowance claimants (per 1000)		
Nov 2011	45.1 %	48.3%

Ethnicity data can be viewed at: http://www.northnorfolk.org/community/9387.asp

Engagement with local patients, carers and stakeholders is built into all clinical pathway redesign. As a matter of course, the CCG undertakes an Equality Impact Assessment (EqIA) to identify the potential impact of policies, services and functions on patients as well as its staff. By undertaking EqIA, this promotes good practice as well as providing evidence of compliance with anti-discrimination and equalities legislation.

In support of this approach and as specified in our Better Care Fund submission, the overarching aims of integrated care are:

- To improve the quality of the services across health and social care for our local population
- To reduce inequalities of both access and outcomes
- To secure a stable future for all health and social care organisations
- To improve the efficiency in the provision of the services.

The CCG is committed to using EDS2 and this has been identified as a key area of work during 2014/15. We currently revising our project sign off processes to ensure that North Norfolk diverse population and communities are fully considered prior to commencing any new initiatives. The CCG is aware that its prevalence of many

chronic diseases, especially circulatory, respiratory and dementia are well above the England average. Much of this reflects our demographic and we are committed to ensuring that the large population of elderly people in its area, many of whom suffer one or more long-term conditions and who are often socially and geographically isolated, are a focus for initiatives designed to improve their health and quality of life. However, we remain alert to the needs of the other elements of our population, especially the other protected groups.

Below are some examples of health initiatives that are focused on our main causes of death or poor health. These serve all of our population but particularly those most disadvantaged and with the worst health outcomes. All the following areas have been informed by patient insight with future engagement also built in.

- Integrated care programme – preventing unplanned admissions
- Care home Access Direct (CHAD) - better care for vulnerable people in residential care
- Review of bed stock to speed CHC assessment and improve rehabilitation services
- Dementia programme – improving diagnosis rate and better post-diagnosis support
- Moving services closer to home – audiology and cataracts
- Ambulatory ECG service – providing rapid diagnosis or reassurance to those suspected of cardiac disease

2.4 Convenient Access for Everyone

NNCCG will adopt the core ethos of the Equality Delivery System (EDS2) by engaging with stakeholders, service users, staff and the local community to ensure that health and social care inequalities are considered and addressed, where possible, in all commissioning activity.

We are committed to commission the right health care services and ensuring that our providers meet the equality duties set out in the Equality Act 2010. We will:

- Be mindful of the rurality of our local population and their ability to access health and social care services;
- Ensure patients and their carers have a positive experience of integrated care, by facilitating access to the right care, at the right time.
- Consider how best to achieve equality of access to health services for people with protected characteristics, focusing on those that our prevalent within our community such as, but not limited to:
    - Looked After Children
    - People with Learning Disabilities
    - People with long-term mental health problems
    - People with life limiting health conditions
- Work with protected and disadvantaged groups to identify their specific needs and ensure that they are aware of the services available to them within the

community, to eliminate any inequalities and improve their access and experience.

We will continue to work in conjunction with other Norfolk CCGs, alongside the Norfolk Equality and Diversity Council, who will act as our voice for all individuals and communities covered by the Equality Act 2010.

2.5 Mental Health Parity of Esteem

The CCG is fully committed to ensuring an equal focus on improving mental health and physical health, so as to make sure that people with mental health problems do not experience inequalities as a result.

Steps that the CCG will take include:

- Improving access to mental health services and make shorter waiting times a priority;
- Working with providers and service users to redesign services and pathways to ensure that mental health service users will experience more joined up care at the appropriate time;
- Commissioning of mental health and learning disability services that are fully integrated into the wider health and social care system. This will include increased investment to better support mental health service users at our local acute hospitals;
- Embed the principle of *Parity of Esteem: Transformative Ideas for Commissioners* into all commissioning activity, to ensure that the mental health needs of our local population are considered at all times and resources allocated appropriately;
- Ensuring that mental health service user have a seamless transition through Mental Health Services, without the need of a GP's intervention or re-referral;
- Develop seamless pathways to Child and Adolescent Mental Health Services (CAMHS) with a view to providing support for children with mental health needs and improving service quality and waiting times and transition to mainstream Mental Health Services, if required; and
- Commission a Mental Wellbeing Service in conjunction with other Norfolk CCGs, which acts on the feedback received from local stakeholders and service users to provide support to people to overcome challenges such as mild depression and anxiety so that they can get back to work and other meaningful activities.

3. Engagement

Patients and carers are central to planning health and care services in North Norfolk. Local patients were involved in the original development of the CCG's Communications and Engagement Strategy in 2012 and since then a variety of mechanisms have been used to consult and engage:

- **Annual Stakeholder events** – Events are held each summer for local stakeholders to review North Norfolk health priorities and hold the CCG to account for progress made over the previous year. The inaugural event in 2012 set the priorities for the CCG and in 2013 the event also looked at how the CCG should support local voluntary and third sector organisations. The insight gathered was used to inform the new North Norfolk volunteer service that will support integrated care;
- **Patient Conferences** – The biannual patient conferences have been running since 2008 and are attended by members of local Patient Participation Groups. The conferences have focused on a variety of topics such as dementia and community services. Insight from these events has been used to take forward this work within the CCG;
- **Referral Management Service** – patients referred by General Practices into the North Norfolk Referral Management Service are being contacted to give patient experience feedback on the referral process and on the services they received. Insight gathered here has been used to inform the local Audiology and LUTS pathways. This is being expanded to collect general experience feedback from a random sample of all patients who have had a referral;
- **Your Voice –** North Norfolk CCG supports the Your Voice Norfolk online consultation database which recruits people from all over the county who are interested in being involved in shaping local public sector services. In 2013/14 the CCG has used the database to contact people who live in North Norfolk about the new Wellbeing Service and to recruit local people with Long Term Conditions (LTCs) and their carers for patient stories;
- **Patient Stories** – Each of the six Governing Body meetings held in public has included a slot at the start of the agenda for a patient story. This gives local people the opportunity to tell their experiences of accessing care in North Norfolk. Stories have covered adults with learning difficulties, dementia, suicide, diabetes, mental health, visual impairment and being a transplant patient. The stories are compiled into an annual report which includes updates on the areas discussed;
- **Partnership News** – A quarterly newsletter was launched in the summer 2013 which is circulated to the North Norfolk CCG stakeholder database and to all Patient Participation Groups. The aim is to keep them aware of the work of the CCG and ask for ideas and feedback, and to present opportunities for partnership working;

3.1 Planned engagement during 2014-16

In addition to the above North Norfolk CCG is in the process of planning and developing engagement in the following areas:

- **patient experience** – working with local provider trusts to access their patient experience insight and use it as part of the picture to inform local commissioning;
- **supporting Patient Participation Groups (PPGs) project** – developing support for local PPGs to maximise their patient engagement role within both practices and commissioning;
- **patient stories** – working with local providers, practices and third sector organisations to routinely gather patient stories and use them to put together action plans for improvements to services; and

NNCCG routinely reports back on the results and outcomes of its engagement activity direct to individuals involved, as well as the wider community.

Work is currently underway on an Engagement Annual Report which is being presented to the Governing Body in May 2014. More details about engagement are available on the CCG website – www.northnorfolkccg.nhs.uk/get-involved

4. Operational Plans for 2014-16

Delivering the vision outlined in this plan will take several years of co-ordinated activity, and therefore it is important that the CCG sets out clear milestones on its journey. The Operational Plan will facilitate improved outcomes for the people of North Norfolk and uphold their rights under the NHS Constitution. Our plan has been divided into five key programme areas as follows:

- Older people
- Planned Care
- Unplanned Care
- Mental Health
- Children

These plans further build on work outlined in our NNCCG 2012-2016 Commissioning Strategy, which went out for public consultation during 2012/13. Additionally our Quality, Innovation, Productivity and Prevention (QIPP) programmes are also aligned to the above programme areas to ensure it remains a core component of the work undertaken by NNCCG.

Throughout the planning process we have used the opportunities to access patient experience and engagement to help us develop and shape this vision. We will continue to identify routes by which we can draw views and feedback from our service users and providers to enable our plans to evolve and deliver the high level of quality we aim to provide.

It is our ambition that our style of clinical leadership and engagement will allow us to develop strong contractual agreements with providers which will deliver credible, evidence based services which are compassionate and inclusive and through the development of our integrated teams will support further innovation and opportunities for safe effective efficiencies.

We are committed to delivering the following improvements by the end of 2016:

4.1 Older People

As a first phase of integration NNCCG has established with partners 4 hubs of integrated teams comprising community nursing/therapy with social care assessment and case management. Integration with General Practice is underway through regular practice based MDTs, based on the use of a Risk Stratification tool to develop shared lists of at risk patients. Integrated Care Coordinators ensure that patients are managed through the system and disparate information systems are accessible to all.

- We will ensure that these arrangements are established consistently across all practices;
- We will have normalised the number of at risk patients for each practice reflecting need and age profile;

- Each at risk patient will have a nominated lead professional and a care plan agreed with the patient which is accessible to all relevant agencies, including 111/OOH;
- A single, common assessment framework will be in place so that people do not need to retell their stories to different professionals;
- The integrated teams will be under a single integrated management structure across Norfolk County Council (NCC) & Norfolk Community Health and Care (NCH&C) including the Norfolk First Support reablement service; and
- The proportion of people being intensively supported at home following a stay in hospital will be increased.

The new Quality and Outcomes Framework (QOF) scheme for General Practice will see all patients age 75 and over given a named GP. This will further strengthen the integrated model described above.

- Ensure alignment of named GP to care management of the at risk population describe above.

In addition, a pilot scheme known as Care Home Access Direct, (CHAD) which ran in February and March 2014 provided a telephone advice line of an experienced GP available to Care Homes and other agencies, via 111, concerning the management of patients with a complex need at the weekend and evenings. The scope of this service is now being refined in the light of our experience of capacity and demand. It will be the first stage in making experienced GP support more available to the at risk population out of hours.

- The CHAD scheme will be evaluated and if successful developed and expanded using the £5 per capita payment to practices.

We will work with our GP Practices, using the available £5 per capita, to develop a range of interventions which will better support their local populations. Actions will include:

- A focus on care homes to ensure that there is improved communication, case management and advanced care planning to better meet the needs of this vulnerable and variable group of patients. This will include regular targeted visits, and clearly outlined parameters for the use of anticipatory medication;
- Better linking of in-hours/out of hours care planning including provision of hand overs to OOH service and next day follow ups for the at risk population; and
- Mentoring and support to Community Matrons and Nurse Practitioners by GPs.

4.1.1 Community and Voluntary Sector Support Services

We will work to provide improved community based support services, closer to people's homes that deliver improved health outcomes and enable people to support themselves better, in order to maintain their independence for longer and reduce the risk of hospitalisation. This will include:

- Commissioning and implementation of a new volunteer service which targets people at risk to ensure they have the right support to:

    - Enable them to remain in their own homes and as independent as possible for longer;
    - Reduce the impact of rural isolation; and
    - Provide a single point of contact and coordination to deliver seamless health and social care services.

- Review all existing Voluntary Sector contracts to ensure that they provide the right support, in the right place, at the right time and deliver value for money.
- Review existing transport for vulnerable people to ensure accessible, joined up and coordinated options are delivered for the future.

The relatively high number of community beds within North Norfolk offers an opportunity to truly transform the way that care is delivered within our community. By focusing on prevention of unnecessary admission to acute care we will further develop safe and effective processes to manage patients' needs locally wherever possible. This will require a quality monitoring framework to ensure that risks and outcomes are clearly identified providing assurance that patients are receiving the most appropriate care. This will mean that patients receive care closer to home with continued support from their integrated team improving continuity of patients' needs and wishes and will also support better management of bed-based lengths of stay. This will require the development of responsive patient focused teams to ensure that patients are supported back into their own environment in a timely and safe way.

4.1.2 Falls Management

Falls are a key indicator of avoidable hospital admissions in North Norfolk, therefore we will develop a comprehensive falls management programme to reduce the number of vulnerable people falling unnecessarily. This will include:

- Development of an integrated Falls Prevention Pathway;
- Home hazard assessment and interventions; and
- Review and remodelling of existing services in line with local requirements.

Many of the above schemes will be supported through the Better Care Fund.

4.2 Planned Care

The NHS 'Everybody Counts: Planning for Patients' guidance requires local providers to achieve a 20% productivity improvement within 5 years against the 2013/14 levels of activity. The CCG is committed to working closely with neighbouring CCGs and our main local acute providers; the Norfolk and Norwich University Hospital and the Queen Elizabeth Hospital in Kings Lynn, in order to deliver this improvement.

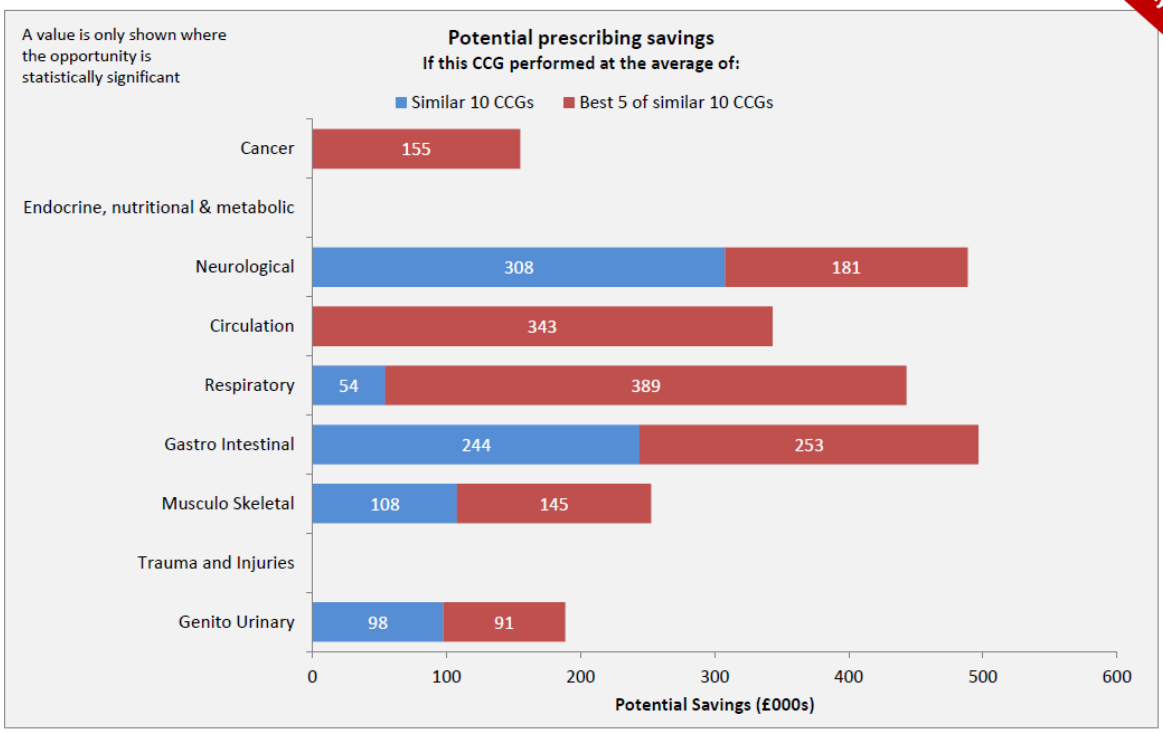
We will continue to redesign elective care pathways having conducted systematic, evidence and outcome based pathway reviews. We will review thresholds for

surgical intervention and develop new clinical guidelines and protocols to ensure consistent, appropriate and timely interventions for North Norfolk patients.

The CCG has conducted a clinical review of the Commissioning for Value Pack for North Norfolk as shown below, which has also helped us to define our priority areas during 2014-16.

What are the potential savings on prescribing?

Analysis



During 2014-16, our priority areas will be:

- Musculoskeletal (MSK) Services – To implement improved access to physical therapy evidence based and consistent pathways for spinal pain etc.;
- To conduct a review of the orthopaedic triage service with a view to assessing it's value for money and, if appropriate, implement a revised pathway for North Norfolk patients;
- Gastroenterology – Develop new a pathway to distinguish between Irritable Bowel Syndrome (IBS) and Inflammatory Bowel Disease (IBD) and review referrals of patients with iron deficiency anaemia;
- To work with the NNUH to enhance capacity for endoscopy;
- The development of a robust system for monitoring and follow-up of patients in primary care;
- To conduct a review and re-specification of the diabetes structured education programme in collaboration with third sector providers;
- To continue to reference baseline data in year, to establish where our local population could benefit from redesigned elective pathways;
- To roll out the Community IV service, currently being piloted, across North Norfolk; and

- To commission a new Tier 3 Weight Management Service with improved links with Tier 2 and Tier 4 services.

4.3 Unplanned Care

Commissioning for Prevention

Commissioning for prevention is one potentially transformative change that CCGs can make, by working closely with Health and Wellbeing Boards, other Norfolk CCGs and local providers to develop programmes designed to reduce acute activity.

It is estimated that only 4% of the NHS budget is currently spent on preventative programmes, despite the fact that preventing premature deaths and chronic disability not only improves patient experience, but is much more cost effective than corrective treatment.

As part of our strategic plan, we are reviewing Phase One of the Keogh Review in respect of Urgent Care Centres. We are also key members of the Central Norfolk Unplanned Care Clinical Network (CNUCCN) which will develop admission prevention strategies and early supported discharge pathways in conjunction with colleagues in South Norfolk and Norwich CCGs.

To date the CNUCCN has overseen successful delivery of the following commissioning activity:

- Expanding ambulance paramedic skills
- Planning for the refurbishment of the NNUH A&E Department, to improve patient flow
- Planning for a clinical decision unit and Acute point of care testing to become core business in 2014/15
- Community IV service
- Community Rapid Response Teams
- Community Matron Acute Pull-out Service
- Home Based Therapy Service
- An integrated clinical Directory of Services
- System Operations Centre
- Development of an Urgent Care Centre, to reduce impact on the NNUH A&E Department

In addition, a programme of work has already been established across Central Norfolk, with a view to streamlining and improving the existing urgent care system. A full PMO and governance structure is now in place to ensure that Project Domino delivers the following work streams:

- Home to Hospital (Blue work-stream)
- Front door of the hospital to back door (discharge) (Red)
- Supporting patients following discharge and readmission prevention (Green)
- Additional Service Commissioning (Purple)

Additionally, we have more local schemes designed to deliver improved, timely and robust access into, and discharge out of, the acute hospital. This will include:

- Acute discharge planning and a Post Discharge Support Programme;
- Remodelling of an Integrated Home from Hospital Service;
- An Integrated Community beds provision and coordination to proactively manage acute access and discharge;
- Reform of the emergency care system so that it works better for patients in a rural area;
- Improvement in the equality of care for stroke patients, so that their care has better outcomes; and
- Ensuring that a Directory of Services, for use by 111, will link with Social Services and Mental Health Services.

We will ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise, in order to maximise chances of survival and good recovery. We aim to achieve this by:

- Commissioning comprehensive contracts in collaboration with Norfolk CCGs, to ensure that the right capacity and range of hospital-based services are available when needed; and
- Work with specialist clinical networks e.g. Cancer, stroke, trauma, cardiac, palliative care, to ensure that low volume / high expertise specialised services are available when needed.

4.3.1 Specialised Services Concentrated in Centres of Excellence

We will work closely with NHS England, who are responsible for commissioning specialised services accessed by a comparatively small number of patients, but with catchment populations of more than one million. These services are located in specialist hospital trusts, which can recruit and develop staff with the appropriate expertise, such as liver transplants, the treatment of rare cancers and renal dialysis

NHS England is currently working toward the production of its five-year strategy for specialised services.

NNCCG will support NHSE's Local Area Team to engage with the local population and stakeholders, with a view to developing coordinated pathways to centres of excellence, whilst representing the issues experienced by the local population, to ensure equity of access to specialist services.

We will continue to work with NNCCG practices to further improve our unplanned admission rates. Our approach will involve:

- Actively targeting variation in admission rates, supporting practices and community integrated teams to identify reasons for the variation, and subsequently implementing initiatives that tackle this; and

- Driving improved links between primary and secondary care in order to deliver a 'system wide' approach.

An example of the top ten primary diagnoses resulting in unplanned admissions for North Norfolk

Primary Diagnosis Name	Activity	Cost
Urinary tract infection, site not specified	401	£1,034,834
Lobar pneumonia, unspecified	360	£1,044,069
Atrial fibrillation and flutter	213	£248,278
Unspecified acute lower respiratory infection	203	£391,354
Cerebral infarction, unspecified	203	£690,645
Fracture of neck of femur; closed	194	£1,052,485
Syncope and collapse	193	£217,641
Other and unspecified abdominal pain	187	£181,471
Acute myocardial infarction, unspecified	171	£586,563
Chest pain, unspecified	164	£124,899
Total	**2289**	**£5,572,239**

By reviewing data such as that shown above we have been able to identify areas that we need to target to both improve care for patients and deliver savings for the CCG. In support of this work we have established a North Norfolk Practice Manager group that works closely with the CCG Commissioning Team to develop projects and initiatives to help improve unplanned care services during 2014-16. This group has already identified a number of areas which includes:

- Improved access and use of Pharmacies to better support the unplanned care system;
- Better/easier access to information for patients – focused by age group; and
- Improved links with Care Homes to help prevent avoidable admissions.

4.3.2 Seven Day Services

Building on plans already in place to implement integrated care for the at risk population of North Norfolk, we aim to prioritise access to 7 day services across health and social care for people with complex mental and physical care needs, facilitated by:

- Availability of support services, both in the secondary, primary, community and mental health settings seven days a week, to ensure timely discharge following an unplanned episode of care, with robust community support in place to avoid re-admission;

- The use of re-ablement support available through Norfolk County Council, in conjunction with our Integrated Care Team, who will be able to switch on packages of social care 7 days a week.

- Better use of local intermediate care beds, coordinated by our Integrated Care Team, to ensure patients maintain care closer to home following discharge.

- Availability of non-emergency Patient Transport seven days a week.

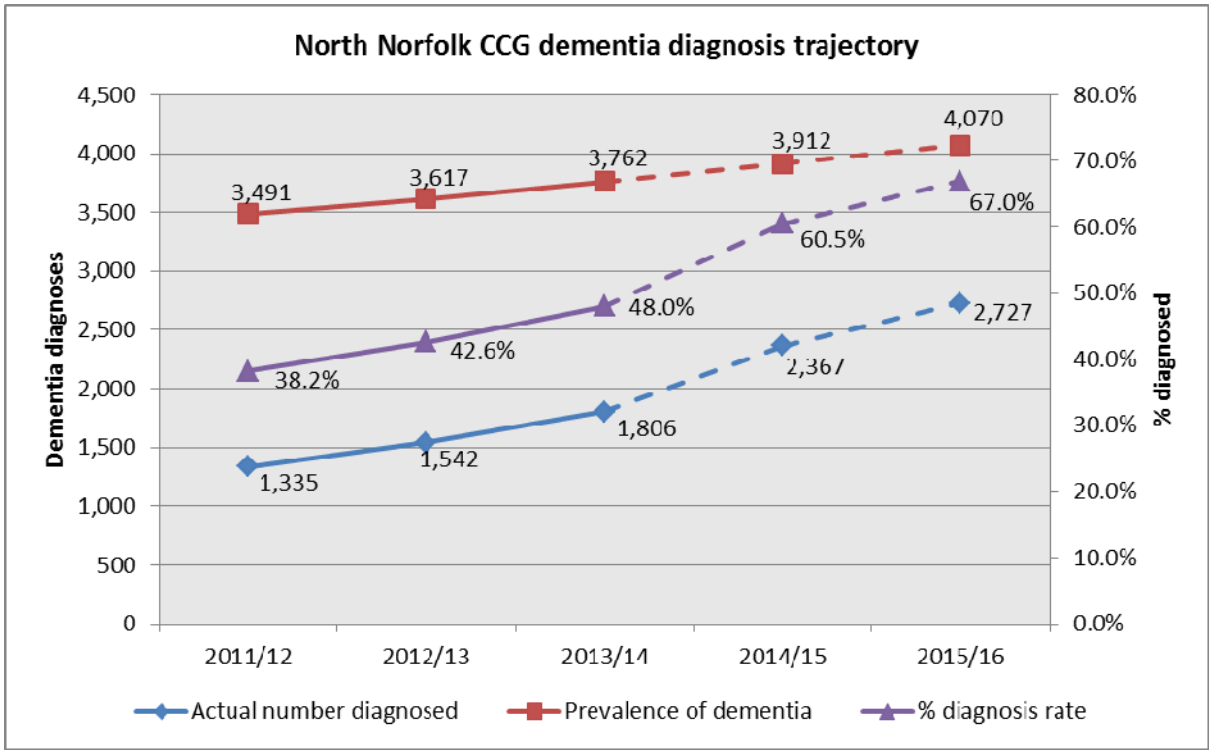
4.4 Mental Health

The CCG will continue to monitor and shape the changes underway in mental health services in North Norfolk. We will ensure effective and safe implementation of the NSFT Mental Health Strategy which will involve:

- All patients requiring emergency and urgent assessments will receive them in 4 or 72 hours. All routine referrals will be seen in 28 days;
- All patients requiring admission will be cared for within Norfolk, unless it is clinically appropriate for care to be delivered elsewhere;
- We will commission a new Improving Access to Psychological Therapies (IAPT) service that better integrates with primary care; and
- We will implement a new local Eating Disorder Pathway in collaboration with our practices.

4.4.1 Dementia

- Ensuring care pathways, systems, training are in place to support local implementation of national dementia standards;
- We will increase the rate of diagnosis; introduce opportunistic screening for key risk groups (such as frail elderly people), especially those with carer responsibility, patients in care homes, and/or with a long term condition;
- We will work with partners to develop and strengthen existing work that is striving to establish community hubs and dementia friendly communities;
- Ensuring patients, carers and families have easy access to a single point of contact for information and support;
- We will conduct a review of locally available services and care pathways and improve their accessibility to dementia patients and their carers/families;
- Engaging with carers and people living with dementia to assist the process of commissioning improved support, pathways and information;
- Establishing effective signposting to support, and pathways for the information of clinicians/carers/people living with dementia; and
- We will increase the use of the Dementia Intensive Support Team (DIST) to better support patients and help avoid crisis in care.



The above graph shows our planned trajectory for improving the dementia diagnosis rate in North Norfolk.

Following publication of the first Dementia Prevalence Calculator in 2013 which showed that the CCG's dementia diagnosis rate for 21011/12 was below the national and regional averages, the CCG created a Living Well with Dementia programme involving a full range of local government, health and voluntary sector partners. The programme has started work with our practices to improve diagnosis rates in two areas, firstly by ensuring that all diagnoses are properly coded and recorded and secondly by trialling new tools that offer speedier and more consistent screening methods. Since the launch of the programme in August 2013 we have seen a significant increase in the number of diagnoses recorded and although we do not feel it realistic to meet the target of 67% before the 2015/16 year, we are confident that in 2014/15 we can double the increase in percentage rates seen in 2013/14 to reach 61%.

4.5 Safeguarding

It is imperative that our plans recognise the needs of those most vulnerable within our community. As such we have developed systems and processes that ensure that the commissioning of services in North Norfolk recognises the principles of safeguarding (DH2011):

- Empowerment;
- Prevention;
- Partnership;
- Protection;

- Proportionality & Accountability

This will ensure that our service continue to be inclusive, focusing on maintaining the independence of our vulnerable patients and empowering individuals to improve the levels of self –management around their own care needs wherever possible. We will ensure that our services remain responsive and accessible by all.

NNCCG has been working with local support organisations to increase participation in commissioning from adults with learning difficulties. We have started by funding the necessary support so representatives can attend our public Governing Body meetings. We also strive to produce key documents in easy read formats.

Systems to protect and prevent harm or abuse within services will be strengthened by ensuring that training is available and undertaken by staff within our commissioned services and primary care colleagues around safeguarding, responding to and recognising domestic violence, mental capacity and the PREVENT agenda. Elements of this training are commissioned and provided in partnership with our commissioned providers, local authority and third sector colleagues to ensure consistency of understanding and delivery. We will continue to work with our Health and Wellbeing Board partners to ensure that there is 'system wide' improvement in this area and as such will be embedded within our work around integration to ensure that it is fundamental practice to our integrated teams.

4.5.1 Safeguarding Children

The CCG will continue to deliver improved outcomes for the children and young people in North Norfolk.

- We will improve access to child and adolescent mental health services;
- Implementation of a new Children's Continence Service;
- We will continue to work in collaboration with both North Norfolk District Council and Broadland District Council to deliver services that support younger people to live a healthy and active lifestyle;
- We will support Young Carers so that they can continue to care but do not miss out on other opportunities in life;
- Working in partnership with Norfolk County Council's Children's Services to help modernise existing services, addressing the issues highlighted in the recent Ofsted report; and
- We will ensure that high quality and appropriate services are commissioned for children with special educational needs.
- We will ensure that our responsibility around Looked after Children will provide effective health assessments in a timely way and that communication between statutory partners is well developed to prevent children from falling between gaps in service provision.

The last 12 months have been characterised by change and the re-focussing of priorities within the safeguarding and looked after children agenda. As a consequence a Children's Services Improvement Plan has been developed following

the three Ofsted inspections that found services across the County Council failing in their delivery of services to children. The Norfolk Safeguarding Children Board (NSCB) had reviewed both the structure and processes for delivery of the safeguarding agenda and has recently set three priority areas of practice:

- Neglect;
- Child sexual abuse; and
- Child sexual exploitation.

Health services, both commissioners and providers, are crucial within the partnership framework and participation in the children's safeguarding agenda has been formalised by the development of the Norfolk Health Safeguarding Children's Advisory Group chaired by the Director of Quality and Safety for NHS Great Yarmouth and Waveney CCG, with representation from all CCGs and NHS providers. The Designated Child safeguarding Team reports quarterly to NHS North Norfolk CCG through the Quality Alliance on issues both general and specific to the individual area, in terms of expanding on the plans for looked after children and their transition into adulthood.

4.5.2 Safeguarding Adults

Partnership working is at the core of effective safeguarding of adults. As such, the CCG Safeguarding Team is actively involved in the Domestic Abuse and Sexual Violence Partnership and the Norfolk Safeguarding Adults Board, on a local level. In addition, on a regional level, there is active participation in the Home office CONTEST programme, particularly in relation to the prevent agenda.

The past year has seen the publication of two Domestic Homicide Reviews in Norfolk and the subsequent implementation of its recommendations. This has seen the development of a bespoke training package, jointly funded by CCGs and the Police and Crime Commissioners Office. Each GP Practice will have an opportunity to host a specialist Domestic Abuse Training Session for its own staff and Community Health Staff that work alongside the practice. The other Norfolk CCGs have also secured centralised funding to facilitate the development of bespoke training packages to increase awareness and support front line practitioners in the application of legislation.

In addition NNCCG will work closely with its counterparts, both in health and social care, and other statutory agencies, to ensure that Norfolk is prepared for the implementation of the Care Bill, which will make Adult Safeguarding statutory and place it on an equal footing a Children's Safeguarding.

Response to Francis, Berwick and Winterbourne View

In February 2013 the Francis report[3] established that proper accountability, a "zero tolerance" approach to breaches of "fundamental standards" and a "common culture" that puts patients first- these were the themes underpinning the 290

[3] https://www.gov.uk/government/news/francis-report-on-mid-staffs-government-accepts-recommendations

recommendations that form the heart of the report. The negative aspects of culture in the system were identified as including a lack of openness to criticism, a lack of consideration for patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions about the judgments and actions of others, an acceptance of poor standards and a failure to put the patient first in everything that is done.

To change that, there needs to be a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care. This means that the patient must be first in everything that is done: there must be no tolerance of substandard care; frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations.

NNCCG is committed to working with all our providers of NHS healthcare to ensure that our patients receive the best possible care, have a positive experience of healthcare and are treated safely. To ensure this is embedded throughout all our commissioned services we have developed and implemented robust processes to monitor report and address any issues that arise. This includes:

- Open and effective Contract Quality Review Meetings (CQRM)
- Continual review and learning from any serious incidents, complaints and never events that occur that lead to improvements in service delivery
- Announced / unannounced clinical provider visits to gain further assurance of the quality of care being delivered
- Continual review of staffing levels
- Review of provider annual training needs

NNCCG will continue to drive forward a culture of openness and transparency in all commissioned services across all providers to ensure that the learning and recommendations made in the above reports are implemented.

4.6 Compassion in Practice

The "NHS Nursing Strategy: Compassion in Practice" sets out the shared purpose for nurses, midwives and care staff to deliver high quality, compassionate care, and to achieve excellent mental and physical health and wellbeing outcomes. It builds on the enduring values of the NHS, and the rights and pledges of the NHS Constitution. The strategy sets out six areas for action to be implemented over the next three years:

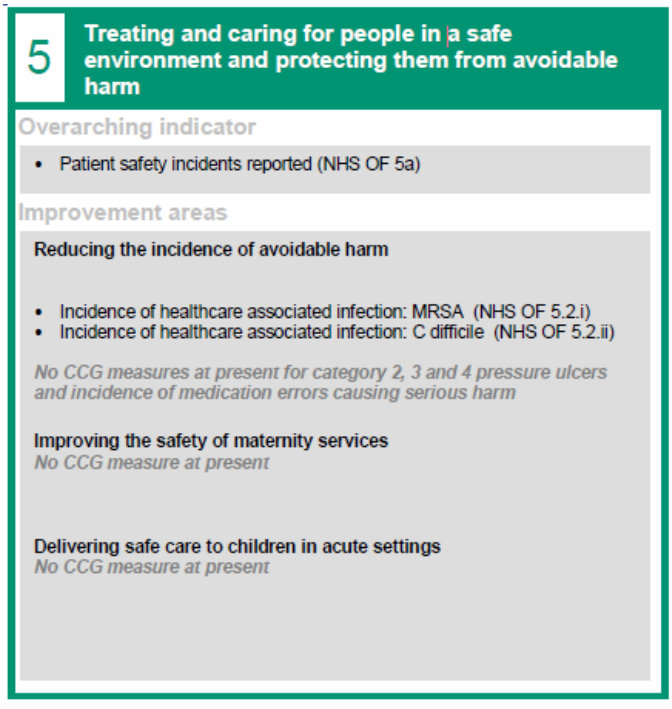
- Staying independent, maximising wellbeing & improving outcomes;
- Improving patient experience
- Delivering high quality care & measuring impact;
- Building & strengthening leadership
- Right staff, right skills, right place;
- Supporting positive staff experience

NNCCG will ensure that local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans and how the 6Cs (Care; Compassion; Competence; Communication; Courage; Commitment) are being rolled out across all staff groups through the monthly Clinical Quality and Patient Safety meetings, and direct observation of practice during site visits to clinical areas as part of our on-going programme of visits to providers.

4.7 Infection Control

The Clinical Quality and Patient Safety Committee review the newly developed CCG Outcome Indicator Set (OIS), which will form an integral part of NHS England's systematic approach to quality improvement. Its primary aim is to support and enable CCGs and health and wellbeing partners to plan for health improvement by providing information for measuring and benchmarking outcomes of services commissioned by CCGs. It is also intended to provide clear, comparative information for patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes.

The Committee will continue to build on learning from local reviews with our providers by scrutinising Root Cause Analysis data in relation to acquired infections such as MRSA and C Difficile, which represents Outcome 5 of the OIS:



We have refreshed our quality schedules with each provider to ensure that the latest Infection Control guidance is reflected in contracts, which will be monitored through local audit and observation of practice. We will also continue to participate in the East of England Quality Surveillance Group, to identify early warnings and quality failings, in order to assess and mitigate potential patient risk.

We will continue to strive to achieve zero MRSA bacteraemia cases for 2014/15, as per the national guidance, through the effective implementation of Infection Prevention and Control standards across all areas of health and social care.

On a local level, NNCCG will continue to work with the Public Health Infection Control and Prevention Team to promote the work of the "Harm-Free Care" Nurse within care homes. The post-holder will support a focused and dedicated training programme for care homes, to enable them to identify and avoid potential areas of harm experienced within the community, such as pressure ulcers and acquired infections Clostridium Difficile).

4.8 Friends and Family Test

4.8.1 Patient Satisfaction

The Friend and Family Test (FFT) is an important opportunity for patients, their family and carers, to provide feedback on the care and treatment received with a view to improving services. Initially introduced in 2013, patients were asked whether they would recommend NHS funded acute inpatient services, A&E departments and NHS funded maternity services, to their friends and family if they needed similar care.

We recognise the importance of this, and have therefore incentivised the uptake of patient FFT through the national CQUIN for 2014/15. In addition NNCCG will work closely with NCHC to design a community hospital quality dashboard that will incorporate the FFT, along with Patient Opinion and local patient survey information.

The experience of vulnerable patients will be improved through learning from serious incidents, complaints and case review findings.

4.8.2 Staff Satisfaction

NNCCG recognise that staff satisfaction is also an important indicator of the quality of care provided to patients. Due to our geography there tends to be less movement of staff in North Norfolk and as such it is vital that the providers in the locality ensure that their staff are supported, developed and have good leadership in order to retain them and remain highly motivated. It is essential that staff providing health services have confidence to both recommend their organisation as an employer and as a provider of health care to their friends and family. As such, in conjunction with the National Staff Survey, the Friends and Family questions for staff is a great reflector of the organisational health of the providers within our locality.

Given our ambition of delivering more Integrated Care for the people of North Norfolk we are committed to evaluating and the impact of such changes on front line staff. We will work with providers to ensure there is a clear focus on:

- Improved communication, consultation and culture
- Clarity of roles, working arrangements and co-location
- Development of policies and processes that support rather than hinder staff

NNCCG recognise that staff satisfaction can have a direct impact on the service and quality of care given to the patient and as such we are committed to seeing improvements in staff satisfaction in our provider services staff survey results and will continue to monitor and report progress in this area to the North Norfolk CCG Governing Body.

4.9 Research and Innovation

Health research is essential to continually improving health outcomes and the effectiveness of health services for patients. There is an expectation that the UK will be the first research-led health service in the world. Searching for and applying innovative approaches to deliver health care must be an integral part of the way the NHS does business. Doing this consistently and comprehensively will dramatically improve the quality of care and service for patients (Health Wealth and Innovation 2012).

The new Health and Social Care Act reflects these commitments and places a clear duty on the Secretary of State, NHS England and Clinical Commissioning Groups (CCGs) to promote research and champion innovation.

4.9.1 Research

In line with the research commitments, North Norfolk CCG supports South Norfolk CCG as host of the Norfolk and Suffolk Primary and Community Care Research Office, on behalf of all CCGs across Norfolk and Waveney, and has signed up to a Memorandum of Understanding. Patient and clinical involvement in research across North Norfolk CCG is strong and the CCG's statutory duty to promote research would include:

- Participation in research;
- Supporting research and using research evidence;
- Proactive engagement with local partners; and
- Meeting treatment costs for patients taking part in research.

In line with the research duty, the CCG will:

- Agree a plan to enhance the research culture of the CCG, addressing leadership, education, use of evidence and partnership.
- Ensure provider contracts are fit for purpose in relation to the Research Governance Framework, Clinical Research Network (CRN) targets, and Quality Account arrangements.
- Through its Research Champions, support the Norfolk and Suffolk Primary and Community Care Research Steering Group, which oversees arrangement for Research Delivery through the Norfolk and Suffolk Primary and Community Care Research Office. This group has a mandate to agree strategic direction for research across Norfolk and Suffolk. The Research Office supports Research Design, Research Assurance, Study Delivery and

Patient Involvement in research across CCGs, academic organisations, primary and community care providers and will deliver an agreed work plan \\inf-fs-1-v1\snccg\Departmental Documents\R&D\R&D Policies & Corporate Docs\Workplan\Workplan updated Feb13.docx

- Through the agreed CCG Chief Officer representation (South Norfolk CCG on behalf of Norfolk and Waveney CCGs) on the new CRN-Eastern Partnership Board continue to support the establishment and development of the CRN; representing the interests of patients, commissioners, and primary care providers; working with CRN partners to support the delivery of the National Institute of Health Research (NIHR) performance framework and agree models of funding for enhanced patient and clinical involvement in research.
- Fully implement the research cost policy with NHS England and Public Health England, including agreeing processes for managing appropriate research treatment costs for provider organisations to ensure provider trusts identify research savings and reinvest these in new studies, and where appropriate, review full provider business cases for study specific research treatment funding from CCGs.
- Build on CCG leadership recommendation to enhance Research Dissemination, particularly through GP Education routes and through the CCG Research Champions. A new research dissemination process will be agreed with CCG leadership, Governing Body and the Norfolk and Suffolk Primary and Community Care Research Office.
- Through its clinical/commissioning executive work with research design leads and UEA academics to develop two research proposals for submission to Research for Patient Benefit programmes for the following areas: Use of emergency care in rural areas and improved understanding of dementia care. The systematic reviews for these will be fed into commissioning programmes.

4.9.2 Innovation

The CCG recognises the importance of the three stages of the innovation agenda – invention, adoption and diffusion and has a statutory duty to champion innovation and the adoption of innovation including:

- Setting out the CCG approach to innovation;
- Ensure strong leadership and accountability for innovation within our organisation; and
- Being an active partner in the local Academic Health Science Network.

In line with the innovation duty the CCG will:

- Work in collaboration with the Academic Health Science Network (AHSN) to support the delivery of innovation, adoption and spread of evidence for Diabetes, Dementia and Chronic Disease Management.

- During 2014-16, the CCG will work with the Research Office and AHSN to develop a post that will support increased involvement in the adoption and spread of evidence for the CCG/AHSN priority areas.
- Through CCG officer time contribute to the delivery by AHSN working groups.
- Use the collaborations such as AHSN to identify funding streams for early adoption projects.
- Review and strengthen CCG leadership and CCG innovation plans.
- Through the Norfolk and Waveney CCG Chief Officers' meetings support the cross CCG representation by West Norfolk CCG on the AHSN Partnership.

4.9.3 Eastern Academic Health Science Network

The Eastern Academic Health Science Network (EAHSN) brings together universities, hospitals, mental health services, primary care, clinical commissioning groups, public health, social care, the voluntary sector and industry, translating world-class research into improved patient care, thus driving economic growth.

North Norfolk CCG is a member of the Norfolk and Suffolk Clinical Community Node, helping to improve patient care through innovations in teaching and research. The Node hosts the Mental Health Research Network and Dementias and Neurodegenerative Disease Research Network for the region, with the aim of influencing the development of dementia pathways in a way that works best for our region.

5. Two Year Finance Plan

The two year Operational Plan is underpinned by an allocation of financial resource that will enable the plan to be delivered in a cost effective, sustainable manner and should ensure the future stability of the CCG going forward.

In 2013, NHS England reset the calculation for the fair distribution of resource with effect from 1st April 2104. That recalculation deemed NNCCG's current financial resource to be very close to its new target fair share. As a result, the CCG has been allocated the lowest growth percentage available for both 2014/15 and 2015/16 (2.14% and 1.7% respectively). The actual allocation for the two year period is:

(£000's)	Opening Programme Resource Limit	Growth Funding	Better Care Fund Allocation	B/FWD Surplus	Running Costs Allowance	Total Resource Allocation
2014/15	207,467	4,440	0	2,048	4,185	**218,140**
2015/16	211,907	3,602	3,809	2,182	3,758	**225,258**

NHS England published a planning guidance document in December 2013 (Everyone Counts) which set out certain parameters, assumptions and directions that each CCG had to incorporate into the financial plans for 2014/15 and 2015/16.

5.1 Surplus and Reserves Requirements

In 2013/14, the CCG is on target to achieve a surplus of just over £2m (1% of programme spend), after allowing for an accounting provision regarding Continuing Healthcare (CHC) Restitution cases, under provided by the previous PCT. As this is a planned surplus, NHS England is allowing the CCG to retain this surplus for use in 2014/15. The planning guidance requires the CCG to make a 1% surplus again in 2014/15 and 2015/16.

The guidance also requires the financial plan to show ½% of resources being set aside each year to act as a contingency for contracts overspending. This equates to around £1.1m each year.

Over the last few years, in order to deliver transformational change, commissioning organisations have had to set aside 2% of its programme spend each year to be utilised on non-recurring expenditure. This planning round is no exception however, for 2014/15 the CCG has to set aside another ½%, making the total non-recurring fund 2.5% (£5.3m). The difference in 2014/15 is that 1% of this is to be spent on pump priming, enabling or initiating schemes that will sit within the Better Care Fund (BCF), which is a joint fund with the Local Authority to deliver integrated care (see below). For 2015/16, the non-recurring requirement reduces back to £2.2m (1%). The CCG will take a cautious approach to the use of transformation funds, after careful consideration of business cases requesting non-recurrent investment. Agreement will be subject to a clear return on investment and controlled risk share

between provider and commissioner, and must fit with the CCG's strategic objectives.

In addition to the above, the CCG has had to set aside a fund of approximately £5 per head of population for GP practices to engage in and deliver the 'Accountable GP' initiative and improving care for older people. For NNCCG this amounts to £850k and will be used in a planned way to support the delivery of the CCG's operational plans and strategic objectives.

5.2 Planning Assumptions

Monitor sets policy and prices regarding Payment by Results (PBR) tariffs which CCGs will need to adhere to (unless there can be a locally agreed tariff). For planning purposes the published tariff uplifts and required efficiency targets are used to inform contract values. The same assumptions are used for other NHS contracts which are block or non PBR based. However, the acute PBR tariff uplifts include 0.3% for Clinical Negligence Scheme for Trusts (CNST) etc. which the other uplifts do not.

In addition to inflation, the plan assumes a demographic (population) growth based on ONS projections and non-demographic growth based on previous trends and to accommodate increased activity due to other factors.

5.3 Better Care Fund

In 2013 the Government announced that the BCF would be set up with contributions from both Health and Local Authorities, which would be held by the Local Authorities to enable truly integrated care across the board. This fund would consist of monies already given over to the Local Authorities for Reablement, Section 256 activities and carer's breaks, plus contributions from current CCG resources. An additional amount is being transferred to CCGs in 2015/16 from NHS England that is currently spent in collaboration with the Local Authority, and will be counted as part of the Better Care resources. All these funds are to be pooled and the spending plans around the fund have to be agreed on a system wide basis and signed off by the local Health and Wellbeing Board. This pooled fund would become fully operational in 2015/16 with some transition, enabling and initiation of some schemes in 2014/15 (as mentioned above). For NNCCG, the total contribution in 2015/16 will be £11.553m. This is made up as follows:

- Current CCG spend attributed to Reablement.....£2,328k
- Contribution from NHS England.....£3,809k
- Additional CCG contribution £5,416k

Although setting aside 1% of the 2014/15 resource and not committing it to current contract spend, helps to some degree to smooth the impact of the 2015/16 additional contribution to the BCF, £3.3m will remain as a cost pressure for 2015/16.

The financial impact of the BCF will result in a further QIPP programme for 2015/16, but at a much smaller value of £2.9m. Efficiencies gained through integrated working and the ethos of preventing people from needing health interventions should help the 2015/16 QIPP programme to be delivered.

5.4 2014/15 Financial Plan Details

Taking account of all the planning assumptions mentioned above and remaining within the Resource Limit set by NHS England, a balanced, budgeted financial plan has been produced and is attached at Appendix 1.

This plan was built upon the recurring committed spend from 2013/14 (recurring outturn), which was derived from the actual forecast outturn (as at month 9 2013/14), adjusted for non-recurring items and recurring items such as the full year effect of 2013/14 QIPP delivery. This gave the recurring committed spend for 2014/15 as £211.42m.

Provider efficiencies and inflation were then applied to the relevant contracts as per the NHS England planning document, which had a beneficial impact of £2.39m. Awards for demographic, non-demographic growth and cost pressures (£4.39m) and setting aside reserves as detailed above (£12.72m, including a reserve for the planned surplus) resulted in a financial gap of £8m.

5.5 QIPP

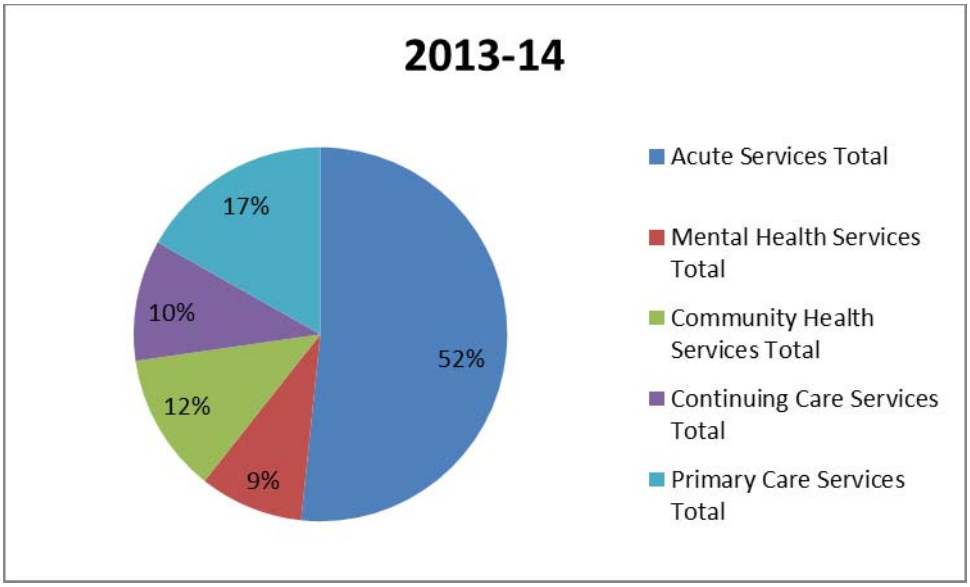
With limited growth in allocation and increasing commitments outside the usual health spend (e.g. the BCF), NNCCG can only produce a balanced financial plan for 2014/15 by planning for a level of QIPP of £8m. Achieving this will not only result in the planned surplus (which underpins financial sustainability) but should also enable the BCF commitment for 2015/16 to have less of an adverse financial impact. In fact some of the QIPP plans should help transform delivery pathways in order to realise the full potential of the BCF plans.

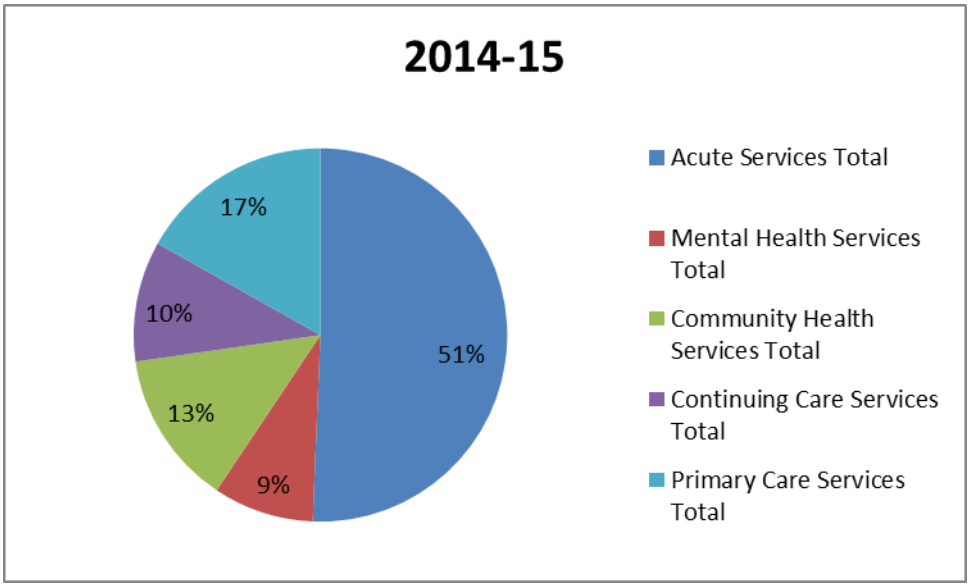
QIPP plans have been developed as follows:

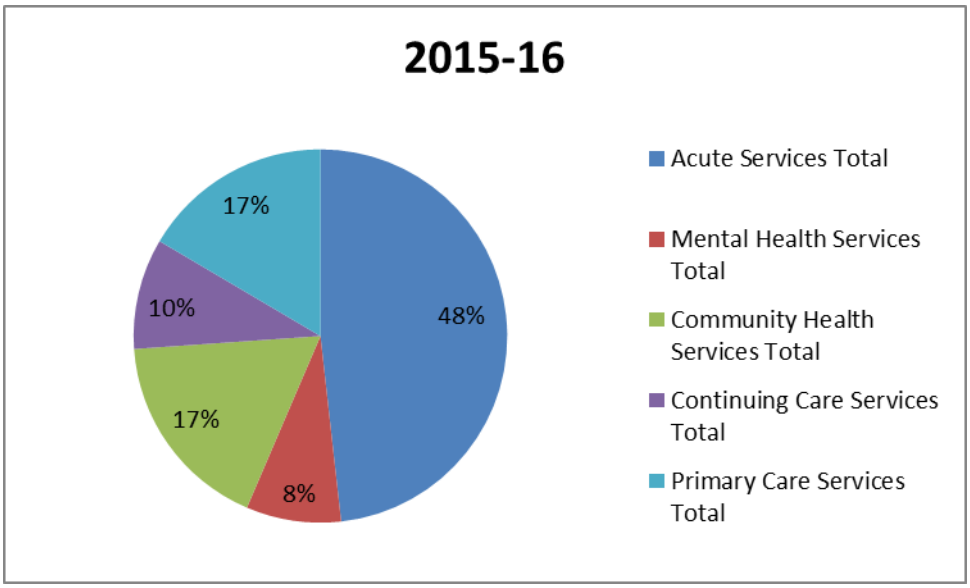
	£000,s
Prescribing	
Formulary review, switches, medicines reviews, good 'housekeeping'	1,200
Continuing Health Care	
Contract banding & more flexible packages	400
High Cost Packages Review	250

Assessments and reviews process and other initiatives	400
MH/LD Packages of Care	500
Decommissioning/Retendering Opportunities	600
Community	
Equipment controls, Intermediate Care Review	150
Acute:	
Community Initiatives that prevent hospital costs	
Dedicated beds to prevent DTOCs etc.	430
Acute rehab unit	150
Dementia Unit (Challenging Behaviour)	580
Care Home monitoring equipment, CHADS and Anticipatory Meds	430
Falls Pathway redesign	300
Initiatives directly impacting on hospital costs	
Service where CCG is a referral outlier	485
Integrated Care Impact	880
Other	1245
Total	**8,000**

The following charts show the planned development of programme services expenditure over the next two years. The primary elements are the implementation of QIPP plans and reinvestment into community services including the Better Care Fund.







5.5.1 QIPP Planning, Monitoring and Delivery

To ensure that the CCG delivers financial balance and the nationally required surplus every year, we continually seek to identify areas where we can implement new QIPP initiatives. The CCG Clinical Executive have been heavily involved in the development of the QIPP plans for 2014-16, and each QIPP initiative has been assigned both a clinical and managerial lead responsible for delivery (see Appendix 1). This process has involved conducting a comprehensive review of many data sources such as the Commissioning for Value packs, NICE guidance and Public Health data in an attempt to identify where there is scope to redesign or improve services and contribute to the QIPP challenge.

Performance of QIPP projects is monitored at a fortnightly Operational Group meeting with input from the project teams, business intelligence and finance representatives. Any issues that cannot be resolved at this group are formally escalated to the Clinical Executive. During 2013 we developed a QIPP monitoring

tracker (example shown in Appendix 2) which enables the teams to clearly see how each project is performing against the planned trajectory. This has enabled swift action to be taken in circumstances where any performance issues have arisen.

Robust Prince2 based Project Management arrangements are used to help the CCG develop and deliver all projects. At the early stages of any project this involves producing concise Project Initiation Documents (PIDs) and project plans with clear milestones and deliverables. (Example shown in Appendix 3) This helps the CCG to ensure there is a clear framework for project delivery and provides the best chance of success for our identified initiatives.

Formal reporting of QIPP performance is monthly to the Governing Body, Council of Members and Clinical Executive to ensure there is clear organisational oversight and challenge of progress.

5.6 Reserves

The Financial Plan has £9.2m set aside in reserves at the start of the year. £2.18m of this is the planned surplus, £1.09m is the contingency reserve of ½%, £1.8m represents money set aside to fund uplifts to contracts that are agreed after this plan is adopted by the Governing Body. At the date of this Governing Body meeting, not all major contracts have been agreed and signed. £5.298m is the 2.5% non-recurring reserve, of which £351k has been committed to fund transitions costs of the new Pathology contract and £823k has been ring-fenced to be returned to NHS England to fund Continuing Care restitution for 2014/15 (as per guidance). Of the remaining £4.124m, £2.12m will be spent enabling the transition towards the BCF and integrated working, although none of it has yet been identified against schemes and plans.

The balance from the £9.2m (£4.156m) is money from the Marginal Rate Credit and represents 70% of the value of non-elective admissions in the 2014/15 plan, which is above the 2008/09 threshold. This leaves 30% of the value in the acute contracts to pay the marginal rate for admissions to the hospitals.

5.7 2015/16 Financial Plan Details

Appendix 2 shows the financial plan for 2015/16, built upon the 2014/15 plan. The opening position of 2015/16 is the closing 2014/15 plan, adjusted for those items deemed non-recurring in 2014/15 (£10.544m) and adjusted for recurring items, for instance the full year effect of 2014/15 QIPP (£2.5m).

Provider efficiencies and inflation were then applied to the relevant contracts as per the NHS England planning document, which had a beneficial impact of £2.2m. Awards for demographic, non-demographic growth and cost pressures (£5.62m), funding the BCF (£11.553m) and setting aside reserves as detailed above (£9.33m, including a reserve for the planned surplus) resulted in a financial gap of £2.9m.

Reserves of £9.33m include £2.253m for planned surplus, £1.127m for contingency, £2.193m for the non-recurring reserve and £3.758m to mitigate against unforeseen cost pressures and movements that might occur in the year leading up to the 2015/16 financial year.

QIPP of £2.85m will broadly target as follows:

	£000,s
Prescribing	1,000
Continuing Health Care	500
MH/LD Packages of Care	500
Acute	850
Total	**2,850**

Appendix 1

North Norfolk CCG 2014/15 QIPP Projects

Transactional Projects

Activity type impacted	Project Title	Project Lead	Clinical Lead	Projected Saving (£000's)												
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Continuing Care	High Cost Packages Review	Mandy Hall	Jackie Schneider													250
Continuing Care	Contract Banding	Mandy Hall	Jackie Schneider													350
Continuing Care	More Flexible Care Packages	Mandy Hall	Jackie Schneider													50
MH - Other	Adult MH Packages of Care Review	Clive Rennie	Dr Penny Ayling													200
MH - Other	Children's MH Packages of Care Review	Clive Rennie	Dr Penny Ayling													100
MH - NCA's	LD Packages of Care Review	Stephen Rogers	Dr Penny Ayling													200
Community	Spending Controls in ICES	John Everson	Rachel Arkieson													75
Acute NHS	Referral Reviews - T&O	Ellis Layward	Dr Linda Hunter / Dr Alasdair Lennox													190
Acute NHS	Referral Reviews - Cardiology	Ellis Layward	Dr Linda Hunter / Dr Alasdair Lennox													70
Acute NHS	Referral Reviews - Cataracts	Ellis Layward	Dr Linda Hunter / Dr Alasdair Lennox													225
Acute NHS	Impact of Integrated Care Work	Mark Burgis	Dr Alasdair Lennox													880
Prescribing	Formulary Reviews	Sally Ross Benham	Dr Linda Hunter													350
Prescribing	Medicine Switches	Sally Ross Benham	Dr Linda Hunter													300
Prescribing	Medicines Reviews	Sally Ross Benham	Dr Linda Hunter													250
Prescribing	Good Housekeeping (eg Waste)	Sally Ross Benham	Dr Linda Hunter													300
Total Transactional																3,790

Transformational Projects

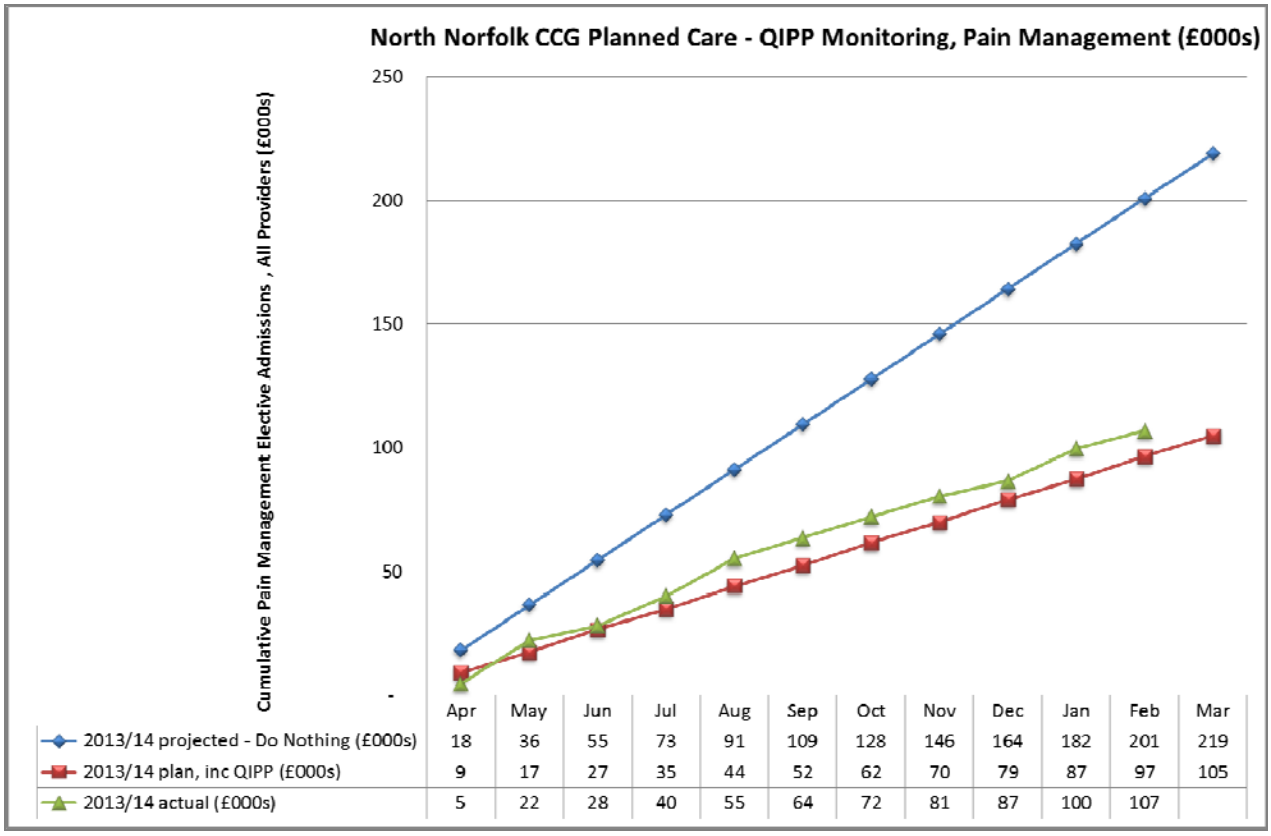
Activity type impacted	Project Title	Project Lead	Clinical Lead	Projected Saving (£000's)												
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Continuing Care	Assessment and Review Processes	Mandy Hall	Jackie Schneider													150
Continuing Care	Dementia unit (Crisis - CHC Impact)	Mandy Hall	Jackie Schneider													150
Continuing Care	Other	Mandy Hall	Jackie Schneider													250
Community - Other	Weight Management Retender	Mark Burgis	Dr Anoop Dhesi													50
Community - Other	Intermediate Care Spot Purchase	Jackie Schneider	Dr James Gair													75
Community - NHS	Decommission Orthopaedic Triage	Ellis Layward	Dr Linda Hunter													50
Acute NHS	Pathology EAP Contract	Helen Stratton	Dr Anoop Dhesi													500
Acute NHS	Dedicated CHC Beds	Michelle Ducker / John Everson	Dr James Gair													300
Acute NHS	Dedicated Palliative Care Beds	Michelle Ducker / John Everson	Dr Anoop Dhesi													130
Acute NHS	Acute Rehab unit in Community	Michelle Ducker / John Everson	Dr Anoop Dhesi													150
Acute NHS	Dementia unit (Crisis - Acute impact)	Michelle Ducker / John Everson	Dr Anoop Dhesi													430
Acute NHS	Care Home Monitoring Equipment	Michelle Ducker	Dr James Gair													80
Acute NHS	CHADS	Michelle Ducker	Dr James Gair													250
Acute NHS	Anticipatory Meds	Michelle Ducker	Dr James Gair													100
Acute NHS	Falls Pathway redesign	Michelle Ducker / John Everson	Dr James Gair													300
Total Transformational																2,965

Other Projects

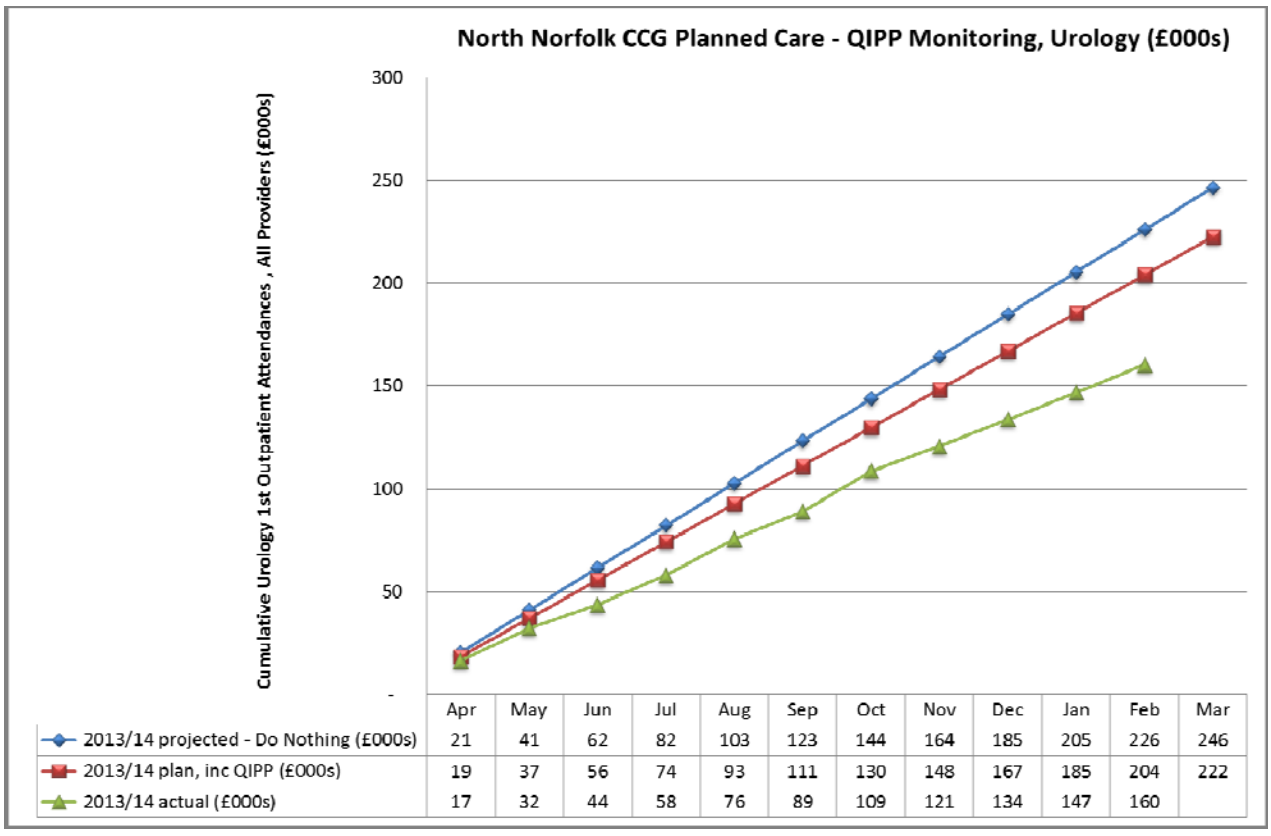
Activity type impacted	Project Title	Project Lead	Clinical Lead	Projected Saving (£000's)												
				Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Acute NHS	Unidentified	N/a	N/a													1,245

Total Plan	8,000

Appendix 2



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14 projected - Do Nothing (£000s)	18	36	55	73	91	109	128	146	164	182	201	219
2013/14 plan, inc QIPP (£000s)	9	17	27	35	44	52	62	70	79	87	97	105
2013/14 actual (£000s)	5	22	28	40	55	64	72	81	87	100	107	



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2013/14 projected - Do Nothing (£000s)	21	41	62	82	103	123	144	164	185	205	226	246
2013/14 plan, inc QIPP (£000s)	19	37	56	74	93	111	130	148	167	185	204	222
2013/14 actual (£000s)	17	32	44	58	76	89	109	121	134	147	160	

Appendix 3

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North Norfolk INTEGRATED CARE PROGRAMME PLAN 2013-15

Senior Officers : Mark Burgis (NNCCG), Jo Cook (NCC), Becky Cooper (NCH&C), Chris Hardwell (NSFT)

Clinical Lead: Dr James Gair (NNCCG), Head of Integrated Commissioning : John Everson (NCC/NNCCG), Project Manager : Fiona Craig (NCC/NNCCG), Project Officer: Jan Turton (NNCCG)

	INTEGRATED CARE OUTCOME MEASURES	*WORKSTREAM LEAD JOHN FOX*	*Linked document*	Baseline	Target	BRAG Status
Measures		**Reported by**				
1	Reduced avoidable emergency admissions to hospital	John Fox (NNCCG)	*ICB - LTC dashboard*	12/13 data	6% reduction	
2	Reduction in numbers of people who fall	John Fox (NNCCG)	*ICB - Community falls dashboard*	12/13 data	tbc	
3	Improved patient / service user experience of integrated care	Rebecca Champion (NNCCG)	*IC patient / carer survey*	12/13 data	100 patients 0/ 6months/	
4	Reduced admissions to residential or nursing homes	NCC data expert (TBC)		12/13 data	tbc	
5	Increased referrals to wider community, self-care & self-management based support	NCC data expert (TBC)	*ICC database*	12/13 data	tbc	
6	Reduced ambulance conveyance to hospital	John Fox (NNCCG)	*North Norfolk Acute Falls Dashboard*	12/13 data	tbc	
Milestones	**RISK STRATIFICATION**	***WORKSTREAM LEAD Fiona Hinton (GP practice)***	***Linked document***	**Target date**	**Actual date**	
		Reported by				
1.1	RP- Early Adopters (5 practices) complete pilot of risk profile tool	GP Practice Mgrs.	*RP Training plan*	31/10/13	05/11/13	
1.2	RP - Risk profiling training complete (SystmOne /EMIS)	Graham Dodd Wayne Bolt (GP Practices)	*RP Training plan*	24/11/13	20/11/13	
1.3	RP - Completion of risk stratification audit return	Sally Ross-Benham (NNCCG)	*Qrtly RP audit return*	31/04/2014		
1.4	RP - Risk Profiling Tool established across all practices	Fiona Hinton (GP Practice)		31/12/13	31/12/13	
1.5	RP - Evaluation of risk profiling tool and future usage	Fiona Hinton (GP Practice)		31/05/14		
1.6	EOL - GSF meetings taking place across all GP surgeries	GP Practice Mgrs.				
1.7	High risk (acute) - using risk profiling to manage patients in/out care homes	Rachel Arkieson (NNCCG)		tbc		
1.8	High risk (acute) - using risk profiling to manage patient in/out hospital	Mark Burgis (NNCCG), Mark Walker (NCH&C)		tbc		
Milestones	**INTEGRATED COMMUNITY CARE TEAMS**	***WORKSTREAM LEAD JO COOK***	***Linked document***	**Target date**	**Actual date**	
		Reported by				
2.1	Linked workers identified for each GP surgery - MH / NCHC / SC	Jo Cook (NCC)/ Becky Cooper (NCH&C)/ Chris	*Linked professionals GP list*	30/11/13	26/11/13	
2.2	ICC team (4 staff) in post (& on-going reporting on their work by BC/JC)	Becky Cooper (NCH&C)/ Jo Cook (NCC)	*ICC activity report*	30/11/13	17/02/14	
2.3	Integrated Care pack available at each practice to clarify process and data sharing protocols	Fiona Craig (NCC/NNCCG)	*IC Framework pack*	30/11/13	14/11/13	
2.4	Integrated care practice reviewed by professional leads	Jo Cook (NCC)		20/11/13	20/11/13	
2.5	Nominated IC Champion at each practice	Rachel Arkieson (NNCCG)	*Practice Mgr meeting minutes*	31/12/13	06/02/14	
2.6	ICC audit database in place	Jan Turton (NNCCG)	*Evaluation report*	31/01/14	28/02/14	
2.7	Integrated care meetings taking place at all 20 GP surgeries	IC champions (GP Practice)	*RP audit return*	31/12/13	31/12/13	
2.8	Alignment of reablement support to integrated teams	Jo cook (NCC), John Everson (NCC, NNCCG)	*Winter pressures action plan*	31/12/13		
2.9	Named key worker and care plan for each at risk patient	IC champions (GP Practice)	*RP audit return*	31/04/14		
2.10	Localised & increased re-ablement support including the scoping the integration with NCH&C rehabilitation services	Michelle Ducker (NNCCG)		tbc		
2.10	Localised & integrated community health and social care 'front door services	John Everson (NCC/NNCCG)		tbc		
2.11	Increased support and local care co-ordination / implementation of MiDoS (directory of services) to support clinicians making appropriate referrals	Fiona Craig (NCC/NNCCG)		tbc		
2.12	Integration of Community Health Social Care OT services	Becky Cooper (NCH&C)/ Jo Cook (NCC)		tbc		
2.13	Introduction of 7 day support services around GP surgeries	Mark Burgis (NNCCG)		tbc		
Milestones	**Independence, Self-Care & Self-Management Programme**	***WORKSTREAM LEAD JOHN EVERSON***	***Linked document***	**Target date**	**Actual date**	
3.1	New volunteer service commissioned to support integrated care outcomes	Caroline-Cunningham Brown (NCC/NNCCG)	*New volunteer specification*	31/03/14		
3.2	Community transport service plan in place to commission support to people accessing alternative community provision	Caroline-Cunningham Brown (NCC/NNCCG)		31/03/14		
3.3	On going review of 3rd Sector contracts aligned to support integrated care outcomes	Caroline-Cunningham Brown (NCC/NNCCG)		31/03/15		
3.4	Range of applicable community self care and self management options for patients and carers identified	Fiona Craig (NNCCG/ NCC)		tbc		
3.5	Mental Wellbeing and support intervention	John Everson (NCC/NNCCG)		tbc		
3.6	Development and piloting of 'help at home' programme including non-social care eligible and end of life	John Everson (NCC/NNCCG)		tbc		

Milestones	Integrated Falls Management Programme	WORKSTREAM LEAD JACKIE SCHNEIDER	Linked document	Target date	Actual date	
		Reported by				
4.1	Establishment of North Norfolk falls reference group	Jackie Schneider (NNCCG)	*Falls action plan*	31/01/14	06/01/14	
4.2	Falls dashboard updated to include data from wider sources	Brett Hobbs (NNCCG)	*ICB Community Falls dashboard*	03/04/14	28/02/14	
4.3	Remodelling falls referral pathways in the community	Michelle Ducker (NNCCG)	*Falls action plan*	03/06/14		
4.4	Review of falls mangement and pathway at N&N	Jackie Schneider (NNCCG)	*Falls action plan*	03/06/14		
4.5	Update GPs on revised falls pathways and educate on bone health pathways	tbc	*Falls action plan*	tbc		
Milestones	**Living Well with Dementia Programme**	**WORKSTREAM LEAD Dr NICOLA PINCHING**	**Linked document**	**Target date**	**Actual date**	
		Reported by				
5.1	Living well with dementia programme board set up and plan agreed	Ellis Layward (NNCCG)	*Dementia programme plan*	31/01/14	22/01/14	
5.2	Review locally available services and care pathways and improve their accessibility	Willie Cruickshank (Alzheimer's Society)	*Dementia programme plan*	tbc		
5.3	Improve recognition, screening, and early access to dementia diagnosis	Nicola Pinching (NNCCG)	*Dementia programme plan*	tbc		
5.4	Develop and strengthen establishment of community hubs and dementia friendly communities	Willie Cruickshank (Alzheimer's Society)	*Dementia programme plan*	tbc		
5.5	Engage with carers and people living with dementia to establish effective signposting to and information pathways	Laura Meadowcroft	*Dementia programme plan*	tbc		
Milestones	**Urgent Care Programme**	**WORKSTREAM LEAD MARK BURGIS**	**Linked document**	**Target date**	**Actual date**	
		Reported by				
6.1	Clinical network group established to identify local needs & priorities	Jackie Schneider (NNCCG)		04/12/13	04/12/13	
6.2	Winter planning initiatives in place	Michelle Ducker (NNCCG)	*Winter pressures project plan*	31/12/13	31/12/13	
6.3	Review impact of winter pressures measures	Michelle Ducker (NNCCG)		31/05/14		
6.4	Scope ways to improve acute discharge planning & post discharge support	Mark Burgis (NNCCG)		tbc		
6.5	Scope remodelling of integrated home from hospital service	Becky Cooper (NCH&C)		tbc		
6.6	Establishment of an integrated care system to manage access and discharge of patients from community hospital beds	Michelle Ducker (NNCCG)		tbc		
Milestones	**COMMUNICATIONs**	**WORKSTREAM LEAD FIONA CRAIG**	**Linked document**	**Target date**	**Actual date**	
		Reported by				
7.1	Dedicated integrated care area on NNCCG website	Christine Mawson (ACSU)		01/11/13	01/11/13	
7.2	ICCs attend Cromer public health event and subsequent press release on their role	Christine Mawson (ACSU)	*Press release*	29/11/13	09/12/13	
7.3	Promotion of warm & well initiatives (Public Health) across North Norfolk	Sarah Barsby (NCC)	*GP Bulletin*	31/12/13	31/12/13	
7.4	Agreed integrated care communications strategy to front line workers across all agencies	All senior officers, Rachel Arkieson (NNCCG)		31/03/14		
7.5	ICC engagement event with northern locality providers forum	Caroline-Cunningham Brown (NCC/NNCCG)		12/02/14		
7.6	IC champions quarterly forum to feedback progress and shape services	Christine Mawson (ACSU)		28/02/14		
7.7	Locality engagement event (x4) with integrated care teams	Christine Mawson (ACSU)		31/03/14		
7.8	Integrated care patient stories published to show new ways of working	Christine Mawson (ACSU)		31/03/14		
7.9	Work to be indertaken within the county workforce development partnership to develop the skills of the social care workforce	Caroline-Cunningham Brown (NCC/NNCCG)		tbc		
Milestones	**PATIENT ENGAGEMENT PLAN**	**WORKSTREAM LEAD REBECCA CHAMPION**	**Linked document**	**Target date**	**Actual date**	
		Reported by				
8.1	Patient focus groups (3) review integrated care approach	Rebecca Champion (NNCCG)	*Focus group report*	31/07/13	05/09/13	
8.2	Patient engagement and co-production plan in place	Rebecca Champion (NNCCG)	*Engagement Plan*	28/02/13		
8.3	IC questionnaire completed by 100 integrated care patients	Rebecca Champion (NNCCG) Rachel Arkieson (GP practice)	*IC patient survey*	31/03/14		
8.4	Trained health coaching professional in each GP surgery	Sandra Edgell (NNCCG)	*Health coaching training report*	31/03/14		
8.5	Patient stories of integrated care in practice collected by patient	Rebecca Champion (NNCCG)		31/03/14		
8.6	Patient response to integrated care at patient conference	Rebecca Champion (NNCCG)		30/04/14		
Milestones	**EVALUATION and REPORTING**	**WORKSTREAM LEAD FIONA CRAIG**	**Linked document**	**Target date**	**Actual date**	
		Reported by				
9.1	Integrated care report to Integrated Care Board	Fiona Craig (NCC/NNCCG)	*Monthly report*	monthly reports		
9.2	Integrated care report to senior officer governing boards	All senior officers	*Bi monthly report*	bi-monthly reports		
9.3	Integrated care baseline evaluation visit by The University of Warwick	Dr Charlotte Croft (The University of Warwick)		19/01/14	28/02/14	
9.4	North Norfolk Better Care Fund initial submission	John Everson (NNCCG/NCC),Mark Burgis (NNCCG)	*Initial BCF report*	14/02/14	14/02/14	
9.5	North Norfolk Better Care Fund final submission	John Everson (NNCCG/NCC),Mark Burgis (NNCCG)		04/04/14		
9.6	6 month integrated care programme report to senior officer reporting boards	All senior officers		30/04/14		
9.7	6 month review visit by The University of Warwick	Dr Charlotte Croft (The University of Warwick)		31/08/14		
9.8	Year 1 integrated care programme report to senior officer reporting boards	Mark Burgis (NNCCG)		30/10/14		

BRAG Key	
	Completed
	Missed target
	Some issues
	On target
	Not started

South Norfolk Clinical Commissioning Group

Operational Plan 2014-16

Version 7

11th April 2014






Document Control Sheet

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9/3/14	Draft V3 – circulated to localities & Governing Body for comment	Louise Browning	3
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3/4/14	Draft V6 – including comments received re: V5	Debbie Oades	6
11/4/14	Draft V7 – including comments received re: V6	Debbie Oades	7

Approvals

This document requires the following approvals either individual(s), group(s) or board.

Name	Title	Date of Issue	Version Number
Approval	SNCCG Governing Body	11/4/2014	V7
Approval	Norfolk Health and Wellbeing Board	11/4/2014	V7
Approval	NHS England	11/4/2014	V7

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GLOSSARY

ACB	Acute Commissioning Board
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
AHSN	Academic Health Science Network
AQP	Any Qualified Provider
ASC	Ambulatory Sensitive Conditions
ASD	Autistic Spectrum Disorder
AT	Area Team
BCF	Better Care Fund
C&B	Choose & Book
CAUTI	Catheter Acquired Urinary Tract Infection
CAMHS	Children's & Adolescent's MH Services
CCG	Clinical Commissioning Group
CCNT	Children's Community Nursing Team
CFS	Chronic Fatigue Syndrome
CHC	Continuing Health Care
CHD	Coronary Heart Disease
CIP	Cost Improvement Programme
CNUCN	Central Norfolk Unplanned Care Network
CoM	Council of Members
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CQRM	Clinical Quality Review Meeting
CQUIN	Contracting for Quality and Innovation
CRN	Clinical Research Network
CVD	Cardiovascular Disease
ENT	Ear, Nose & Throat
DASH	Disability and/or Additional Healthcare Needs
DCLG	Department for Communities & Local Government
DH	Department of Health
DHR	Domestic Homicide Review
DoLS	Deprivation of Liberty Safeguards
EASC	Emergency Ambulatory Sensitive Conditions
EDS	Equality Delivery System
EEAST	East of England Ambulance Services NHS Trust
EoE	East of England
EoL	End of Life
EPAU	Early Pregnancy Assessment Unit
EPOC	Effective Practice and Organisation of Care Group (Cochrane)
ERPHO	East of England Public Health Observatory
FAP	Frequently Admitted Patients
FFT	Friends & Family Test
FOP	Frail Older People
FOPP	Frail Older People's Project
FT	Foundation Trust
GB	Governing Body
GBAF	Governing Body Assurance Framework
GP	General Practitioner

GSF	Gold Standards Framework
HALO	Hospital Ambulance Liaison Officers
HCA	Health Care Assistant
HCAI	Healthcare Associated Infection
HEE	Health Education England
HEI	Health Environment Inspectorate
HR	Human Resources
H&WBB	Health & Well Being Board
IAPT	Improving Access to Psychological Therapies
ICO	Integrated Care Organisations
IP&C	Infection Prevention & Control
IM&T	Information Management and Technology
IST	Intensive Support Team
IV	Intravenous
JHWS	Joint Health and Wellbeing Strategy
JPUHFT	James Paget University Hospital Foundation Trust
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked After Children
LD	Learning Disability
LOS	Length of Stay
LT	Leadership Team
LTCs	Long Term Conditions
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
ME	Myalgic Encephalopathy
MFE	Medicine for the Elderly
MH	MH
MONITOR	NHS Foundation Trust Regulator
MRI	Magnetic Resonance Imaging
MRSA	Methicillin Resistant Staphylococcus Aureus
MSK	Musculoskeletal
MSOA	Middle Layer Super Output Area
NCC	Norfolk County Council
NCHC	Norfolk Community Health & Care
NELCSU	North East London Commissioning Support Unit
NHS	National Health Service
NHSE	NHS England
NHSIC	NHS Information Centre
NICE	National Institute for Health and Care Excellence
NIHR	National Institute of Health Research
NCCG	Norwich Clinical Commissioning Group
NNCCG	North Norfolk Clinical Commissioning Group
NNUHFT	Norfolk and Norwich University Hospitals Foundation Trust
NRLS	National Reporting & Learning System
NSCB	Norfolk Children's Safeguarding Board
NSFT	Norfolk and Suffolk NHS Foundation Trust
OOH	Out of Hours
PANSI	Projecting Adult Needs and Service Information
PbR	Payment by Results
PMS	Primary Medical Services

POPPI	Predicting Older People Population Information
PPG	Patient Participation Group
PTL	Primary Targeting List
QALY	Quality Adjusted Life Year
QEHKLFT	Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
QR	Quality Requirements
R&D	Research & Development
RCPCH	Royal College of Paediatrics & Child Health
RTT	Referral to Treatment
SNHIP	South Norfolk Health Improvement Partnership
SPA	Single Point of Access
SCN	Strategic Clinical Network
SCR	Serious Case Review
SEND	Special Educational Needs & Disability
SI	Serious Incident
SNCCG	South Norfolk Clinical Commissioning Group
SNDC	South Norfolk District Council
TIA	Transient Ischaemic Attack
T&O	Trauma & Orthopaedics
UTI	Urinary Tract Infection
VFM	Value for Money
VTE	Venous Thrombo-Embolism
WSHFT	West Suffolk Hospital Foundation Trust
2ww	Two Week Wait

National Background & Context

This section gives an overview of the national context in which South Norfolk Clinical Commissioning Group (SNCCG) is working and key areas of healthcare policy guiding our planning and commissioning process.

Introduction

NHS England's publication *"Everyone Counts: Planning for Patients 2014/15 to 2018/19"*[1] establishes the approach for CCGs to work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable, high quality care for all.

This document emphasises the need for an outcomes focused approach to planning, aligned to the NHS National Outcomes Framework, and for Clinical Commissioning Groups (CCGs) plans to reflect stretching local ambition over the next 5-year period.

SNCCG Strategic Plan 2014/15-18/19

SNCCG has joined together with North Norfolk CCG (NNCCG) and Norwich CCG (NCCG) to work as one strategic unit of planning particularly in relation to the interface with the principal acute services provider, the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT). We are committed to working with all providers, local government partners, patients and the public to develop a strong, robust and ambitious 5-year strategic plan. This collaborative plan will secure the continuity of sustainable high quality care for everyone in North Norfolk, Norwich and South Norfolk and is due for publication in June 2014.

Organisations in Norfolk are already committed to creating and delivering an integrated health and care system that supports our population to remain living independently with a good quality of life for as long as possible. All partners are committed to delivering high quality person-centred services, and agree that the only way to do this effectively is to work together to remove barriers, share the financial commitments and risks and ensure that we spend as much as possible of our budgets on integrated care.

The current national, regional and local position provides a significant opportunity for planning transformational change in the system, integrating service provision where it is appropriate and radically re-thinking how care can be provided to the populations of NNCCG, NCCG and SNCCG.

To do this, the three CCGs and all our local health services, primary and community care services, District and City Councils, Norfolk County Council (NCC), our local General Practitioners (GPs) and our voluntary sector and communities need to develop a common, united vision for integrated services.

However, this transformational change is taking place when the health and social care system in Norfolk is facing a number of major challenges over the next few years including:

[1] http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

- Workforce and staffing – significant recruitment and retention difficulties in certain key areas and an ageing workforce
- Seven day working leading to further staffing and resourcing issues
- The impact of the Care Bill[2]
- Significant financial constraints – against a background of an ageing population, an increase in Long Term Conditions (LTCs), rising costs and increased public expectations
- Significant continued reductions in social care funding/services

Our collaborative strategic planning process will consider all options to ensure resilient, viable, high quality services are available for SNCCG, NCCG and NNCCG residents. It is therefore imperative that this is co-produced with providers, patients/service users and other stakeholders and develops a joint approach between health and care for assessment and care planning. The development of our 5-year Strategic Plan will be informed by the planning and implementation of the Better Care Fund initiatives.

Our draft 5-year strategic 'Plan on a Page' is contained in ***Appendix 1***

Better Care Fund (BCF)

The £3.8 billion national *Better Care Fund*[3] (formerly the Integration Transformation Fund) was announced by the Government as part of the Comprehensive Spending Review in June 2013. It requires local areas to formulate joint plans for integrated health and social care, and to set out how the single 'pooled' budget will be used to facilitate closer working between health and social care to provide consistent, joined-up, high quality services for everyone and achieve the best outcomes for local people.

In order to access the BCF, CCGs and Local Authorities (LAs) must submit a five year delivery plan for approval by Government.

In addition to the Norfolk Health and Wellbeing Board (H&WBB) and individual partner organisations, the process of developing the delivery plan is supported jointly by SNCCG, NNCCG and NCCG, under the governance of the System Leadership Partnerships that bring together relevant commissioners and providers.

The BCF provides an opportunity to progress rapidly the delivery of the vision of the Norfolk H&WBB. In particular the focus is on early intervention and prevention, ensuring services are integrated at the point of delivery, that there are seamless services, including Mental Health (MH), and a focus on reducing loneliness and social isolation for older people.

The BCF provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and quality of life. It will also support the aim of providing people with the right care, in the right place, at the right time, including a significant expansion of care in community settings. This will build on the existing work of Norfolk CCGs and the LA. Further detail around the use of the BCF locally, and the 5-year

[2] http://services.parliament.uk/bills/2013-14/care.html
[3] https://www.gov.uk/government/publications/better-care-fund

delivery plan that underpins it, is set out in the Out of Hospital and BCF workstream sections (pages 60-68).

NHS Outcomes Framework

The *NHS National Outcomes Framework 2014/15*[4], together with the *Adult Social Care*[5] *and Public Health Outcomes*[6] *Frameworks* together support the Government's desire to improve integration of services. These documents set the national policy context and describe a range of indicators by which performance and outcomes for the NHS will be measured. These policy documents support SNCCG's desire to improve integration of services.

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on:

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with LTCs
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm

The *Public Health Outcomes Framework* consists of two overarching outcomes that set the vision for the whole public health system and outline what is to be achieved for the public's health. The outcomes are:

Outcome 1	Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life
Outcome 2	Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

These outcomes have been translated into **seven specific, measurable ambitions**, or critical indicators of success, which form the foundation of this Operational Plan, and against which SNCCG will demonstrate significant improvement:

4 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf

5 https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-2014-to-2015

6 http://www.phoutcomes.info/

Ambition 1	Securing additional years of life for people with treatable mental and physical health conditions
Ambition 2	Improving health-related quality of life for people with LTCs, including MH
Ambition 3	Reducing the amount of time people spend in hospital by having better more integrated care in community
Ambition 4	Increasing the proportion of older people living at home independently following discharge from hospital
Ambition 5	Increasing the number of people with physical and MH conditions who have a positive experience of hospital care
Ambition 6	Increasing the number of people with a positive experience of care outside of hospital, in General Practice and in the community
Ambition 7	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Additionally, NHS England (NHSE) has identified **three more key measures** where there is an expectation of significant focus and rapid improvement:

NHSE key measure 1	Improving health through promoting healthy environment and lifestyles
NHSE key measure 2	Reducing health inequalities between communities and within communities
NHSE key measure 3	Moving towards parity of esteem, ensuring an ***equal*** focus of improving MH and physical health

Improving the health of local people

In November 2013, NHS England published *"A Call to Action: Commissioning for Prevention"*[7] which suggests prevention programmes can be important enablers for reducing acute activity and capacity over the medium term, and sets out a five-step framework intended to support CCGs in commissioning for effective prevention:

[7] http://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf

	1 Analyse key health problems	2 Prioritise & set common goals	3 Identify high-impact programmes	4 Plan resources	5 Measure & experiment
Mature	• Local of analysis of deaths, chronic disability & risk factors in place, with understanding of sub-populations & potential future trends • Performance bench-marked nationally	• Small set of priorities focused on top health problems • Priorities supported by all major players local health economy • Priorities are quantified, including early detection	• Jointly commissioned primary & secondary initiatives highly focused on risk factors & key causes of morbidity and mortality • Early detection initiatives identified	• Reallocation is meaningful & phased realistically • Innovative use of health economy-wide funding including ITF • Investment linked to reduction in acute capacity over time	• Outcome & process metrics in place to measure progress on each prevention priority & programme • Experimental approaches where evidence base is poor that can be evaluated
Emerging	• Local analysis of causes of premature deaths, chronic disability & risk factors is in place • Collaboration with peers in the area/region to understand relative performance	• Priorities are focused on the big problems but set organisation- by-organisation • Some key players are not engaged in prevention goals • Quantified targets are not yet shared	• Isolated primary & secondary programmes driven by different organisations • No early detection activities outside nationally mandated programmes (e.g. screening)	• Targets for reallocating resources over time established • Funding for priorities provided organisaiton- by-organisation; little joint commissioning • Plans in place to deploy ITF	• Outcome & process metrics in place to measure progress on each prevention priority but tend to be long-term • Innovations are difficult to evaluate
At the start	• Data on premature deaths, chronic disability & risk factors are national only • Understanding of performance v peers is anecdotal	• Priorities attempt to embrace too much • Priorities are driven by legacy activities rather than epidemiology • Priorities are not translated into targets	• Prevention initiatives are limited to national screening, QOF-driven activities & other centrally driven initiatives	• Priorities not backed up by reallocation in resources • Funding driven by what's been done in the past rather than future needs	• Difficult to measure progress against preventative priorities • Measures are very long-term (e.g survival rate) and reactive (e.g. prevalence)

SNCCG will proactively work with Norfolk H&WBB partners, utilising the principles outlined in the above framework, to deliver the Health and Wellbeing Strategy[8] including those areas of the strategy focusing on health improvement and prevention.

As part of the development of a combined 5-year strategic plan with NNCCG and NCCG nine areas of intervention have been agreed to support the ambitions and outcomes framework. They are as follows:

Intervention 1	Development of primary care localities
Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Intervention 3	Proactive use of predictive modelling and risk stratification
Intervention 4	Easy to access, seven day health and social care provision for people with complex mental and physical health and care needs
Intervention 5	Enable independence, self care and self management
Intervention 6	Improved support for people with Dementia and their carers
Intervention 7	Deliver major redesign of urgent care system
Intervention 8	Ensuring effective end of life pathways and support
Intervention 9	Ensuring effective workforce planning

[8] http://www.norfolk.gov.uk/view/NCC122775

Parity of Esteem[9]

SNCCG understand that the delivery of health improvement and a reduction in health inequalities for the people of South Norfolk must also be delivered alongside a focus on improving mental as well as physical health i.e. ensuring there is parity of esteem.

SNCCG will seek to utilise the tool produced by NHS England *Parity of Esteem: transformative ideas for Commissioners*[10] which outlines how CCGs can achieve parity of esteem between physical and MH by allocating their resources differently through the provision of an evidence base, case studies and a guide to managing, securing and evaluating services.

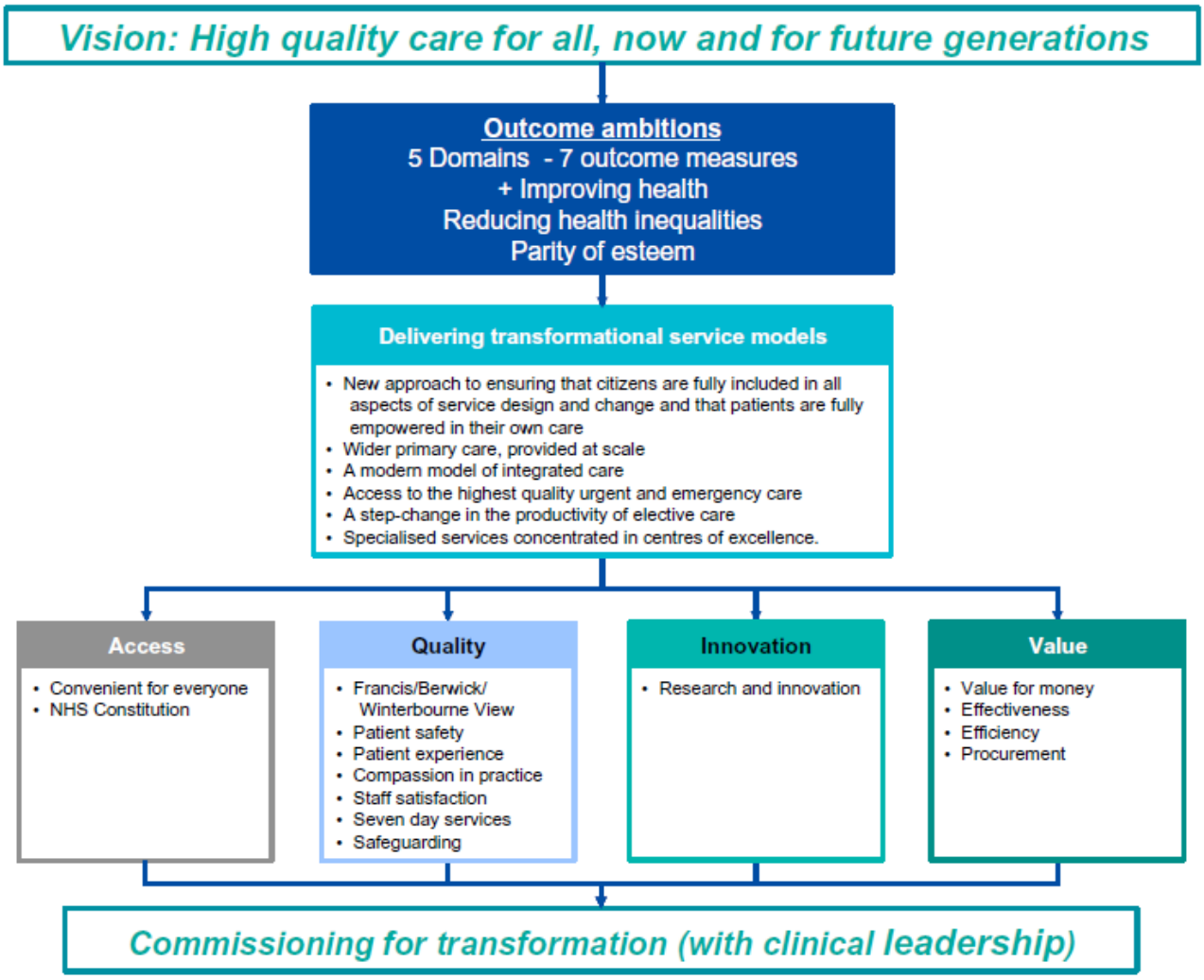
SNCCG will also ensure that the principle of parity of esteem is a central and fundamental element of all commissioning decisions, work streams and projects. This will be done by ensuring that the SNCCG population's MH needs become a core consideration at each stage of the commissioning process for all services being commissioned not just MH services. Key to this will be moving to the development (through our responses within the BCF) of further joint working and integration between MH and physical health care services at every level. In addition SNCCG will ensure effective joint working across children and young people's MH and physical healthcare services.

Reducing health inequalities

Health inequality can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mortality rates between people from different socioeconomic groups. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned.

The diagram below summarises the national framework through which NHS England's overarching vision and ambitions will be delivered, and which the CCG will deliver locally for the people South Norfolk.

[9] http://www.england.nhs.uk/ourwork/qual-clin-lead/pe/
[10] http://www.england.nhs.uk/wp-content/uploads/2014/02/nhs-parity.pdf



How SNCCG will reduce health inequalities

SNCCG's demography is outlined on pages 19-28 of this *'Integrated Commissioning Strategy'* and presents a number of challenges in reducing health inequalities.

SNCCG will tackle health inequalities by:

- Continue to work with Norfolk & Suffolk Primary & Community Care Research Office in understanding the health challenges facing South Norfolk's patient population, and the national context of health and social care research
- Collaboratively commission and strategically link with Public Health Norfolk to target health improvement programmes to areas of need, based on the ethos of the *'Fair Society, Healthy Lives' Marmot Review*.
- Engage with stakeholders across health and social care, local government, the voluntary and community sector and the wider statutory sector to understand areas of health inequality across South Norfolk and commission effectively.
- Work with patients and the public in areas of demographic deprivation and across rural communities to ensure that SNCCG is involving the population in the health and social care services it commissions

- Co-produce commissioning intentions and service developments by working with the communities it impacts on, with particular emphasis on under-represented communities and areas of deprivation.
- Development of the accessibility of SNCCG's communications aimed at the population of South Norfolk, focusing on areas of deprivation and information needs of specific groups

SNCCG is committed to improving its approach to equality and diversity linked to health inequalities, and has set out four equality objectives:

Equality objective 1	Patients and carers experience joined-up healthcare, ensuring access to the right services at the right time
Equality objective 2	The CCG will improve use of equality data and information about SNCCG's population and communities to inform its work
Equality objective 3	The CCG will improve the way that the Governing Body (GB) and Leadership Team (LT) can learn from healthcare experiences of diverse and marginalised individuals, groups and carers
Equality objective 4	Senior leaders and other managers provide leadership, support and motivation for their staff to uphold the CCG's value of equality of opportunity to improve the health of those most in need

It is acknowledged that significant changes to the way health service are delivered will be required if the above outcomes and ambitions are to be fulfilled.

In terms of the detail around the SNCCG essential elements of Quality, Access, Innovation and Value for Money (VFM) they are as follows:

Quality	Focusing on: • Patient safety • Patient experience • Compassion in practice • Staff satisfaction • Seven day services • Safeguarding
Access	Focusing on: • Disadvantaged and minority groups • Extending access in primary care
Innovation	Delivering change through: • Innovation • Adopting and promoting best practice

	• Continual research and evaluation
VFM	Focusing on: • Effectiveness Efficiency • Improved procurement

Strategic Clinical Networks

Strategic Clinical Networks (SCNs), hosted and funded by NHS England, were established in April 2013 and cover conditions or patient groups where improvements can be made through an integrated, whole system approach. These networks help NHS commissioners to reduce unwarranted variation in services and encourage innovation.

The conditions or patient groups covered by the East of England (EoE) SCNs are:

- Cancer
- Cardiovascular disease (including cardiac, Stroke, Diabetes and renal disease)
- Maternity and children's services
- MH, Dementia and neurological conditions

SNCCG clinical leaders play an active part in these networks and support the development of quality improvement in local services.

NHS Constitution

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it. The NHS Constitution[11] establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Under the Constitution patient's rights and privileges include the delivery of:

- Maximum of 18 weeks from referral to treatment (RTT)
- Maximum 6 weeks wait for diagnostic tests from referral
- Cancer waits for RTT
- Patient admission, transfer or discharge within 4 hours from arrival in Accident & Emergency (A&E)
- Ambulance response times.

SNCCG has embraced these rights and pledges within this Operational Plan and sets out its plans to commission sufficient services to ensure it can deliver those rights and pledges for patients on access to treatment.

[11] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Mandated in the Standard NHS Contract[12] is the requirement for the provider to comply with the NHS Constitution. This is set out in Service Condition No 1, and stipulates that the Parties must abide by and promote awareness of the NHS Constitution, including the rights and pledges set out in it. The Provider must ensure that all Sub-Contractors and all Staff abide by the NHS Constitution.
Specifically, set out in the Particulars, within the Quality Requirements (QR) is:

- The requirement for patients to start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral. The provider is also required to take all reasonable steps to offer a range of alternatives if this is not possible.
- The requirement for patients to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

As well as the lever to apply financial consequence for failing to meet the mandated Operational Thresholds, there are supportive local Thresholds to hold Providers to account. These include sanctions that can be applied if planned operations are cancelled if escalation is required under General Condition 9 of the Contract, the Provider is required to agree a Remedial Action Plan, and actions will be set out to ensure remedy accommodating demand and peaks in activity.

RTT (18 weeks) and monitoring of 18 week data

While the NNUHFT, as SNCCG's main provider, achieve the 18 week RTT threshold at an aggregated level as a Trust and for SNCCG, the standard has not been met in all areas at specialty level. Following an action plan in 2013/14 it is anticipated that performance standards will improve during 2014.

An integrated CCG clinical/commissioner working group of the Collaborative Acute Commissioning Board (ACB) is addressing activity and cost pressures in T&O through the review of pre and post hospital musculoskeletal (MSK) services. This work will ensure that every non-surgical intervention is employed prior to referral to the Acute Trust and that surgery is only recommended after appropriate triage, based on clinical thresholds. Additionally every patient will have a complete diagnostic review prior to their first outpatient appointment to improve the efficiency of this process for patients, Consultants and CCG finances.

Assurances around the timely delivery of the 18 week RTT standard form part of the contractual particulars SNCCG has with each Provider delivering services to its population, and are held within Schedule 4 of the particulars within the Operational Standards of Quality Requirements[13]. Ensuring delivery of these standards is one responsibility of the monthly Service Performance Review Group (SPRG) which functions as the contractual interface between Commissioner and Provider.

A summary of these requirements and performance management mechanisms is illustrated in *Appendix 2.*

[12] http://www.england.nhs.uk/nhs-standard-contract/
[13] http://www.england.nhs.uk/wp-content/uploads/2013/12/sec-a-part-1415.pdf

Delivery of timely recovery plans – down to specialty level

Where operational standards are not achieved, the Trust in question is obliged to produce a remedial action plan detailing the specific, time lined tasks they will undertake to rectify the standard. Failure to achieve agreed recovery plans will ultimately result in withholding 2% of the overall contract value.

Delivering improved outcomes for local people

NHS England is asking SNCCG to review its strategic and operational plans that were developed as part of the 'Authorisation' process completed in 2013 (the process whereby CCGs were formally ratified).

SNCCG's *'Integrated Commissioning Strategy, 2012-2016*[14]*'* gave a four-year strategic overview of the health and social care priorities in the South Norfolk area, and detailed the commissioning priorities and intentions of SNCCG within the local health economy. This overview was also captured in a visual matrix in SNCCG's 2013 'Plan on a Page'[15].

'Everyone Counts: Planning for Patients 2014/15 to 2018/19' provides SNCCG with the opportunity to refresh its *Integrated Commissioning Strategy* 2012-2016 and develop a robust and ambitious five-year plan (through to 2018/19) in collaboration with NCCG and NNCCG. The jointly prepared draft 5-year 'Plan on a Page' for 2014-19 is illustrated in *Appendix 1.*

SNCCG along with NCCG and NNCCG already have plans in place to jointly further develop the 5-year strategy that is due for publication in June 2014.

Norfolk Health and Wellbeing Board (H&WBB)

The H&WBB provides a focus for bringing together social care (for adults and children), public health and the CCG's priorities; its high-level membership reflects this with representatives including Directors of Community Services, Children's Services, Public Health, as well as representation from SNCCG and the other Norfolk CCGs. It is chaired by the leader of NCC.

The H&WBB's strategy for Norfolk has helped to inform our Joint Strategic Needs Assessments (JSNAs) which formed the evidence base for our 2013-16 Strategy and this 2014-16 Operational Plan.

The priorities for the H&WBB are:

- Promote healthy lifestyles,
- Strengthen investment in prevention and early intervention,
- Promote integration of care pathways,
- Reduce health inequalities.

14 http://www.southnorfolkccg.nhs.uk/sites/default/files/pdf/Integrated%20Commissioning%20Strategy%20-%202012-16.pdf

15 http://www.southnorfolkccg.nhs.uk/sites/default/files/pdf/South%20Norfolk%20CCG%20-%20Plan%20on%20page.pdf

Collaborative working with District Councils

A key approach by SNCCG is to work in partnership with South Norfolk and Breckland District Councils to help deliver a number of commissioning initiatives, in particular around tackling adult and child obesity.

Going forward the CCG is fully committed to continued working and development of a package of bespoke initiatives with District Councils and these will be developed under the auspices of a localised H&WBB. This is key to delivering the objectives of integration and the BCF. District Councils have rich insights into the needs of their communities and are well placed to support the local NHS to identify opportunities for early intervention to support people at home and avoid unnecessary secondary care admission.

About SNCCG

This section gives an overview of South Norfolk Clinical Commissioning Group (SNCCG) as an organisation, summarises the health issues in the population and sets out the vision and strategic goals to tackle these.

SNCCG was formed in July 2012 bringing together two original constituencies – Mid Norfolk and South Norfolk. The CCG has strong collaborative commissioning partnerships with other CCGs, North East London Commissioning Support Unit (NELCSU), NCC and Breckland & South Norfolk District Councils.

There is generally highly regarded primary and secondary care provision and long established clinical relationships across all healthcare organisations.

SNCCG comprises 26 General Practices and has a population of 223,000 (weighted 227,000). The CCG covers a predominantly rural area to the south and west of the city of Norwich and the main district towns are: Thetford, Dereham, Attleborough, Watton and Diss.

The current model of delivery in SNCCG is locality based. Its constituent member Practices are organised into four localities:

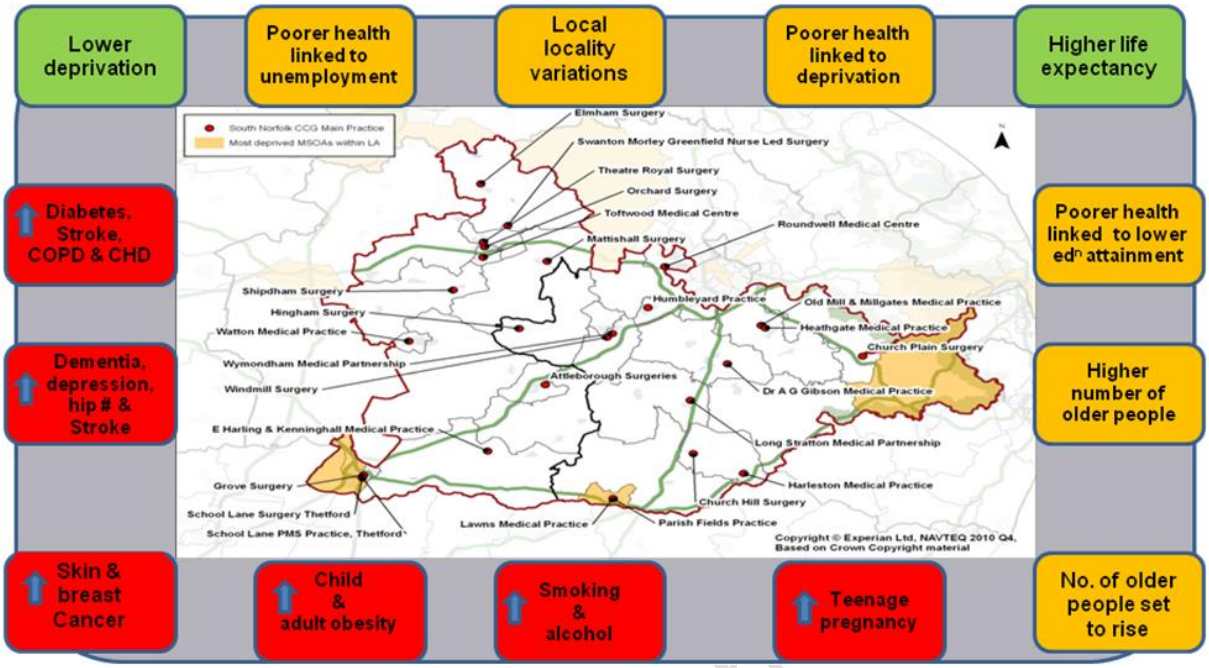
- Breckland,
- Ketts Oak,
- Mid-Norfolk,
- South Norfolk Health Improvement Partnership (SNHIP)

SNCCG spans two District Councils:

- South Norfolk District Council,
- Part of Breckland District Council (the remainder forming part of West Norfolk CCG).

SNCCG also commissions services for a section of population who live in Suffolk, but registered to a SNCCG Thetford Practice.

Practice locations and deprivation



SNCCG has developed as a collaborative membership organisation of clinical leaders with a strong Leadership Team. The CCG has a small core team which supports active clinical leadership and Practice engagement with the commissioning agenda.

The NELCSU provide support to SNCCG that includes contract finance, procurement, supporting the negotiation and management of contracts and back office functions such as Human Resources (HR) and Information Management &Technology (IM&T).

During the first year of operation following authorisation in April 2013 SNCCG has grasped the opportunity to focus on service redesign and community and out of hospital services in the localities. This continues to be delivered locally in strong partnership with key providers and LA partners. New structures and processes have also been strengthened in the past year to ensure that this alignment with partners delivers both better services for local people and better value for money, through, for example the development of an Integrated Commissioning Team with NCC.

Health issues in the population

People in SNCCG's area enjoy relatively good health compared with the rest of England. Deprivation is lower than average and life expectancy higher than average but the CCG-wide data mask variation at local level between localities, with some with poor health status largely linked to deprivation, unemployment and the low level of educational attainment.

Over half the population are of working age, there are higher numbers of older people than across Norfolk as a whole and the number of older people is set to rise over the next 20 years.

All cause mortality rates have fallen over the last ten years but there is a high incidence of Diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), Dementia, depression, Stroke, Cancer (skin & breast) and hip fracture. Whilst it is important

to tackle these diseases it is equally important to focus on the health improvement issues including adult and childhood obesity, smoking, alcohol consumption and teenage pregnancy.

This Operational Plan is being shaped by the health needs of, and the unique service delivery challenges faced by, the rural population of SNCCG, namely:

- An older population living longer with at least one LTC,
- A large rural area with poor transport infrastructure making access to services and the need to deliver more care at or closer to home more challenging,
- Unwarranted variation in health status and outcomes in particular parts of the locality, particularly for young people,
- A need to promote healthy lifestyles and improve quality of life,
- The need to prioritise resources accordingly in a time of economic constraint.

SNCCG also recognise the need to ensure equality of access to services for it's non UK resident population of approximately16,075 (6.9%) and 8,838 (3.8%) European residents; particularly Portuguese, Lithuanian and Ukrainian.

All of these characteristics present a challenge to SNCCG in designing services which excel at both preventing and managing the effects of LTCs, avoiding unnecessary reliance on acute hospital admission, and that promote well-being and independent living amongst the whole population but especially older people. SNCCG's focus remains on areas where it can have the greatest impact by reviewing pathways and seeing how they can be adapted to meet the challenges set out above.

The CCG's success will be measured by its ability to make consistent, incremental improvements in outcomes and cost effectiveness, and to tackle unwarranted variation, across its whole programme of commissioning activity in order to free up the resources to address future health needs.

Mission and values

The aim of SNCCG's mission and values is to create a strong sense of purpose and direction and as a new organisation the CCG has worked hard to determine its vision and core values. They will be the guiding principles by which SNCCG will conduct business and on which this commissioning strategy will be shaped.

The mission of the CCG is the statement of intent, setting out ambition for the future. SNCCG has agreed this mission to guide its commissioning as follows:

"SNCCG aspires to deliver the highest quality integrated healthcare, which is appropriate, effective, efficient and sustainable, in order to improve the health and well-being of the whole and diverse population of South Norfolk."

The values which underpin this mission and will impact on all our activities are:

- **The provision of quality services that are evidence-based, focused on patient safety, with measurable outcomes,**
- **Financial rigour in the planning, commissioning and on-going review of service delivery,**
- **The inclusion of patients, and others, affected across all elements of clinical commissioning, with particular emphasis on hard to reach groups,**
- **The provision of locally led clinical commissioning, placing our member Practices and our patient population at the heart of every decision we make.**

The CCG also aims to support people to have the healthiest lifestyle they can achieve. Central to this will be our continued work with local government and the voluntary sector partners to ensure our population is empowered and well informed to live healthy lives and manage their own health and wellbeing.

Aims

The CCG aims to promote its mission and values by:

- Promoting a culture of safety, continuous improvement and innovation through the commissioning of effective clinical services within a clear framework of quality standards,
- Avoiding reactive approaches to commissioning, replacing short-termism with a planned and sustainable approach to pathways of care,
- Working with key stakeholders on true collaboration and integration thereby delivering whole-systems approaches to clinical patient care,
- Nurturing clinical engagement by way of on-going support, development and training
- Utilising local patient experience to inform and challenge process. Embedding patient participation and engagement across all elements of the commissioning cycle,
- Identifying hard to reach groups and looking to innovative approaches to achieve their involvement.

The activities of SNCCG are guided by the *NHS Constitution*, national and regional policy, and *Everyone Counts: Planning for Patients 2014/15 to 2018/19.*

The CCG's strategy is to commission the best possible health services & outcomes for local people in financially challenging times by:

- Critically reviewing and maximising the value of our current investment in services (which could lead to disinvestment),
- Rigorously driving up the quality, effectiveness and efficiency of our commissioned services by better engagement of clinicians and intelligent but rigorous performance management of contracts,
- Relentlessly reviewing primary care quality markers, such as referral rates, prescribing and outcomes across our Practices so as to minimise unwarranted clinical variation,
- Commissioning care in the right setting, at the right time by the right team and practitioner,
- Delivering fully integrated community health and social care teams as the norm, working in full partnership with local General Practice to support people in their homes.

Partnership working with NHS England

The GB of SNCCG will assist and support NHS Engalnd in its duty to improve the quality of primary medical services (PMS) and specialised services. This will be undertaken partly through assurance from the CCG's Quality and Patient Safety Assurance Committee.

The GB will drive progress on the delivery of commissioned Primary Medical Services (PMS) and specialised services through rigorous reporting mechanisms. SNCCG will provide comprehensive and reliable information to NHS England to identify the use of, and requirement for, specialised services for its population and will work closely with NHS England to agree the optimal way to work in partnership to achieve this.

What will be different by 2016?

The development of this Operational Plan has been led by, and with, GPs. The next two years will have a number of characteristics, these will include:

- The delivery of this plan led by GPs, working with clinicians and patients,
- The patient and their quality of care will be the prime focus of the CCG's work,
- Collaboration across GP Practices and with key partners will build relationships and ways of working to benefit patients, clinicians, and other local professionals,
- Engagement with patients and the public and their involvement in the CCG's decision making processes will build a new partnership between a statutory commissioning organisation and the local population it serves using clinical expertise and ideas from others to develop opportunities for innovation.

More recently SNCCG has been developing its vision of what differences its residents would experience in healthcare by 2016/17. The CCG wish to see a health and social care system where the whole population (but especially older people and those with LTCs which impact their quality of life) have access to a fully integrated primary and community health and social care service. Importantly, appropriate and timely access to more specialist healthcare that is safe and delivered with compassion and dignity is critical. Over the next two years there is commitment to focus on specific pathways and the priorities are cancer and stroke.

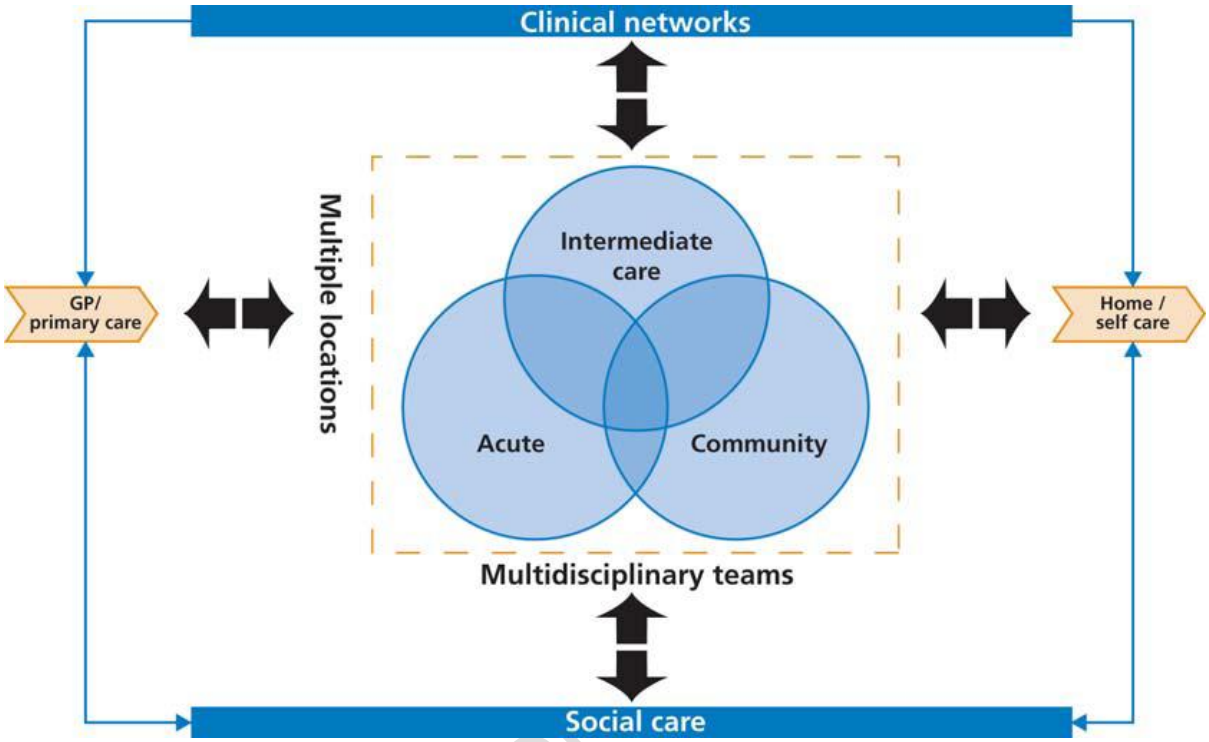
Our vision of integrated care includes:

- A comprehensive, single assessment process across health and social care,
- Greater local access to services which are planned and appropriate for delivery in the locality,
- Identified key workers who understand individual patient's social as well as medical contexts,
- Services which are simple to use and can be "switched on" via a single call and assessment,
- Services being arranged around patients' GP surgeries with access to a wider range of social, voluntary and housing related services,
- Fully integrated health and social care delivery teams which fully support the 26 GP Practices.
- A universal expectation that all services delivered in a timely and safe way at, or close to home, will be delivered with respect, compassion and a personalised approach to care.

SNCCG wishes to see less unwarranted variation in referral practice and we will strive to deliver more care in an out of hospital setting. In order to do this, excellent collaboration between clinicians across primary, secondary and community care must continue in order that services can be redesigned effectively to deliver these goals.

However, SNCCG will ensure that there is a balance between collaboration with providers, the use of contracting levers to secure delivery and the use of competitive procurement approaches to reform services and increase choice for patients and carers.

The conceptual model below illustrates the overall vision for care delivery:



Joint Strategic Needs Assessment (JSNA)

The Norfolk-wide JSNA[16] has been disaggregated to provide a rich picture of the health needs of the population. Key highlights are set out below.

Summary of local health priorities

The SNCCG health profile puts a clear emphasis on the following key elements that need to be at the heart of the CCG's future commissioning plans:

- Demographic changes - it is estimated that the older people population will increase significantly in number,
- Addressing health inequalities and deprivation,
- An increase in age related conditions putting economic pressures on the health system as a whole, such as prevalent LTCs (in particular Dementia and Diabetes), Falls as a result of increased frailty and Cancers,
- Obesity,
- Promoting healthy lifestyles: tackling smoking, alcohol and exercise as priority areas.

[16] http://www.norfolkinsight.org.uk/jsna

Population demographics

The registered population of SNCCG is estimated to be 223,000 (weighted 227,000). The population density is 1.0 and 1.3 persons per hectare in Breckland and South Norfolk districts respectively, both low if compared with Norfolk and the rest of England.

From mid-2008 to mid-2009 the population increased due to gains from migration from England and elsewhere, births and deaths being more or less in balance.

South Norfolk has a relatively larger proportion in the 40-70 year age group compared to England and a lower proportion of all age groups under 40, except for ages 16-19, compared to England. However, the male/female ratio is comparable to the England ratio.

Around 57% of the population in SNCCG are of working age, below the county and national figures, with a higher proportion of children than Norfolk, but lower than England. There also a higher proportion of older people, particularly in comparison with England. As already mentioned there is a 6.9% of our population that are non UK residents and 3.8% from the European Union, particularly Portuguese, Lithuanian and Ukrainian.

Full details of our health needs can be found in the 2012/16 SNCCG commissioning strategy (pages 12-24)[17].

17 http://www.southnorfolkccg.nhs.uk/sites/default/files/pdf/Integrated%20Commissioning%20Strategy%20-%202012-16.pdf

Age profile for South Norfolk CCG in 2011 compared to England (ONS 2012)

Key priorities

Although South Norfolk is overall less deprived, there are pockets of deprivation which lead to health inequalities. Health profiles published in 2012 show that while South Norfolk has relatively better scores for health indicators, Breckland has a significantly higher number of people diagnosed with Diabetes and the educational achievement is significantly lower than England average.

South Norfolk has a relatively lower prevalence of adult and childhood obesity, however, the proportion of overweight and obese children is increasing. Similarly, though the ward level teenage conception rates in Norfolk and South Norfolk are generally low, there are some wards which have levels above the England upper quartile. With an ageing population, there will be an increase in Dementia, depression and learning difficulties.

Priorities for improving health in SNCCG include:

- Stopping smoking
- Tackling alcohol misuse
- Addressing obesity by promoting healthy lifestyles.

For the ageing population the CCG will have an increased focus on:

- Prevention and management of age related LTCs such as Dementia, Diabetes, cancer and falls. The following table illustrates the predicted increase in the incidence of Dementia over the next eight years[18,19]

Condition	2012	2017	2022
Dementia	3,437	3,920	4,882
Depression	5,750	6,032	6,317
Learning difficulties	4,438	4,602	4,788
Estimated numbers with condition for South Norfolk CCG (POPPI and PANSI, 2009)			

For primary prevention the CCG will also tackle:

- Reducing variation in referrals and access to healthcare
- Improve flu immunisation

Key challenges emerging from population demography and epidemiology

SNCCG recognise the following key challenges:

- Reducing health inequalities within the population – whilst SNCCG covers a population which enjoys relatively good health, the district population data mask variations at super output level.
- An ageing population and the percentage of older people with one or more LTCs, such as Diabetes, COPD and Dementia.
- Rurality and access to treatment and care.

[18] http://www.poppi.org.uk/ Projecting Older People Population Information (POPPI)
[19] http://www.pansi.org.uk/ Projecting Adult Needs & Service Information (PANSI)

Communications and Engagement with Stakeholders

SNCCG's Communication and Engagement Strategy is produced and coordinated by the Engagement Lead and GB Lay Member Representative for Patient and Public Involvement in conjunction with the wide range of organisations and groups that represent people who use health and social care services.

Engagement mechanisms include:

- Annual stakeholder event (most recently in November 2013),
- Working actively with Patient Participation Groups at each of the 26 GP Practices in South Norfolk,
- A Patient Involvement event planned for Spring 2014 to bring representatives from all the PPGs together in one forum where integration will be a key topic,
- Local strategic forums across SNCCG area to bring together key commissioners from health, social care and district councils with input from key provider, service user groups and local Healthwatch,
- Regular attendance and input at health and social care forums in South Norfolk and Breckland, including Older People's forums, Youth Advisory Boards, MH and Carer's Locality groups,
- The involvement of members of the public (people who use services, carers) in specific pieces of commissioning work.

The multi-agency integration stakeholders group includes regular input from the older people's forum and Healthwatch. It is looking to ensure a wider range of voices are involved in strategic planning for integrated services. Discussions are underway with local interested groups about what integration of health and social care means and will look like from the perspective of the people who use services, with particular emphasis in under-represented patient groups and communities.

The existing local links will be built on, specifically with Breckland and South Norfolk Older People Forums; with Opening Doors (a self-advocacy organisation for people with learning disabilities) and with Equal Lives (a user led organisation for people with physical or sensory impairments, mental ill health and people with learning difficulties).

Patient and Public Involvement leads for the central planning cluster CCGs are collaborating to arrange for some joint engagement events to inform integration planning. SNCCG will also involve patients, people who use services and the public in co-producing the implementation programme, which will seek to:

- Involve people across a range of mechanisms (including workshops, discussion forums, online questionnaires and information streams) and build on existing work with Healthwatch Norfolk and the 'Your Voice' engagement network in Norfolk, as well as current co-produced commissioning projects,
- Involve people at strategic levels of decision making to inform the vision, strategic and financial forward planning,
- Involve people as 'experts by experience' in key aspects of the implementation of the integration programme e.g. in service redesign, as researchers to gather further evidence of people's experience of health and social care services; to agree co-produced outcomes and measures; as evaluators of the impact of integrated services on the lives of people.

Empowering patients

SNCCG fully recognises that the people in South Norfolk want to be

- Fully engaged in making positive choices about their own health and lifestyles,
- Participating in the shaping and development of health and care services,
- Have access to data and advice about health and services,
- Be able to choose which health services they can use and how to access them.

SNCCG will continue to use a range of ways to ensure patients and the wider public have a much greater say in how health services are organised, and to support patients and their carers in having a greater say in how their personal care is delivered. The CCG will continue to consult with patient forums and local representative groups. SNCCG have developed an inclusive approach to decision-making processes through Board and public meetings and other stakeholder events such as our recent Care homes Pressure Ulcer awareness workshop.

The CCG will continually improve the quality of the services commissioned by both listening and responding the views of patients, carers and the wider community.

SNCCG recognises that communicating effectively is important to everything we do. We aspire to the highest levels of honesty, openness and transparency, and actively promote both its successes and opportunities to improve. The well-established communications service has strong networks of communications professionals in all the provider organisations, and the CCG continues to build those networks with partners.

SNCCG published a Communication & Engagement Strategy 2012-15[20] in April 2013 and this document illustrates the approach to working with key stakeholders and partners across a range of sectors in South Norfolk.

SNCCG is in the process of consulting with key stakeholder organisations and patients to:

- Inform on why SNCCG is producing their strategic and operational plans,
- Ensure the role of carers is fully supported in all our strategies and plans,
- Explain and discuss some of the commissioning intentions SNCCG has developed,
- Involve stakeholder views in the development of these detailed plans,
- Ensure that at every stage of the planning and commissioning process there is a parity of esteem between physical and MH[21].

We also have plans for real-time experience feedback from patients and carers by 2015.

Engagement with communities

Many of the SNCCG GP Practices already have established patient participation groups (PPGs). These groups consult with their patients on a regular basis providing a formal mechanism for patients to air their views on their insights and choices. These choices will be

[20] http://www.southnorfolkccg.nhs.uk/sites/default/files/pdf/SNCCG%20Communications%20and%20Engagement%20Strategy%20V5%2024%2004%2013.pdf

[21] http://www.england.nhs.uk/2013/11/25/martin-mcshane-4/

brought to the SNCCG Governing Body through regular stakeholder events/feedback sessions and will help to influence future commissioning intentions of the organisation.

Some of the priorities emerging from PPGs are:

- The expansion of towns across South Norfolk and concern about the impact on clinical capacity,
- Clearer articulation of joint working between SNCCG and Breckland / South Norfolk District Councils,
- Clearer articulation of joint working between SNCCG and Norfolk County Council (NCC),
- The cultural and physical barriers restricting access to primary care across the locality.

Promoting patient choice

The CCG will continue to ensure that it meets all of its statutory duties in relation to patient choice and decision making and will work with local Practices to promote and publicise patient entitlement to choice. The rights of patients set out in the NHS Constitution are vital and SCCCG will strive to ensure they are effectively delivered.

Our plans include:

- **Choice in Primary Care** – including greater choice of GP Practice and choice of Any Qualified Provider (AQP) in community and MH services, providing support to people with long term conditions,
- **Choice before Diagnosis** – choice of diagnostic test provider,
- **Choice at Referral** – choice of provider, named consultant led team, MH and maternity services,
- **Choice after Diagnosis** – choice of treatment, choice of alternative provider at 18 weeks, and end of life care.

Equality Delivery System

In January 2014, SNCCG refreshed its Equality Delivery System (EDS) Outcomes Framework after extensive work and consultation with communities (particularly under-represented and protected communities under the definitions of the EDS Framework), support organisations and other local NHS CCGs and organisations. This information can be found on SNCCG's website.[22]

SNCCG's EDS Framework 2014-17 underpins its legal and statutory role in protecting the rights of the communities it works with and commissions on behalf of; it also outlines how SNCCG will proactively work with under-represented communities within the commissioning cycle to tackle health inequalities and improve access to care.

[22] http://www.southnorfolkccg.nhs.uk/about-us/equality-and-diversity

In the on-going development of SNCCG's commissioning intentions and strategic planning, the CCG works closely with a wide range of patients, public groups and cross-sector stakeholders to ensure that all opinions and views are recognised.

SNCCG does this by:

- Working with organisations that advocate on behalf of those under-represented and seek their guidance about best practice,
- Implementing Norfolk Guidelines 'Accessibility Matters' 1, 2 and 3[23] on the publication of printed materials, accessibility of public events and development of consultation resources and materials,
- Utilising equality impact analyses to plan and assess public involvement activities (including information resources, workshops, events and consultations).

[23] http://www.norfolk.gov.uk/view/NCC121308

Provider Landscape and Changes by 2016

The local infrastructure will ensure the continued delivery of high quality services and improved outcomes for patients, and ensure that the local health system is sustainable in the light of the financial challenges it faces. The health system will continue to work closely in partnership and with other stakeholders, to ensure that the significant changes to the way that services are delivered continue to provide value for money services that meet the needs of the local population.

There will be changes in the ways that patients use and access urgent and emergency services, with the majority of patients being seen rapidly, and supported, in a primary or community care setting.

Patients and the wider public will be well-informed about where and how to access their local health services and patients will be largely in control of when and how services are provided to them, and offered a choice of their care provider for specific services through the Any Qualified Provider programme.

Patients with a LTC or chronic condition will be firmly in control of accessing a range of local health and social care services that meet their own personal circumstances and needs.

To achieve this requires a combination of improved prevention and rehabilitation services, strong community and primary care services and the ability for the whole system to work effectively together to meet the needs of patients.

SNCCG is committed to ensuring a clinically and financially sustainable future for the local acute hospitals, and to ensuring that primary, community and social care services ensure that patients are only treated in a hospital setting when this is the best place to deliver the assessment and treatment the patient needs.

The local provider landscape is going through a period of significant change as part of the wider health and care review and we will continue to actively develop the provider landscape to support improved health outcomes, reduced health inequality and ensuring clinical sustainability.

SNCCG interfaces with more than one Acute care provider with near monopoly providers for MH care, community services and ambulance services. Services are generally highly regarded by patients and carers with positive results published in inpatient and GP surveys. The Providers are as follows:

- **Norfolk and Norwich University Hospitals NHS Foundation Trust** (NNUHFT) a large Acute service provider to the south of the city of Norwich. Access to the Trust is a challenge for some patients from some parts of SNCCG.

Governance risk rating = GREEN	Financial risk rating = 3

- **West Suffolk Hospitals NHS Foundation Trust (WSHFT)**, a medium sized Acute service provider in West Suffolk that includes a catchment from the south of Norfolk.

Governance risk rating Monitor is requesting further information following concerns about the Trust's sustainability and financial governance before deciding next steps.	Financial risk rating = 2

- **Norfolk Community Health and Care (NCHC)**, a county wide provider of community services, an aspirant FT, which operates from a number of community sites across the CCG.

- **Norfolk and Suffolk NHS Foundation Trust (NSFT)**, a large MH and learning disabilities NHS Foundation Trust provider.

Governance risk rating =GREEN	Financial risk rating = 3

- **East of England Ambulance Service Trust (EEAST)**, a large provider, an aspirant but delayed FT, which covers the counties of Norfolk, Suffolk, Cambridgeshire, Bedfordshire, Hertfordshire and Essex for emergency ambulances.

- **SERCO**, provider of community services to Suffolk CCGs and some services to some residents of SNCCG around the Thetford GP Practices.

- A range of Independent and voluntary sector providers based in Norwich, Bury St Edmunds and throughout the SNCCG area deliver local and countywide services.

Current areas of concern regarding variability of performance of providers include:

- Variable performance against key targets e.g. A&E 4 hour wait, 18 week wait RTT targets at NNUHFT,
- Poor ambulance response and turnaround times for EEAST.

Acute hospital services

NNUHFT provides around 85% by value of SNCCG's Acute hospital services. There are fairly small referral flows to the east, to James Paget University Hospitals NHS Foundation Trust (JPUHFT), and west, to Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEHKLFT). The NNUHFT is by far the largest and most influential Acute services provider with whom the CCG needs to work in partnership to deliver service redesign. There are also a number of referrals, around 10%, that are directed to WSHFT in Bury St Edmunds, mainly from Practices in and around the Thetford area.

Independent sector Acute provision is limited with a small SPIRE Norwich facility and Global Diagnostics both close to the NNUHFT site. Other independent sector providers are in King's Lynn, Cambridge and Peterborough; these are a 1-2 hour journey away from Norwich by car and almost inaccessible from rural areas by public transport.

Urgent care sector

EEAST provide a wide range of emergency and patient transport services across the eastern region.

Performance for category A (8 minutes) and category B (19 minutes) responses is variable even at times when demand is relatively low. This is an area of specific concern to SNCCG. There is a consistent failure to achieve performance targets primarily because of issues of rurality and distances to be travelled which is of significant concern to patients and GPs.

Mental Health (MH) and Learning Disabilities (LD) sector

NSFT was formed by a merger in 2011 of the former Norfolk & Waveney MH NHS Foundation Trust and Suffolk MH NHS Partnership Trust to provide MH services. Approximately 7% of the CCG's allocation is invested in services delivered by NSFT.

A proportion of Norfolk's LD services are run by Hertfordshire Partnership NHS Foundation Trust.

An overview of Trust performance is outlined below:

- Waiting times against service line standards are a cause for concern,
- Performance against Care Plan Approach (CPA) indicators is good,
- Performance against the percentage of patients transfer of care being delayed has improved.

SNCCG will continue to work closely with the Trust during its continued implementation of it's service strategy to assess any potential impact on the quality of patient care across South Norfolk as a direct consequence of proposed change.

Community health services

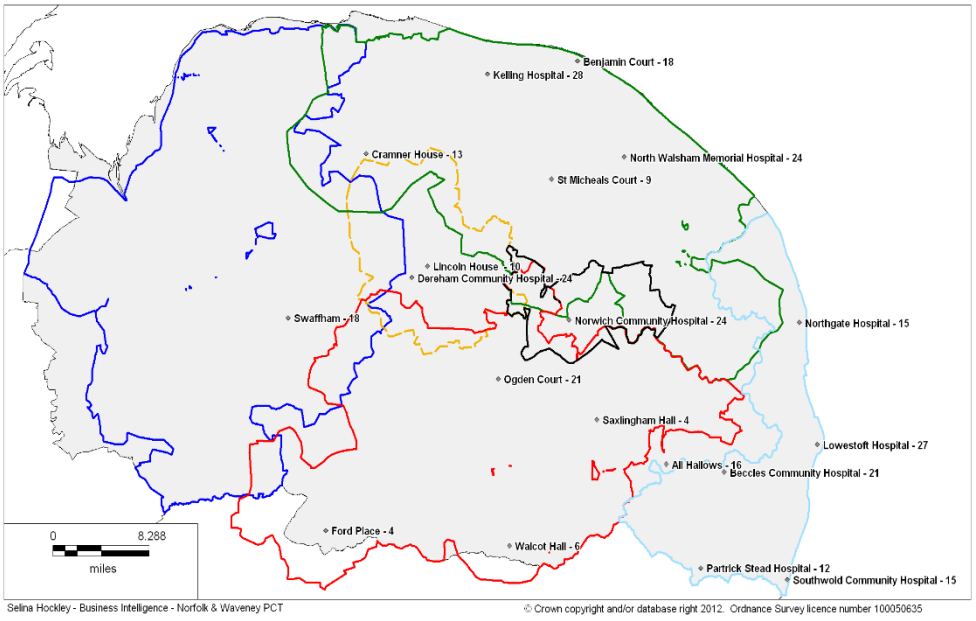
NCHC provides 50% by value of SNCCG's out of hospital care services along with a Norfolk-wide integrated LD services and Children's services. The Trust runs services which include community nursing and therapy, intermediate care beds and specialist community services such as Diabetes, heart failure, COPD, Epilepsy and Lymphoedema, from a variety of community hospital sites including Dereham to the west of Norwich and Ogden Court, Wymondham to the south of Norwich.

As part of the plan for integration and transformation, the Trust is moving to a 'hub and spoke' model of service delivery and SNCCG intend that this will be based on localities identified as part of the BCF plan.

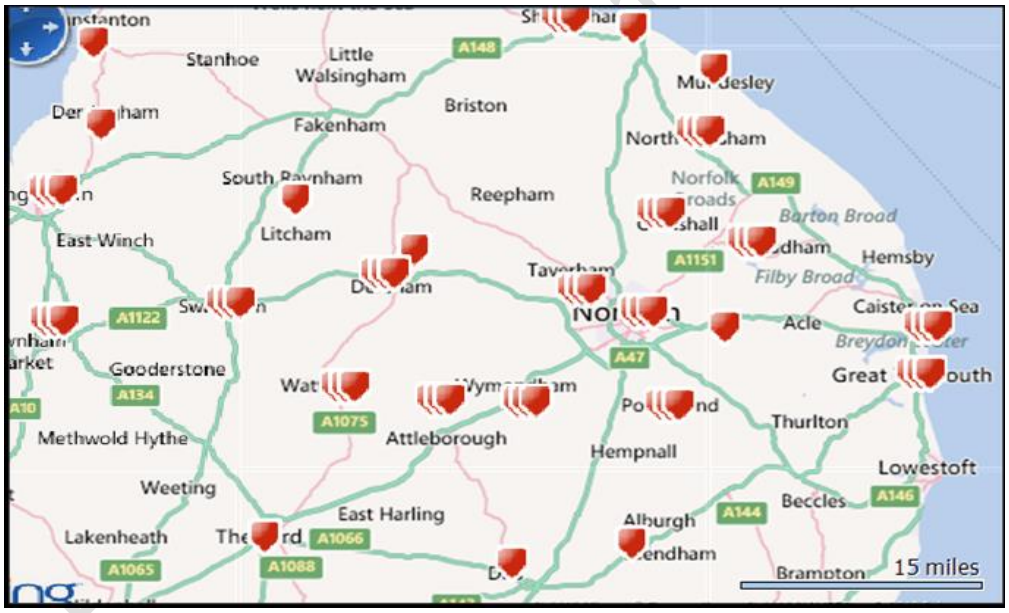
Independent sector

There are 374 care homes in Norfolk and there is also a thriving third sector in the community providing domiciliary care and day care services.

Non Acute bed mapping of intermediate care beds - with CCG boundaries
May 2012



Private Nursing Homes



Strengths, weaknesses, opportunities and threats in current provider market

Strengths	• General high quality local service provision • Foundation Trusts are largely financially viable
Weaknesses	• Provider monopoly for a number of service areas which has arguably led to a lack of ambition in service delivery • Choice operates more within providers rather than through competing providers given the challenges of access to other parts of the region. • Service redesign implementation has seen changes to provision that in some cases had a negative impact on delivery and in particular impacted on communications and joint working between services at locality levels.
Opportunities	• Potential for good collaboration between secondary and primary care to reform pathways • Potential for greater integration of care at a local level • Use of contracting levers including Contracting for Quality and Innovation (CQUIN) to drive up performance • Potential to further join up services for children and families and achieve better outcomes • Good relationships with Social Services
Threats	• Financial challenges impact upon maintaining and improving quality and performance • Ensuring delivery through challenging times • Ensuring patient and public confidence is maintained about the NHS in the face of significant organisation restructure and change. • Ageing workforce and demographic.

Patient Experience, Quality and Safety

Response to Francis, Berwick and Winterbourne View

In February 2013 the Francis report[24] established that proper accountability, a "zero tolerance" approach to breaches of "fundamental standards" and a "common culture" that puts patients first - these were the themes underpinning the 290 recommendations that form the heart of the report. The negative aspects of culture in the system were identified as including a lack of openness to criticism, a lack of consideration for patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions about the judgments and actions of others, an acceptance of poor standards and a failure to put the patient first in everything that is done.

To change that, there needs to be a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care. This means that the patient must be first in everything that is done: there must be no tolerance of substandard care; frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations.

SNCCG is committed to working with all our providers of NHS healthcare to ensure that our patients receive the best possible care, have a positive experience of healthcare and are treated safely. To ensure this is embedded throughout all our commissioned services we have developed and implemented a robust action plan that reflects the following key principles:

Quality and Safety first (getting the basics right)

- SNCCG will ensure that the services commissioned will demonstrate how safety issues such as infection control, management of serious untoward incidents, treatment interventions and the prevention of pressure ulcers are addressed,
- The minimum standards set by the Care Quality Commission (CQC) should not be the only standard for contracting services. The aim of SNCCG will always be to contract for best practice standards,
- The care that SNCCG commissions needs to be of the highest standard and clinically effective and take into account National Institute of Health & Care Excellence (NICE) quality standards[25] and new innovations in clinical care and service delivery,
- The CCG is committed to ensuring that children and vulnerable adults are not at risk from being abused or neglected and receive the care they require. Safeguarding is an important function through commissioning and through the delivery of care from those contracted by us.

[24] https://www.gov.uk/government/news/francis-report-on-mid-staffs-government-accepts-recommendations
[25] http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp

Ensuring robust accountability

SNCCG will:

- Scrutinise and ensure we have the capacity to undertake audits, inspections and investigations of individual/ group cases and clinical services,
- Ensure our Clinical Leaders will be at the heart of our Quality and safety surveillance,
- Ensure clinicians from SNCCG will be visible on provider sites and will work in partnership with the hospitals and community services providing care to patients,
- At all times be accountable for the scope and quality of all the services that we commission.

An open culture (transparency, openness and candour)

- Patient feedback on the services that we commission will be routinely collected and published. We will use this data to act like a smoke alarm to detect service failures. We will also highlight patients who receive good care as well as bad,
- We will use this feedback to address issues of concern with any of our providers.
- As a CCG we will welcome complaints, be open in acknowledging service difficulties, and encourage providers to do the same,
- We will make comparable information freely available at hospitals, surgeries and care homes and we will help patients to make judgments based on objective data about standards & outcomes,
- We will have active and on-going engagements with patients, the public and all interested stakeholders. We will use their feedback and patient stories to both challenge and improve clinical services.

The CCG is actively working with the public, patients, patient group and patient advocates; other commissioners, health regulators, employers and representatives of the professions to ensure mechanisms are in place whereby we are made aware of poor and unsafe practice so we can act quickly to protect patients.

Through joint working with the LA and NHS England Area Team (AT), SNCG is seeking to ensure openness, transparency and candour throughout the system about matters of concern. These are discussed regularly by the CCG's Governing Body and with other stakeholders, e.g. at the Norfolk Quality Strategic Alliance and Local Area Quality Surveillance Group.

Contracts that work for patients and clinicians

- We will make it clear the standard of services that we expect to be delivered by all of our providers,
- We will ensure that enhanced quality standards are embedded in our contracts and that we incentivise providers to constantly improve and deliver the highest possible care,
- We will ensure that quality standards are agreed by the doctors and nurses who deliver the service,
- The contract standards will be monitored and both the sanctions and incentives will be understandable and acceptable to clinical leaders and patients who receive clinical services,
- We will ensure clinical leadership is in place in all of our providers services.

Contract specifications and incentives e.g. CQUIN, are being used to enable improvement in local services and to encourage and enhance the local providers of services to pursue high quality effective services. The CCG will continue to monitor quality information generated by providers collected through inspections carried out at Quality Improvement Visits and from investigations of incidents and from complaints.

Providers are held to account for necessary improvements and action plans and to report on themes and trends in their Boards and Annual Reports and Quality accounts. The CCG also chair monthly Clinical Quality Review meetings (CQRM) with our main NHS providers, this includes NCHC, NNUHFT, NSFT and Out of Hours/111. This enables commissioners to work collaboratively and effectively together to identify early or potential concerns around the quality and safety of clinical services.

Berwick Report

Following on from the Francis Report, In August 2013 the Berwick Report[26] made further recommendations regarding patient safety in the NHS in England. It made a number of recommendations to help the NHS make care safer. The CCG's response to each is set out below:

Francis Recommendations	SNCCG response
The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning:	Learning from incidents and serious incidents is routinely scrutinised by the Quality and Patient safety team. The CCG Governing Body (BG) and Clinical Executive overview and scrutiny of trends and themes occurs and the monitoring of improvement plans and quality standards and performance supports and triangulates findings.
All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support:	The CCG engages in Quality Improvement visits to engage with providers and increase visibility of commissioners. This ensures commissioned services are of a high quality and risk and issues subject to early warning trigger systems.
Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.	The CCG is committed to the active engagement of patients and the public in our work. We work closely with all our providers to ensure this approach is reflective in the services we commission this is evident through the Friends and Family test ,Patient Opinion and local patient survey data that we review each month at CQRM. We also are working with NCHC to develop a community hospitals quality dashboard with a range of indicators that will aim to triangulate patient feedback/ information about the clinical care they have received.

[26] https://www.gov.uk/government/publications/berwick-review-into-patient-safety

Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.	A fundamental element of our clinical quality review process is to ensure that organisations have capacity to deliver safe services through well trained and adequate staffing resource. We do this by reviewing with our providers their Cost Improvement programmes, workforce plans and any transformation proposals to ensure any potential impact on clinical care has been fully assessed as safe.
Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executive	SNCCG ensures that the providers of services have in place adequate training and support to their staff to ensure that good quality care and patient safety approaches are adopted and are part of the service specification of its commissioned services. Further to this to support the training and education of staff through partnership working and planning through Health Education England (HEE) and locally in relation to Crown Prosecution Service (CPS) e.g. contract with Health Environment Inspectorate.
The NHS should become a learning organisation. Its leaders should create and support the capability for learning and therefore change, at scale within the NHS. Transparency should be complete, timely and unequivocal. All data on quality and safety ... should be shared in a timely fashion with all parties who want it, including... the public	SNCCG's Integrated Performance Report, which reports on clinical quality and patient safety issues is presented monthly to the Leadership Team and also to the public meeting of GB. The report is also made available to members of the public on the CCG's website.
All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.	The Community Engagement Group is a subcommittee of the GB, made up of appointed members of the public, who influence and scrutinise the CCG at a strategic level. Meeting are held in public across South Norfolk.
Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.	The CCG will continue to monitor the implementation of patient safety alerts issued through NHSE in monitoring of its local contracts and quality measures with providers.
We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.	The CCG will ensure it collaborates in the use and requests for information from providers in support of quality, safety and regulation by CQC e.g. through quality surveillance groups and shared intelligence. It will utilise datasets and metric available through the NHS Information Centre (NHSIC) to monitor and benchmark the quality of local services.

The Winterbourne View Report[27]

The Winterbourne report set out the type of care that people with learning disabilities/autism and behavioural issues should receive. These are:

- People should receive local personalised services that meet their needs, which should be planned from childhood,
- People should be supported in the community, in their home or close to their home and family,
- People should only go to hospital for assessment and treatment if it is necessary and they cannot get the support they need at home or in a community service,
- People that do have to go into hospital for assessment and treatment should receive good quality care as near to their home as possible,
- People should be moved on from hospitals as quickly as possible – either back home or on to other community support,
- Commissioners who place people with learning disabilities/autism in hospital or community support settings should have clear responsibility for each person,
- Commissioners should also make sure that people with learning disabilities/autism are able to see and speak to their families regularly,
- There should be local services that stop people with learning disabilities from having a crisis. If a crisis does happen then there should be local services to help people deal with the crisis.

The CCG has reviewed the cohort of South Norfolk Winterbourne clients as per Winterbourne concordat.

All clients had a joint review by the SNCCG, NNCCG, NCCG and NCC. All clients have discharge dates and are aided to access supported living arrangements in Norfolk, where appropriate. A joint Winterbourne sub-group will feed into a joint commissioning forum to ensure the needs of the learning disability client within Norfolk have the right services in place to ensure they are supported to live as independently as possible. The Winterbourne concordat will also provide a backdrop for improving services for other vulnerable groups including children and young people.

Patient safety

The scrutiny of information and metrics by the CCG of measures including the safety thermometer, never event and serious incident data and the other quality metrics enables the consideration and of emerging themes and trends in patient safety and harm to patients. The CCG cooperates with, and participates in, the emerging patient safety collaborative being set up by NHS England whose aim is to provide a network of patient safety learning and improvement to continually improve care at the front line and to reduce the likelihood of harm to patients.

The increase in reporting of harm and in particular the reporting of medicines related incidents will continue to be promoted through contractual and quality improvement discussions with providers and stakeholders. Monitoring of the levels of reporting through the

[27] https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

National Reporting and Learning System (NRLS) and through Serious Incident (SI) reporting routes will support the NHS Outcomes framework aim of higher reporting. SNCCG will continue to work closely with commissioned providers to reduce levels of harm by increasing awareness of best practice and innovative approaches to service delivery. In particular we are focusing on four national high impact actions: Pressure ulcer prevalence, Catheter acquired urinary tract infections (CAUTI), Falls, Venous Thrombo Embolism (VTE). In addition we are focusing closely on the early identification and treatment of Sepsis.

Infection Control

Over the coming year we will build on learning from local reviews with our providers by continuing to optimise the use of root cause analysis of all incidents, including those in the infection control review process for Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile to identify lessons learned and action required to prevent recurrence. We have refreshed all our quality schedules with each provider to ensure latest infection control guidance is reflected in contracts which will be monitored through local audit and observation of practice. We will also continue to participate in the EoE Quality Surveillance group to identify early warnings of service and quality failings, in order to address the risks to patient that the potentially raise.

We continue to strive in Norfolk to achieve zero MRSA bacteraemia cases for 2014-15 as per national guidance. A substantial effort to achieve this end continues throughout Norfolk in terms of implementation of robust Infection Prevention &Control (IP&C) standards in all areas of healthcare. This is reflected in our ongoing excellent performance for MRSA bacteraemias in acute trusts i.e. No acute hospital bacteraemias for 23 months.

Through the Post Infection Review process for some of our most recent community MRSA bacteraemia cases it is apparent that best practice has been met at each stage of the patient journey and unlikely that any other interventions would have made a difference to the patient outcome in terms of developing the bacteraemia. Therefore the question can be posed ‘have we begun to reach an irreducible minimum’?

Norfolk will continue to exercise 100% efforts in ensuring the highest standards in IP&C across the health economy to strive to achieve zero MRSA bacteraemias for 2014/15.

Regarding Clostridium Difficile infections, we are committed to keeping the number of infections to a minimum.

For SNCCG we have a target of no more than 59 cases during 2014/15 and have also set our main hospital and community providers individual targets.

Health Associated Infection Control - New initiatives for 2014

- The Public Health Infection Control Team Liaison Nurse will be focusing on the learning from CDIFF Community root cause analysis (RCA.)
- In order to follow up on patients who have been discharged from an Acute setting to a Community setting prior to their MRSA results being received to ensure there is effective liaison with the patients GP and the relevant Community Team. It is anticipated that this will have an impact by reducing MRSA Bacteraemia which is an outcome from RCA learning.

- The role will also support our understanding around the Epidemiology of Community of Community related CDIFF cases. To date Norfolk has observed CDIFF cases reducing in the Acute setting but not in the Community.
- A greater emphasis will be placed by the Health Care Associated Infection (HCAI) Team on behalf of South Norfolk Clinical Commissioning Group (CCG) on our Care Homes. This will be achieved by working collaboratively with Norfolk County Council (NCC) and other partners to meet the Harm Free Care agenda. A particular focus will on producing Catheter acquired infections by educating Care Home staff and improving clinical competencies.
- The HCAI Team on behalf of SNCCG will work in collaboration with Public Health England to develop and implement a range of study days to support all providers of commissioned health care.
- The HCAI Team on behalf of SNCCG will work closely with domiciliary care providers to identify the needs of domiciliary care staff. This will include joint working with NCC Joint Response Team.
- The HCAI Team with SNCCG will work with other providers including Acute Hospitals outside of the Norfolk area to identify best practice, innovation and shared learning.
- SNCCG will work closely with the HCAI Team to design a 5 year Health Care Infection Control strategy. This will also involve collaborative working with the Norfolk HCAI Network.
- SNCCG will continue to ensure zero tolerance for all MRSA Bacteraemia across all providers.

Patient Experience

Patient experience metrics are reviewed contractually for all commissioned providers identifying trends and themes of the complaint and feedback received and whether there are month on month improvements. Evidence is provided through ward to board that complaints are efficiently and effectively addressed.

The CCG will continue to focus on feedback from patients and staff, ensuring whistleblowing policies are known and understood and that staff trust the organisation has a no blame culture.

Patient experience of vulnerable patients will be improved through learning from serious incidents, complaints and serious case review findings.

Joint working through the *Domino* initiative and urgent care network with all providers and CCGs will continue to ensure admission prevention strategies and early supported discharge are in place.

Development of specific feedback mechanisms related to each vulnerable group will continue to be integral to capturing issues important to them as well as capturing carer feedback. Adult safeguarding forums and information sharing mechanisms with Healthwatch, CQC, NCC and the CCG will continue and be strengthened by joining the quality monitoring of providers, particularly in the care home sector and supported living

All patient experience feedback from both the provider and the CCG is reported monthly through performance reporting to both the Clinical Executive (senior leadership) and the CCG GB.

Triangulation of Patient Experience, Complaints and Incidents

The CQRM for NHS provider organisations monitor patient satisfaction, incidents and NHS provider organisations reported complaints. This information is triangulated with the commissioner's complaints that are received by SNCCG and/or via the NELCSU on behalf of SNCCG. SNCCG regularly review this information for any potential early warning signs and to identify any themes or trends that could affect the quality and safety of services for SNCCG patients.

Friends and Family Test (FFT)

The FFT is applicable to all providers' inpatient areas, A&E, paediatrics, obstetrics and gynaecology, and outpatient clinics. An increase in the number of patients asked is being incentivised through the national CQUIN for 2014/15. This will include FFT staff surveys, as well as annual staff surveys and recruitment that are focused on each organisations values and behaviours.

SNCCG are also working closely with NCHC to design a Community hospitals quality dashboard that will incorporate the FFT along with patient opinion and local patient survey information to provide a robust quality indicator for a number of clinical pathways. It is hoped that this help inform future application of the Friends and Family test across other areas of the NHS. The CQUIN for FFT is driving zero detractors and this will be concentrated within inpatient areas of all providers. This will provide an additional dimension for providers to review patient safety, clinical quality, and patient experience metrics to improve the overall patient satisfaction in their experience of care.

The initial role out of FFT has proved to be a learning curve both locally and nationally. The learning that has been gained has been shared, and will aid us in supporting providers in the further role out.

Through the joined up working of the CCGs, Area Team and providers we are able to look ahead at the future role out plans and prepare providers for what they should expect and ask them in advance to consider how FFT will function and the challenges they foresee, in order to begin trouble shooting early on.

SNCCG has been successful in winning a national bid for a three month project to look at the practicalities of FFT being used within the community hospital setting and on specific pathways. This will enable the CCG to explore with our providers prior to roll out what this will look like and work with the national team to show the practicalities that need to be considered prior to official implementation. This project will also lead to the development of a community hospital quality dashboard that will allow us to easily triangulate patient experience data in a way that will give both ourselves and providers a holistic picture of performance.

NCHC have already piloted FFT for the past year through their own initiative and gathered a wealth of information as to the barriers they have faced. This will be shared in summary with other similar providers locally. We will work with providers to achieve and maintain their FFT response rates and work with the East Anglia Area Team to learn from other provider success stories, as well as sharing our own.

The FFT scores for providers will be monitored to drive improvement and we will work closely with providers to support them in implementing learning from the qualitative feedback. Ways of using technology to drive patient experience feedback and response rate improvement with providers who are struggling will form part of our ongoing assessments and again our successful project funding will support this. We will also work with local health watch PPGs to evolve our co-production of service improvement through FFT feedback.

Quarterly staff FFT will be reviewed and we will work with providers to ensure they share openly the feedback and work with staff to take on board qualitative comments and where possible implement change.

We want to ensure providers give positive feedback received through FFT to staff and that they work with staff on negative feedback received in a way that gives them ownership and input to improvement and learning. We will be ensuring all providers operate an honest and open environment to share the '*You said… We did…*' concept in public areas and staff rooms.

The FFT placement in GP contracts for 2014/15 from December will mean GP's are obliged to participate in the collection of this data. SNCCG will commence work early on in 2014 with PPG groups and the AT to look at how this will impact GPs and the way in which they will go about the practicalities of the implementation. Questions we want to answer prior to roll out:

- With what frequency will FFT be delivered to patients?
- How will the frequency be monitored?
- How will the response rate be recorded to match the frequency?

Compassion in practice

The "NHS Nursing Strategy: Compassion in Practice"[28] sets out the shared purpose for nurses, midwives and care staff to deliver high quality, compassionate care, and to achieve excellent mental and physical health and wellbeing outcomes. It builds on the enduring values of the NHS, and the rights and pledges of the NHS Constitution. The strategy sets out six areas for action to be implemented over the next three years:

- Staying independent, maximising wellbeing & improving outcomes,
- Improving patient experience,
- Delivering high quality care & measuring impact,
- Building & strengthening leadership,
- Right staff, right skills, right place,
- Supporting positive staff experience.

SNCCG will ensure that all local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans and how the 6Cs[29] are being rolled out across all staff groups through the Clinical Quality Review meetings held monthly each month but more importantly by direct observation of practice during site visits to clinical areas as part of our on-going programme of visits to providers.

[28] http://www.england.nhs.uk/nursingvision/
[29] http://www.england.nhs.uk/wp-content/uploads/2012/12/6c-a5-leaflet.pdf

Safeguarding

The Norfolk-wide system has reviewed its adult safeguarding strategy as well as developing a system-wide action plan of implementation. This will include information sharing mechanisms and aligning clinical incident and serious incident reporting to NCC, identifying reporting thresholds in line with the national guidance, and 'No secrets' guidance which is facilitated by the health sub group chaired by all Norfolk CCGs.

SNCCG are also ensuring the following actions are undertaken with regard to safeguarding:

- Adult safeguarding training will be standardised against the Bournemouth competency framework. The Mental Capacity Act (MCA)/Deprivation of Liberty Standards (DOLS) competency framework will be developed and rolled out as a Norfolk-wide system within health.
- Reporting mechanisms in the form of Key Performance Indicators (KPIs) will be clearly set out in each contract with providers and reporting on all aspects will take place monthly.
- Quality Inspection visits are in place to review safeguarding systems and processes, as well as asking staff and patients for feedback.
- Safeguarding referrals and lack of reporting will be monitored through quality sub group meetings that fit within the contractual process.
- Workshops and training to raise awareness of the Prevent strategy within the healthcare will take place with a DVD-based training package called HealthWRAP – Workshop to Raise Awareness of Prevent. The workshop, aimed at any NHS staff; front line staff, managers and clinicians, is designed to help make them aware about their contribution in preventing vulnerable people being exploited for terrorist purposes. The workshop improves understanding of the processes used by terrorists to radicalise individuals and ensures staff are aware of who to contact within their organisation to discuss any concerns. Numbers of staff who access this training will be monitored through the contractual process.
- All providers have this new guidance built into quality schedules which will be monitored going forward via the CQRM process.

SNCCG's response to Winterbourne View, requires an end to all inappropriate healthcare placements for every person with a LD and/or Autistic Spectrum Disorder (ASD) with complex needs and challenging behaviour by June 2014, and that they receive the right care in the right place, in accordance with the Winterbourne Concordat

For all detained patients with a LD within private hospitals, both the CCG and NCC have undertaken a joint review of all placements. Where appropriate, discharge dates into community settings and access to supported living arrangements in South Norfolk, have been established.

Safeguarding Adults

Adult Safeguarding has become firmly enshrined in our commissioning activity, with significant amendments made to contracts and quality schedules for the coming financial year. This is to reflect how changes to national policy and guidance impact locally, to build upon locally identified gaps in provision and to ensure that findings of recommendations from Serious Case Reviews (SCR) and Domestic Homicide Reviews (DHR) are implemented. Performance indicators are in place to ensure that NHS provider organisations implement

appropriate training and have appropriate systems in place to ensure that their staff have the skills to identify individuals at risk and that they are able to manage their needs appropriately. This includes a requirement to report on provision of training regarding Adult Safeguarding, MCA/DOLS, Domestic Abuse and individuals at risk of radicalisation (Prevent).

The CCG will continue work actively with partnership organisations to support the Norfolk Safeguarding Adults Board and to implement its strategies in delivery of a system that protects adults at risk of harm and that respond appropriately where abuse or neglect have occurred. Key work by health over the coming year will see a bespoke training package rolled out in relation to the MCA/DOLS/Best Interests, which will be available to all NHS providers including those in Primary Care. A number of training sessions will be implemented within CCG's and NHS providers to widen the understanding of the joint Home Office/Department of Health (DH) Prevent agenda, which looks at early intervention to prevent many of society's most vulnerable people becoming involved in criminal activity. In addition, in partnership with the Norfolk Police and Crime Commissioners Office, a training package has been developed to increase awareness in primary care regarding the risk factors and early warning signs in domestic abuse, alongside information on how to raise these concerns appropriately and source support for service users.

Safeguarding Children

Health organisations in Norfolk continue to meet requirements as set out in the working together to safeguard children March 2013 and execute their roles and responsibilities to safeguard and protect children and young people from significant harm. They will strive to meet their statutory requirements as stated in statutory guidance (2009) in promoting the health and well -being of Looked After Children (LAC) and implement recommendations from the system wide review for LAC as agreed at the Child Health and Maternity Commissioning Board.

Children and young people in Norfolk continue to be a priority to improve safeguarding and looked after children arrangements. There are clear plans to bring about improvement within the multi- agency context. Norfolk health has a clear structure and ownership at all levels to ensure that there is buy in to achieve a strategic vision to bring about improvement and partnership working. Health will be represented on the improvement board that has been set up following areas highlighted in Ofsted inspections as requiring improvement as well as NSCB and subgroups.

There will be measures in place that is included in contracts to report key areas of performance and any actions that come from those reports. Each health organisation will have a Work plan related to the improvements to safeguarding and Looked After children and the designated team will have an overarching view and have oversight of development and progress from inspection and serious case reviews included in the plans. There will be single and multi agency audits to demonstrate meeting required standards that have been set which will be reported to boards for further scrutiny.

Key strategies and areas identified as a priority with a national direction such as Child Sexual Exploitation will continue to be progressed and developed within Norfolk health with regular reports on progression.

Identifying and reporting Domestic abuse will be monitored and any identified challenges with recommendation and actions will be delivered and escalated where highlighted.

Safeguarding children Training in health continues will be developed and delivered both single agency and multi- agency in line with the Safeguarding Children and Young People: roles and competencies for health care staff Intercollegiate Document' (Royal College of Paediatrics and Child Health (RCPCH)[30], September 2010 and Looked after children Knowledge, skills and competence of health care staff Intercollegiate Role Framework (RCPCH, May 2012) and monitored through the contractual framework.

Safeguarding Clinical Leads

SNCCG has direct support from the Norfolk Health children's safeguarding team that we commission and there is a named Safeguarding nurse (Sandra Corry) and a Children's Safeguarding GP (Dr Hilary Byrne). Both are members of the South Norfolk children's safeguarding board and are represented at the Norfolk Children's Board.

Governance

The following section describes the governance arrangements and supporting business processes for the delivery of the strategic and operational plans, including information on:

- The decision making and planning arrangements within SNCCG, and how this supports delivery of quality services,
- The agreed programme management approach to track delivery of the Quality, Innovation, Productivity and Prevention (QIPP) programme,
- Responsibilities and accountability for performance delivery, including financial balance and activity levels.

Governance arrangements

The CCG GB meets bi-monthly in public and has prime responsibility for the scrutiny and approval of strategic and operational plans. The agenda and minutes of each meeting are published on the CCG website, so they are accessible to all. The GB is supported by a weekly senior management team meeting and a monthly Leadership Team meeting (including elected governing body members and senior managers) as well as monthly GP locality meetings. In addition, we have good links with all of our local stakeholders through a dedicated full time engagement lead.

In accordance with statutory legislation, the GB has responsibility for:

- Ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance (its main function),
- Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish; (2006 Act),
- Approving any functions of the group that are specified in regulations (2006 Act).

As a member of the CCG's GB, each individual will share responsibility as part of the team to ensure that the CCG exercises its functions effectively, efficiently, economically, with good

30 http://www.rcpch.ac.uk/sites/default/files/asset_library/Education%20Department/Safeguarding/Safeguarding%20Children%20and%20Young%20people%202010G.pdf

governance and in accordance with the terms of the CCG constitution as agreed by its members. Each individual is there to bring their unique perspective, informed by their expertise and experience.

Individual members of the group's GB will bring their unique perspective, informed by their expertise and experience. This will underpin decisions made by the group's GB and will help ensure that as far as reasonably practicable:

- The values and principles of the NHS Constitution are actively promoted,
- The interests of patients and the community remain at the heart of discussions and decisions,
- The group's governing body and the wider CCG acts in the best interests of the local population at all times,
- The CCG commissions the highest quality services and best possible outcomes for their patients within their resource allocation, and
- Good governance remains central at all times.

The GB has appointed within its constitution an audit, remuneration and quality and patient safety assurance committee as formal committees of the GB as such, minutes from meetings will be published in the public domain as part of the GB papers.

Council of Members (CoM)

The CoM meets quarterly and responsibilities include ratifying the vision, values and strategic direction of the CCG as a whole. The CoM is made up of the practice representative from each member practice. Members of the GB are invited to update members as to the work of the CCG and are held to account by the membership accordingly.

Clinical portfolios

Each GB member holds a clinical portfolio and leads on the development and oversees the delivery of the redesign work programme for that area of work within South Norfolk. It is their responsibility to oversee implementation and evaluation of the impact of a redesign programme that supports:

- The vision and priorities for the CCG as outlined in the Integrated Plan,
- Improving quality of care delivery locally,
- Delivery of the QIPP objectives,
- Ensuring that principles of clinical leadership and public engagement are paramount.

The clinical portfolios are: emergency and urgent care; integrated care and out of hospital; MH and learning disabilities; children and families; quality in primary care and planned care.

Performance and Delivery

The CCG has robust mechanisms in place to monitor and scrutinise delivery of nationally and locally defined standards and targets. Each month the Leadership Team receives a Performance Report, covering the following areas:

- Performance against key national and local targets;
- Key clinical quality and patient safety issue;
- Delivery of QIPP;
- Financial performance;
- Analysis of acute activity.

The Report provides:

- The Leadership Team with a detailed 'early warning' system across the performance landscape, highlighting those areas where performance delivery is not in accordance with agreed targets or trajectories.
- Outlines the mitigating actions being undertaken to address the issues.

The Report is subsequently presented to the GB, providing a further level of scrutiny and accountability.

GB Assurance Framework (GBAF)

GBAF provides SNCCG with a simple but comprehensive method for the effective and focused management of risk. Through the GBAF the CCG GB gains assurance that risks are being appropriately managed throughout the organisation.

The GBAF identifies which of SNCCG's strategic objectives may be at risk because of inadequacies in the operation of controls, or where the CCG has insufficient assurance. At the same time it encompasses the control of risk, provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the GB to determine how to make the most efficient use of resources and address the issues identified in order to improve the quality and safety of care. The GBAF also brings together all of the evidence required to support the Annual Governance Statement.

The GBAF is seen as a working document and is updated regularly by the Senior Management Team, monitored by the Audit Committee and reported to the GB at each of its meetings.

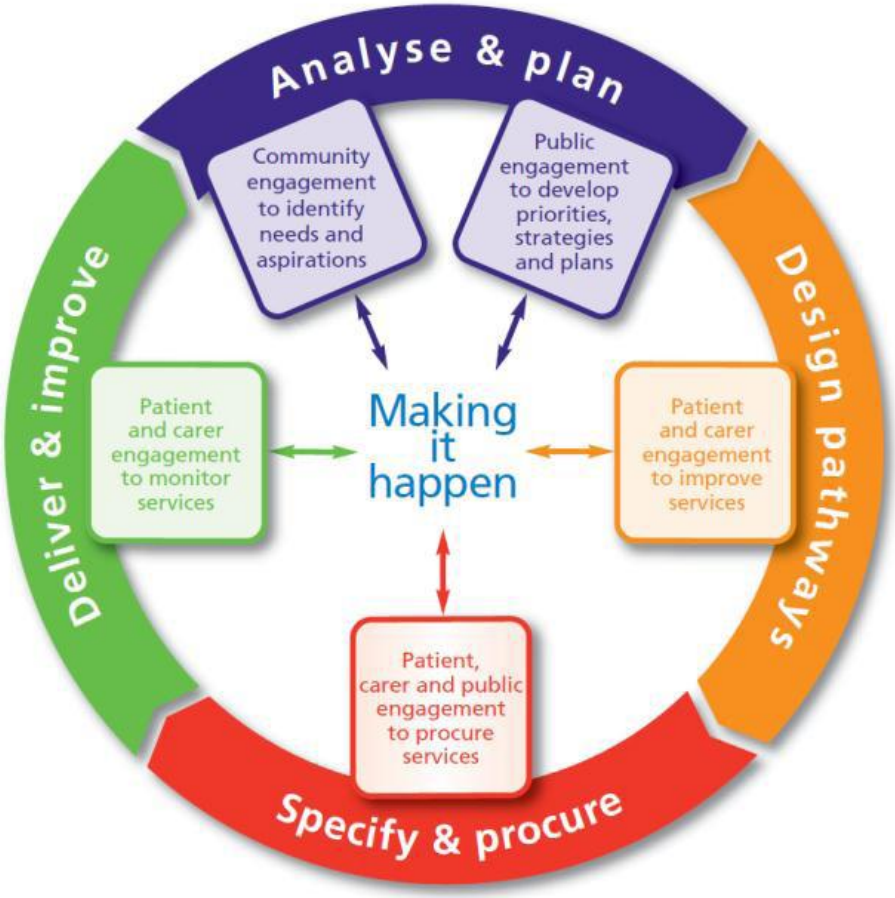
Identified Priority Areas for Quality Improvement

- Development of Clinical Quality review process for LD.
- Continue emphasis on Pressure Ulcer Prevention in the Community.
- Early identification and treatment of Sepsis across Community and Acute settings.
- Focus on continued improvement of reducing unplanned admissions.
- Shift the routine assessment and intervention of Diabetes type 1 and 2 care from the acute setting to Primary Care.
- Focus on prevention of CAUTI.
- Development of Community Hospital quality indicator set/dashboard.
- Development of FFT to provide pathway specific patient and family experience.
- Continue to improve MH provider's utilisation of data to inform quality and Patient Safety Assurance processes.
- Focus on recruitment and retention of MH staff and improve quality and capability.
- Continue to improve the assessment and on-going monitoring of people with MH needs physical health.
- Work collaboratively with NCCG and NNCCG in the review of the Ligature framework and suicide rates.
- Review with NSFT the use and monitoring of out of area placements.
- Continue to improve patient experience of Section 136[31] by redesigning existing arrangements between providers including the police to ensure improved speed of assessment and transportation.

[31] http://www.legislation.gov.uk/ukpga/1983/20/section/136

Commissioning and Planning

At specific times in the year, the CCG will review its medium to long-term strategic plans and set out its annual commissioning and operational plans. SNCCG adopts the planning model cycle set out below:



Built into this process is an annual programme of patient and public engagement that will give all of our stakeholders and partners the opportunity to understand and contribute to planning decisions.

Commissioning Intentions 2014/15-15/16

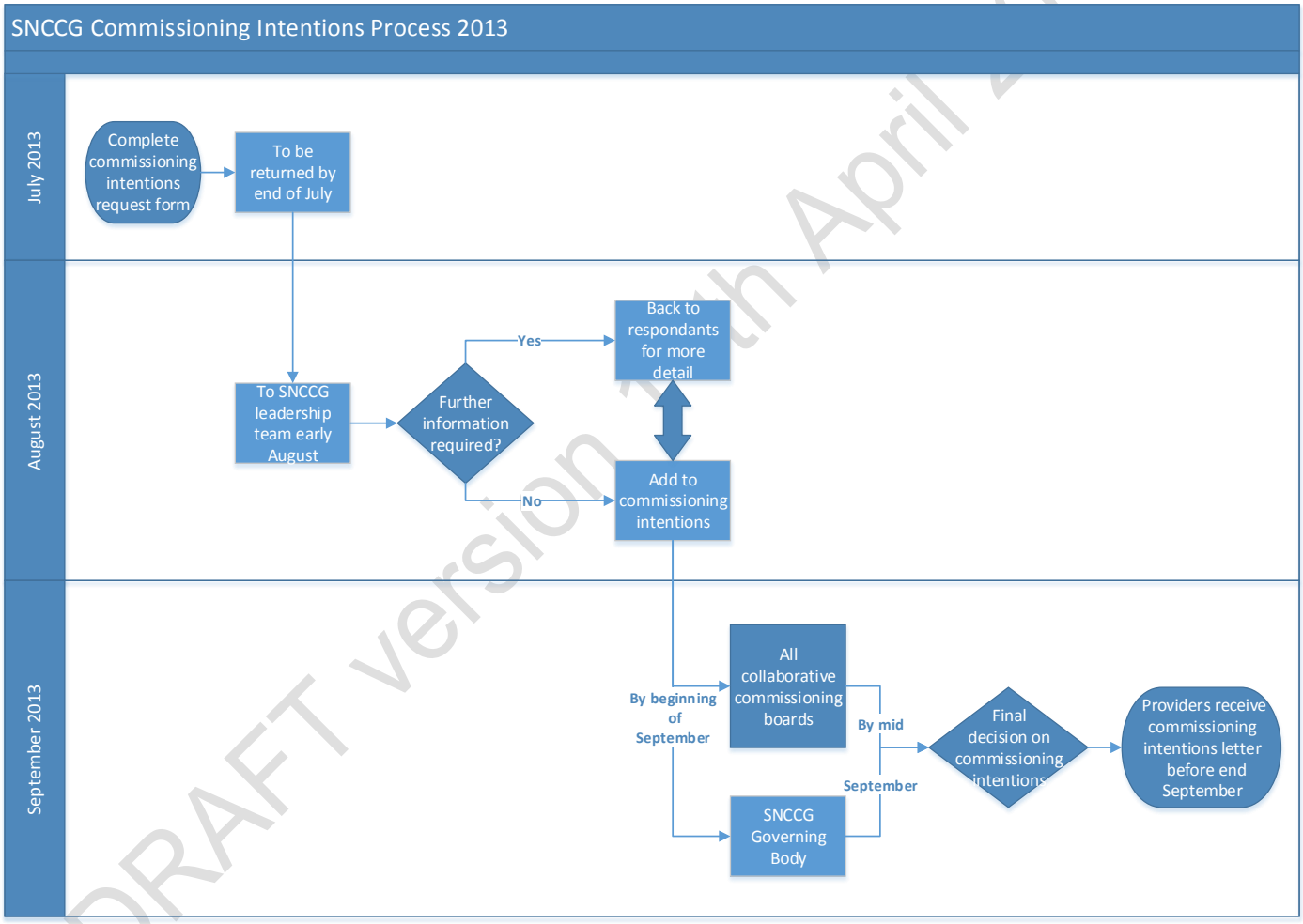
The following section sets out SNCCG's commissioning intentions for 2014/15 and beyond. The detailed projects which support these intentions and continue to provide high quality, sustainable and efficient services to the local population are set out in the following sections.

SNCCG's commissioning intentions form part of the annual planning cycle which commences development in the summer and finishes with agreed and signed contracts with providers by the 31st March of the following year.

SNCCG is required to demonstrate that the process for developing its plans and priorities is inclusive and transparent and that stakeholders are aware of and understand SNCCG priorities. SNCCG must also ensure that member practices understand, at least at a high level, their local plan and priorities.

The 2014/15 planning process commenced in June 2013 to ensure there was sufficient time to develop plans that have evolved from a local level based on the JSNA and SNCCG Commissioning Strategy 2012/16.

SNCCG Locality Groups were all made aware of the requirement for their involvement during June 2013 and the Commissioning Intentions Process was presented at the CoM on 10th July 2013.



The draft commissioning intentions were discussed and prioritised at a GB Workshop on 6th August 2013 where the GB evaluated the commissioning intentions via a two stage process designed to support them in prioritisation:

Stage 1 - comprised a standardised scoring system against which all commissioning suggestions could be evaluated to ensure that the scheme would deliver cost savings and/or quality improvement. It also looked in more detail at the scheme's QIPP aspects.

Stage 2 - considered which, if any, strategic requirements it supports, overall impact and importance to SNCCG's members.

SNCCG then proceeded to issue letters to all major providers setting out the Commissioning intentions for 2014/15 in line with the priorities agreed by the GB.

The Commissioning Intentions fall into two categories:

Contract Negotiation

The contract issues have been negotiated from November 2013 onwards with an anticipated completion date for negotiations by 28th February 2014. Although some items are clarification of technical coding and counting, much of the negotiation will be around improving patient experience, and quality and safety.

Commissioning for QIPP

The remainder of the commissioning intentions will form SNCCG's QIPP programme for 2014/15. The QIPP process for SNCCG developed during 2013 has resulted in a sophisticated QIPP Tracker that will be used for all commissioning projects in 2014/15. It is designed to record the essential information and data to enable electronic monitoring of progress and performance. Each project has a charter and progress against the QIPP targets in these is reported monthly to the NHS England Area Team via the usual financial reporting returns and at the quarterly assurance meetings.

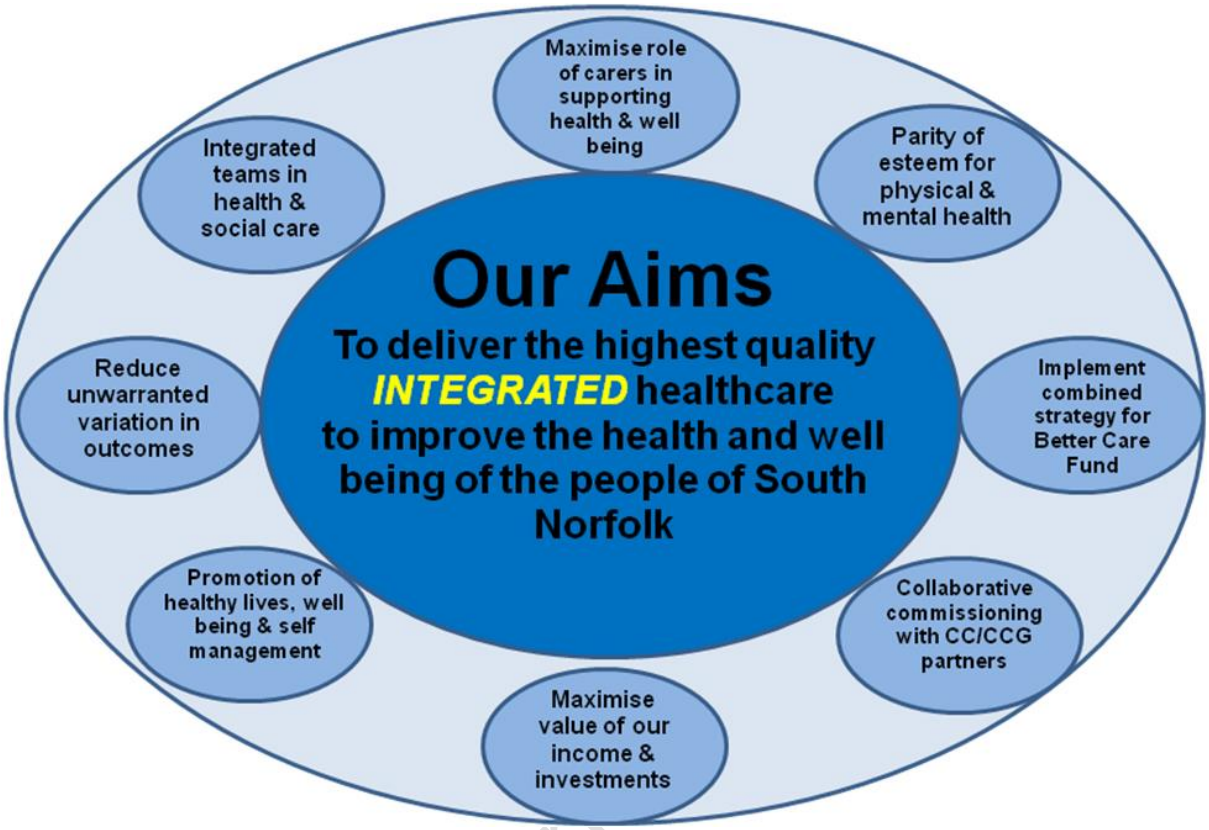
The QIPP Tracker and its associated business processes give the GB greater assurance of progress as it provides:

- Timeframes and electronic reporting templates
- Summary highlight reports for each project delivered by the project team
- Key Risks for each project
- Milestones for each project
- Work Stream descriptions for each project
- Deliverables for each project
- Measurable outcomes for each project
- Areas within the commissioning programme affected by each scheme.

SNCCG has a QIPP target of £8.8m in 2014/15 and has developed plans to this value. To provide some contingency and risk mitigation other potential initiatives are in development.

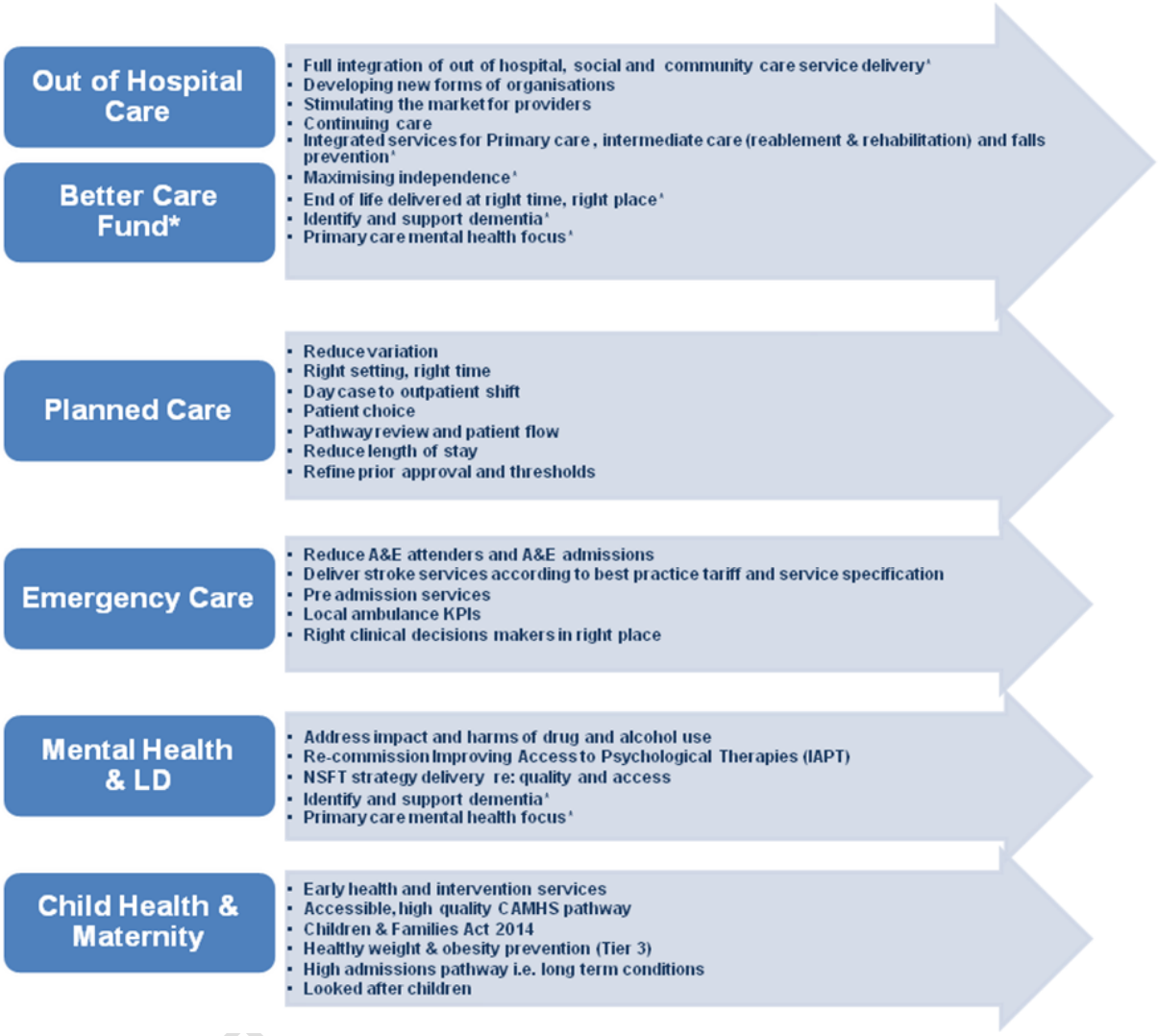
Details of the developed plans, other potential initiatives and their related QIPP targets are provided in the programme areas detailed in the following sections. For more detail on the Finance and Governance of QIPP please see the Financial Plan section of this document.

SNCCG aims for 2014-16

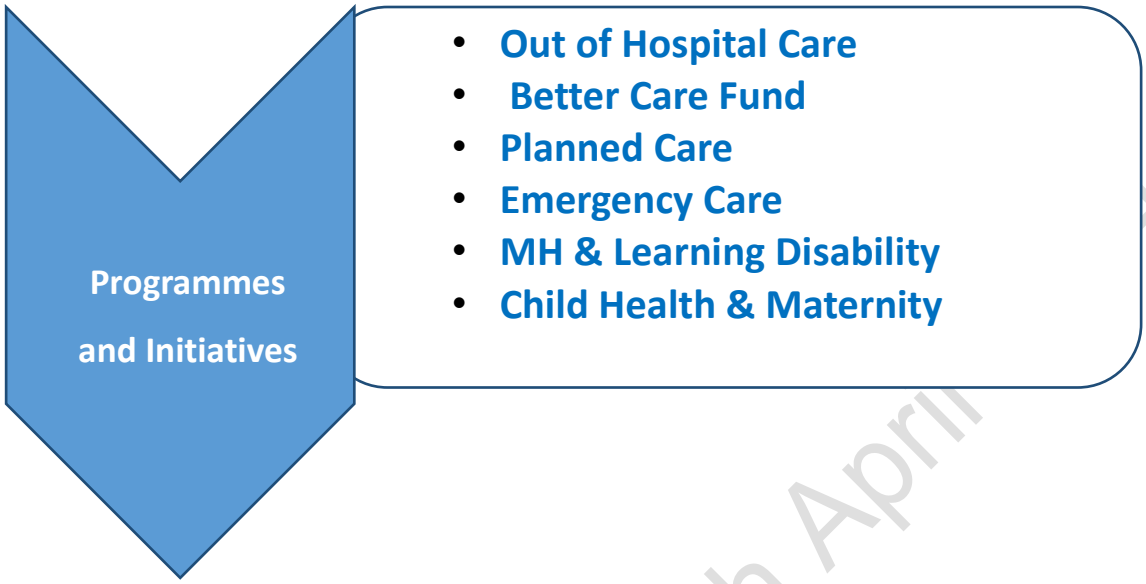


These aims are supported by six main programme areas that will drive the delivery of this Operational Plan and are illustrated overleaf;

SNCCG Programmes



Programmes and initiatives



The CCG's work programmes and initiatives are delivered through six work stream sponsored and led by GB members. Each of the work stream is clinically led except Child Health & Maternity.

The SNCCG Health Profile puts a clear emphasis on the following key elements that will impact on the health of the local population and need to be at the heart of our commissioning and operational plans:

- **Demographic changes** – particularly increases in the population of older people,
- **Increases in age related and long term conditions** - putting economic pressures on the health system as a whole; in particular Dementia, Diabetes, Cancers and Falls as a result of increased frailty,
- **Obesity**,
- **Promoting healthy lifestyles** - tackling smoking, alcohol and exercise and addressing health inequalities and deprivation,
- **Reducing variation in referrals and access** – particularly given the rurality challenges.

A summary of the key health issues that have informed the healthcare strategy and commissioning intentions of SNCCG during the planning period 2014-16 are:

- Cardiovascular Disease (CVD)
- Coronary Heart Disease (CHD)
- Stroke or Transient Ischaemic Attacks (TIA)
- Cancer
- Diabetes Mellitus (ages 17+)
- Depression
- Chronic Obstructive Pulmonary Disease (COPD)

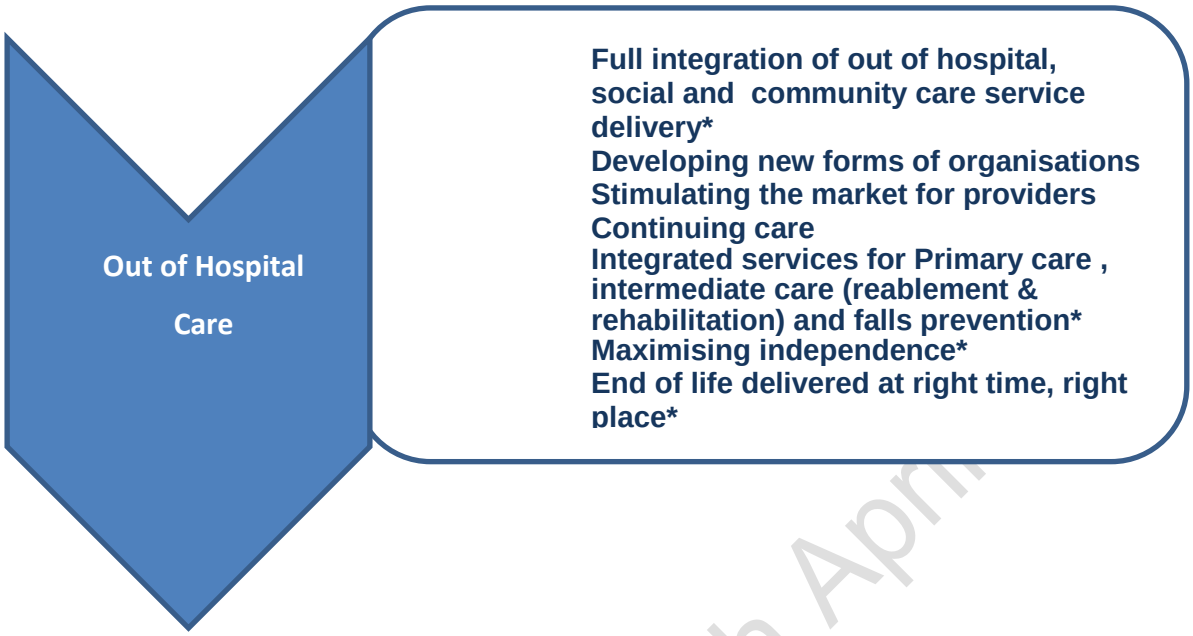
- Obesity
- Teenage Pregnancy
- Depression and Mental Illness
- Dementia
- Falls
- Osteoporosis
- Smoking, including smoking in pregnancy

Health improvement interventions to tackle smoking, alcohol consumption and exercise will be commissioned by NCC's PH team, supported by the SNCCG. This team will also take on the responsibility for the commissioning of 0-5 years children's services from April to October 2015 but this may happen earlier and SNCCG are preparing to work collaboratively with PH when required.

All workstream projects are also summarised in an accompanying Excel document http://www.southnorfolkccg.nhs.uk/about-us/publications that illustrates:

- Workstream leads
- Key aims of each project
- Timeframes for commencement
- Proposed KPI / project metrics

Out of Hospital Care



SNCCG's overall aim with regard to out of hospital service and service integration is:

"Better outcomes for people and patients in South Norfolk, indicated by maximising their potential for independence and living (or dying) at home wherever possible if they choose"

The vision of integrated care includes:

- A single assessment process across health and social care, with systems to allow appropriate sharing of necessary information,
- Identified key workers who understand individual patient's social as well as medical contexts,
- Services that are simple to use and can be "switched on" via a single call and assessment,
- Services being arranged around patients' GP surgeries with access to a wider range of social, voluntary and housing-related services,
- A Single Point of Access (SPA) to the range of services available in both health and social care,
- A universal expectation that all services delivered at or close to home will be delivered with respect, compassion and a personalised approach to care.
- A reduction in health inequalities and inequities in access for disadvantaged and minority groups.

A key focus of integrated care is the need to achieve increased levels of integration of service delivery across services provided by different providers, both NHS and beyond, in order to improve service quality, efficiency and clinical outcomes. SNCCG is developing a

performance management framework that will drive integration through measurement against a range of key indicators.

Examples include:

- Reduction in number of visits to site and no repeated tests,
- Patients only give information once,
- Patients are provided with public health / well being advice at each visit,
- Develop and improve End of Life (EoL) care at home (including 'closer to home' and local specialised services),
- Develop and review information sharing protocols and adopt "e-PACCS" system or similar (with the pilot project already in place),
- Integration (contractual not just organisational) of health providers (community and investigate potential for acute) and social care and third sector (plus independent sector), e.g., SNCCG will plan to commission all care for the people of South Norfolk, i.e., not just health but social care, housing, advice and support to ensure that the outcomes of all organisations are focussed on the same goal – the patient/service user – despite different organisational objectives and government-driven pressures,
- Community-based rehabilitation and reablement; effective model of and management of community beds and virtual wards integrated with social care and independent providers.
- Develop a system of hospital care at home,
- Greater emphasis on prevention; i.e., falls, LTCs; attempting to reduce avoidable emergency hospital admissions further and slow the rise in inappropriate referrals,
- Define outcome-based performance indicators for each provider and the health and social care system,
- Develop a universal currency for health (and social care) interventions based on outcomes not just inputs,
- Develop integrated care pathways with GPs and social care to support more (older) people to live independently at home for longer with lower calls on the care system and to develop systems that allow the GP to be at the centre of (older) people's care.

What initiatives will SNCCG undertake to tackle these health challenges?

Primary care Provided at Scale

SNCCG will support NHS England in the development of wider primary care – delivered at scale – particularly for people with long term conditions, including mental health conditions. This work runs through every aspect of the out of hospital plan and will enable general practice, community pharmacy services, dental services and primary eye health services to play a much stronger role in integrated services.

Support for people with Long Term Conditions: Case Management and Self Management

SNCCG seeks to improve the patient experience by promoting and enabling self-management and is aiming to provide support to allow people to manage their own conditions. The LTC priorities for SNCCG currently include:

- Dementia
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Heart Disease (CHD)
- IBS (see Mental Health)

The improved outcomes for people with LTCs will be measured through:

- Reduced permanent admissions of older people to residential and nursing care;
- Increased proportion of older people still at home 91 days after discharge into reablement /rehabilitation;
- Reduced delayed transfers of care from hospital;
- Reduced avoidable emergency admissions;
- Improved patient/service user experience of care.

SNCCG is undertaking an evaluation of case management as a model of improved coordination of care and outcomes for the patient, not simply as an admission avoidance technique (for which the latest evidence indicates it is not truly effective). SNCCG is considering a risk-stratification approach to case management and we wish to review the effectiveness of established education programmes for LTCs and develop further into other clinical areas such as neurology, pulmonary rehabilitation, angina and arthritis care. There is also a plan to expand and improve the specialist heart failure nurse service over time. The risk stratification approach will also allow identification and prioritisation of those people with clinical risk factors, enabling support to be delivered as described below.

Plans for case management of LTCs and self management builds on the developments and foundations that the Frail Older Person (FOP) and integrated care organisations (ICO) projects have provided, particularly that of the Integrated Care Liaison Officers (ICLOs) and the embedding and strengthening of Practice based multidisciplinary team (MDT) meetings (which are being included in the 'Better Care' proposals). The CCG has recognised the value of targeted use of assistive technology in the management of certain LTCs and will investigate this further and where practicable link to GPs being at the heart of the care for older people and to risk stratification and integration.

The CCG's outcomes for people with LTCs are outlined in the 'Better Care' /integration proposals and include:

- People with long-term conditions being comprehensively supported because their care is closer to home;
    - GPs and practices will be at the centre of teams in which access to skills, knowledge and health and social care is seamless;
    - GPs, patients and carers will feel confident that there are support services available following diagnosis;
    - People will feel more confident about managing their long-term conditions with services arranged to deliver 'the right intervention at the right time' to prevent unnecessary hospital admission and to support timely discharge.

- Effective liaison and support will enable mental health problems to be picked up in a timely way, especially where there are concurrent physical health problems, and will promote effective management and recovery;

- Patients and carers will have planned ahead, will be in control if their care at the end of their life and will feel confident the right support will be there when they need it.

Community Nursing Specification Improvements

SNCCG has led improvements in its Community Nursing Service specification (in collaboration with the other Norfolk CCGs), seeking to simplify and better performance-manage the service provided by NCHC. The intention is to develop better outcome-based

performance and a wider recognition by the provider of the whole-system approach to patients – a 'virtual integration' through the coordination of specifications and a more transparent link to the NHS ambitions and the ambitions of the CCG.

Continuing Healthcare

SNCCG continues to work towards avoiding patients having automatically to change their provider (community health and/or social care) as a result of becoming eligible for continuing healthcare.

Working with NCHC and NCC and NNUH, the CCG wishes to ensure that the majority of patients identified as potentially eligible for NHS Continuing Healthcare while in an Acute hospital are more appropriately assessed in a community setting, where possible, as this is a more robust indicator for a person's long-term care needs. It can also enhance their chances of maintaining their current level of independence and quality of life – one of the stated ambitions of the CCG.

Reablement (enhanced)

The SNCCG area has been the site of two successful pilot schemes to integrate the health and social care elements of reablement and improve discharge from hospital. SNCCG wishes to roll these principles out into community hospital (rehabilitation and intermediate care) beds in NHS and independent-sector facilities. The intention is to reduce the length of stay (LOS) in all bed environments and maximise independence for individuals for as long as possible at the lowest level of appropriate health and/or social care intervention.

Falls service

Recognising the importance of falls prevention and of helping older people recover their independence after illness or injury we have established a local falls and dementia group to coordinate improvements. We have enhanced the existing specifications within the Community Nursing and Therapy service to increase the element of primary prevention and make links with other partners (especially District Councils and Housing Associations) to ensure they are able to form part of a network of prevention. Further work with partners should see a reduction in the number of people conveyed to hospital and a much wider emphasis on, and understanding of, falls prevention and risks across all sectors of the community.

Frail and Older Peoples Project (FOPP)

SNCCG is planning to refine, review and develop the approach to the FOPP, integrated care and care homes initiatives (and building further through the 'Better Care' plans) and multi-agency working via the BCF plans (see following section).

This initiative is designed to reduce the impact of acute non-elective admission for the over 65 age group, vulnerable adults and at risk patients. SNCCG will continue to use (and explore greater exploitation of) case management, local step-up/admission avoidance beds and access to local Medicine for the Elderly (MFE) clinical advice. We are looking to work more closely with our providers to develop integrated 'hubs', taking advantage of the specialist skills and knowledge from centres providing specialist intermediate care and rehabilitation and the clinical cover within to be more widely available across the community, including the independent sector as part of the team, as recommended in our recent intermediate care review.

SNCCG will also look at case management of patients in care homes, e.g., review of care plans by community matrons or therapists, work with care home staff – nutrition, tissue viability, continence and mobility assessments.

End of Life (EoL)

SNCCG is looking to deliver FOP and EoL care with a focus on integration and quality of care by collaborative multiagency arrangements that have an impact on Quality Adjusted Life Years (QALYs) of vulnerable patients.

The CCG will also undertake the following to facilitate the delivery of this workstream:

- Establish a SNCCG steering group for EoL services,
- Explore the need for specialist EoL beds in the locality,
- Explore the hospice at home model and better community outreach,
- Explore continuity of care at home when needs change,
- Encourage greater coordination and GP leadership,
- Reduce acute admissions towards the very end of life,
- Increase the proportion of people dying in their preferred place of care,
- Increase the appropriate uptake of patient-held information (currently known as yellow folders) and electronic coordination of information.

Diabetes

As part of an end-to-end review for the type 1 and type 2 diabetes pathway SNCCG are leading on a project to provide better clinical outcomes (which include fast access to expert support, and individualised patient-centred care) for patients.

Stakeholder engagement in this project has already started with a multi-agency /multi-disciplinary workshop held in February 2014. This event looked at mapping and analysing the current patient pathways.

This project links with NNCCG and NCCG to develop an improved pathway that will deliver the following aspects of care:

- A standard pre-diabetes pathway with improved levels of screening plus on-line support for clinicians and patients,
- Standardised patient experience across GP practices, and the skills of practice staff including GP leads, diabetes nurses and Health Care Assistants (HCAs),
- A structured education programme for patients who are newly diagnosed with diabetes (this could be DESMOND or EXPERT),
- A review of medicine management in order to identify any cost savings to bring SNCCG in line with other low-cost, high-outcome-performing CCGs,
- A review of the 'year of care' process to activate links and minimise patient interaction with practices,
- A review of the current service specification of the diabetes facilitator service to ensure appropriate referrals are forwarded.

Clinical Pathways

SNCCG will seek to implement pathways that provide good care and patient satisfaction, particularly for Dementia.

Reducing emergency admissions

SNCCG will focus on reducing the growth of emergency admissions by seeking to move activity, where appropriate, out of an Acute setting.

Community beds for discharge planning and respite

Building on the recommendations of the SNCCG-led review of community beds, the CCG will continue to support a system of cohesive service redesign that encompasses;

- Community beds (intermediate, step-up, step-down etc.),
- Discharge planning beds (social care),
- Respite beds (social and health care beds, including dementia),
- Domiciliary care in order to reduce unnecessary admissions to acute and ensure quicker discharge home and improved patient outcomes,
- Links to the reablement service integration to reduce the length of stay and get people home sooner to increase their potential for independence,
- Work to develop a local tariff for intermediate care beds or home-based intermediate care.

Thetford community health services

SNCCG will finalise the appropriate service specifications, KPIs and a sourcing strategy for community health services for patients at Practices that are on county borders.

Other areas of work include:

- Gold Standards Framework (GSF) (or equivalent standard) for care homes
- Community geriatrician service
- Third sector services review
- Volunteering strategy
- Home Catheterisation Service
- Cellulitis review
- Community Intravenous (IV) Therapy: roll out of CQUIN/IV therapy in all localities;
- Specialist epilepsy service: to increase the scope of epilepsy care in the community and ensure alignment with best practice models of care.

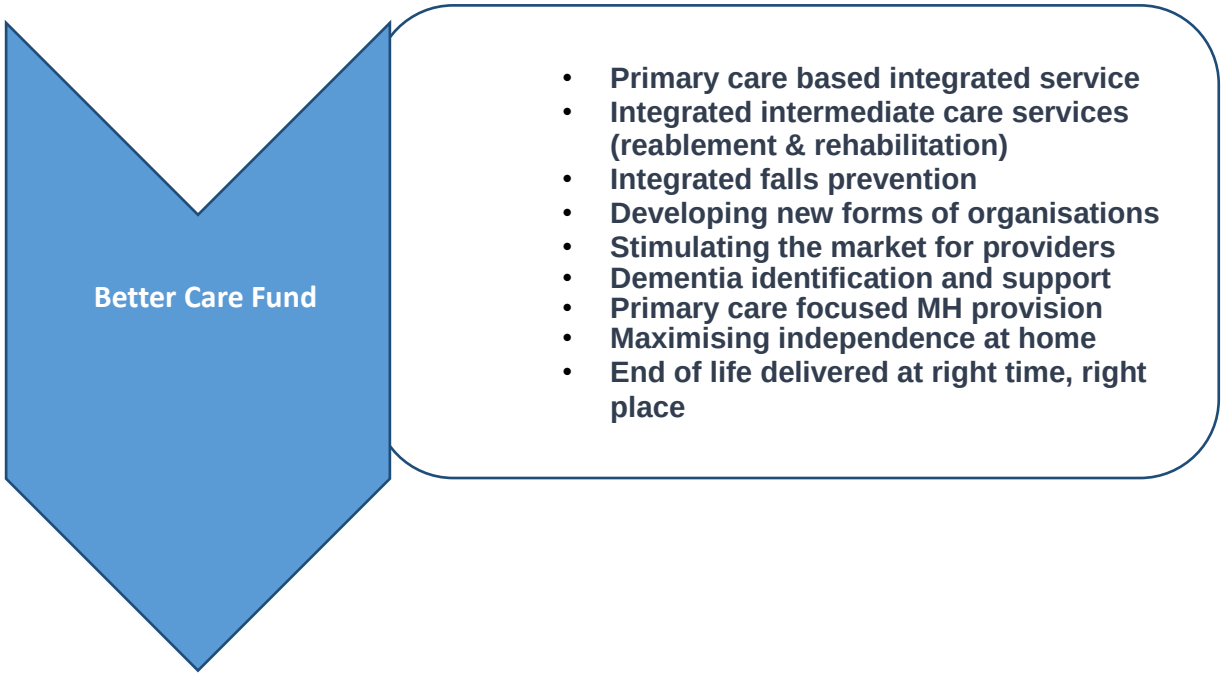
Seven day working – report by Sir Bruce Keogh[32]

SNCCG will be working at a local level to develop a more comprehensive "24/7 community integrated support service for older people and people with LTCs" and seeking to develop an operational model with our CCG and LA partners over the next few months taking into account the full financial and workforce implications of delivering this initiative.

SNCCG is expecting to receive a business case for 24/7 working for specialist palliative care cover from NCHC at the April Community Commissioning Board, which will be considered against the developing EoL plan.

[32] http://www.england.nhs.uk/2013/12/15/sir-bruce-keogh-7ds/

Better Care Fund (BCF)



In January 2014 the Norfolk H&WBB received a paper from NCC's Director of Community Services which set out the new joint initiative from the DH and the Department for Communities and Local Government (DCLG) concerning the BCF[33].

The paper noted that the initiative is focused on furthering the integration of health and social care services and requires CCGs and Councils with responsibility for social services (i.e. NCC) to create a pooled budget for the provision of integrated community health and care services. A minimum sum is required to be in the pool, and how this pool is made up is specified nationally. For Norfolk the minimum sum to be transferred into the pool for 2013/14 is £3.482m and for 2014/15 is £62.404m.

The final plan is required to be approved by Norfolk H&WBB by 4th April 2014, it then passes to NHS England and the DCLG.

Progress to date

The latest work around planning for the BCF has been focused on how the BCF will be implemented in Norfolk. This has focused largely at CCG geography level in order to build on existing integration initiatives in the context of local need and local health and care systems. Attention is paid to how the areas work collaboratively in relation to community and acute health services.

The plan is a draft at this stage but it captures the strong vision, engagement and commitment to integration that all partners have affirmed. It is also able to set out the

[33] http://www.norfolk.gov.uk/view/healthwell080114supagendapdf#page=3

integration models that each area has developed, founded on detailed work prior to this initiative.

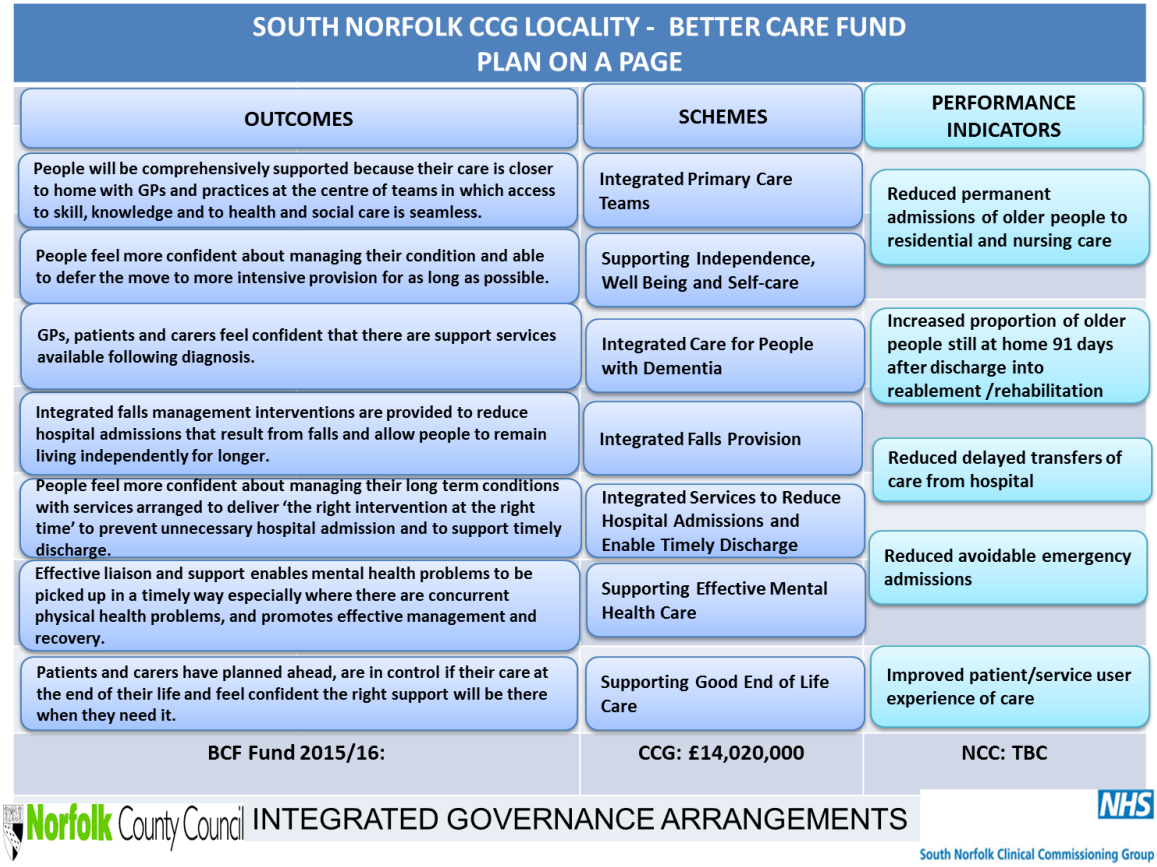
Detailed financial planning will be included in the final plan. The plan will set out how the investment we have in services will support the transformation we need and how this will have an impact on service activity.

The planning process has taken account of the JSNA for Norfolk, the voices of patients and service users and of best practice from both local and national experience. The continuing work to develop a final plan will secure further stakeholder engagement in refining the plans to transform the health and care system. This plan will come to the Board for approval by 4th April 2014. There is a broad similarity of approach (e.g. around developing MDTs) between NNCCG, NCCG and SNCCG but the key task now is to bring plans together into one jointly agreed plan including joint decision making around key elements of the plan, such as a shared local measure; a shared risk register; a shared vision; financial and project plans.

SNCCG continue to make good progress both strategically and operationally on integration including:

- Well established FOP initiatives,
- Developing Multi Disciplinary Teams (MDTs) around GP practices,
- Action plan for NCC, NCHC and NSFT integration priorities,
- An outline Integration plan agreed by the GB,
- Intermediate beds programme,
- Communication and involvement of key stakeholders re: BCF and wider strategic plans.

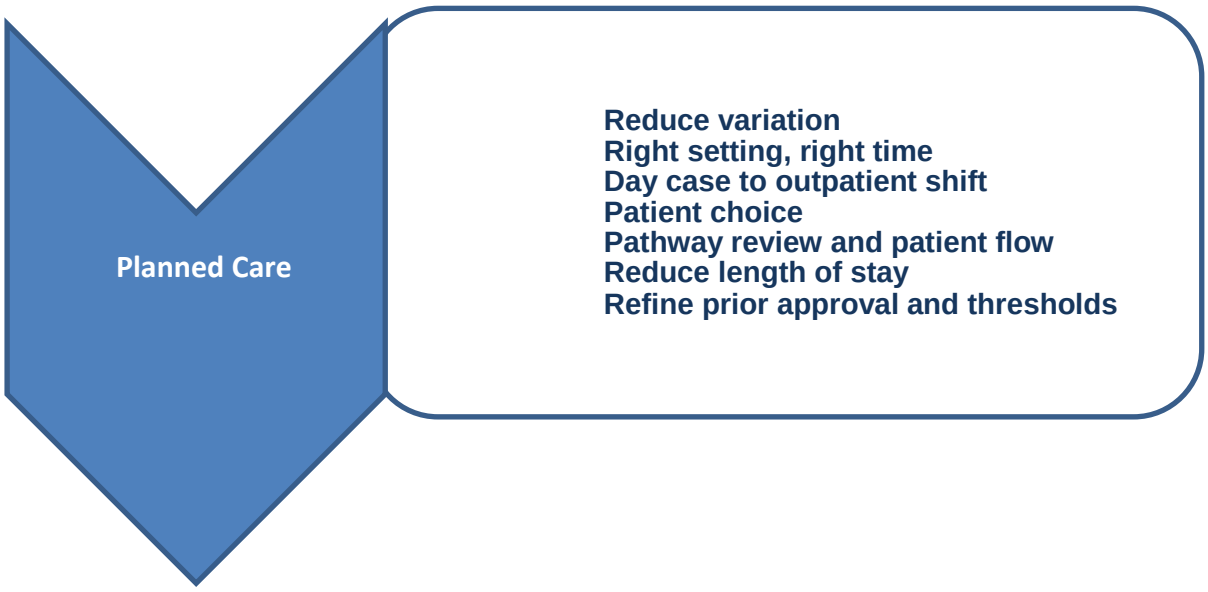
SNCCG's overall plan is summarised in the illustration below:



QIPP savings for Out of Hospital and BCF work stream

PROJECT TITLE	CCG LEAD NAME	PROJECT START DATE	ACTIVITY IMPACT START DATE	Net QIPP Saving	Proposed KPI or Metric
Full Year Effect of initiatives From 13/14				1148	
Continuing Health Care	Chris Coath	01/04/2013	01/07/2014	750	Financial performance against the plan
Return on primary care investment	Jossy Pike	01/01/2013	01/10/2014	574	Reduction in admissions for > 75
Reablement	Rob Cooper	01/04/2014	01/04/2014	180	Long stay payments
Patient Transport	Hannah Martin	01/04/2013	01/10/2014	163	Actual contract performance
Intermediate Care Beds	Chris Coath	01/04/2013	01/07/2014	150	Reduction of occupancy in of independent sector beds
End of Life	Hannah Martin	01/04/2013	01/04/2014	100	Increase in choice of death in care homes and at home
Frail & Older People Project	Wendy Hicks	01/04/2013	01/01/2015	95	Reduction in emergency admissions over 75s
			TOTAL	3160	
Potential initiatives					
Long Term Conditions Review	Katy Blakley	01/04/2013	01/10/2014	125	Reduction in emergency admissions over 75s for patients diagnosed with diabetes, COPD, CHD
Various Initiative £50k or Less		01/10/2013	01/12/2014	105	
			TOTAL	230	

Planned care



Hospital care, in addition to representing a significant part of overall spend for CCGs, can be a less cost effective means of treating patients than care options which are provided in community and primary care settings. Because of this, the planned care agenda is a key area of focus for SNCCG in responding to the needs of the South Norfolk population and providing high quality, routine services which represent value for money and bringing care closer to home.

SNCCG aim to deliver the best quality clinical services for people with non-urgent medical conditions while curtailing the growth in demand for elective treatments in secondary care. The CCG also aim to reform planned care and systems of referral to ensure that patients receive referral to the most appropriate forms of treatment at the right time and in the best setting for them. SNCCG will work closely, where relevant, with other CCGs through the established collaborative Acute Commissioning Board (ACB) and NELCSU in contract management, pathway redesign and the delivery of strategic objectives.

SNCCG compared its Health Profile Data (from the Eastern Region Public Health Observatory[34,35] (ERPHO)) in 2013 and these reflect the following issues:

	SNCCG rate against national average
GP referral rates	Higher
Growth trend for GP referral rates	Lower
Number of non elective admissions	Lowest quintile
Growth rate for non elective admissions	Below national average
Number of elective admissions	Equal
Growth trend for elective admissions	Faster

[34] http://www.erpho.org.uk/
[35] http://www.apho.org.uk/default.aspx?QN=HP_METADATA&AreaID=50526

What initiatives will SNCCG undertake to tackle these health challenges?

Reduce variation

SNCCG will work to improve the quality of referrals to reduce unwarranted variation by increased clinical education, improved pre-referral work up and closer monitoring of adherence to local or national guidelines.

We also aim to reduce prescribing expenditure and restrict growth to the national levels.

Day case to outpatient shift of activity

SNCCG will continue to review activity which is clinically appropriate for either a day case or an outpatient setting and seek to embed clinical conditions to ensure patients are managed in the most appropriate setting for their condition.

Clinical audits and discussion will take place to review activity that has both a day case and outpatient procedure tariffs. It is our intention to pay for procedures in line with the level of care provided and also in line with national guidance.

Review of day case activity levels will include:

- Age-related macular degeneration and other eye conditions in the community,
- Community Dermatology Service – working to increase the scope of dermatology services provided in the community for conditions such as Cellulitis and skin lesions.

Patient Choice

SNCCG will continue the development of raising awareness of Patient Choice initiatives and seek to commission alternative services in order to increase patient choice. SNCCG will also ensure there is a full menu of services on Choose & Book (C&B) that is published and freely available.

The National 20% Elective Care productivity challenge

In *Everyone Counts: Planning for Patients 2014/15 to 2018/19* NHS England describe the need for elective care, and access to services to be designed and managed from start to finish to remove error, maximise quality and to achieve a major step-change in productivity. The suggestion is to review how routine planned admissions for patients requiring less complex treatments are delivered. This instruction fits well with SNCCG's strategy for delivering more treatments for patients either within an outpatient setting or without the need to travel to an Acute Provider, such as for eye and joint injections and minor dermatological procedures.

However, such initiatives are only likely to elicit single year gains when the needs framework stipulates annual productivity gains of 4% year on year until 2019-20. SNCCG are reviewing the most recent guidance such as *Better Procurement, Better Value, Better Care* (DH,

August 2013)[36], and latterly Monitor's *'Closing the NHS funding gap: how to get better value health care for patients* (October 2013)[37] to establish a sustainable productivity improvement strategy. However, early guidance indicates gains can be achieved in four main areas:

1. **Improving productivity within existing services.** Valuable opportunities to improve quality, safety and efficiency are available within existing configurations of primary, community, acute and MH care. These include measures to reduce waste and running costs, improve procurement, reduce LOS in hospitals, collaborate better with social services, redesign clinical roles and avoid using procedures or drugs of low clinical value. Many such measures are in progress as part of SNCCG's existing QIPP and Cost Improvement Programmes (CIPs).

2. **Delivering the right care in the right setting.** Many patients could enjoy better outcomes at lower cost to SNCCG if their care were delivered in a more appropriate setting. For example, increasing care in the community for the millions of people who have LTCs could both improve their experience as patients and reduce costly hospital visits.

3. **Developing new ways of delivering care.** Measures to improve the productivity of established ways of delivering health care in the two categories above will not be enough to close the whole financial gap. Success will depend on developing new and more productive ways to organise and deliver care.

4. **Allocating spending more rationally.** The direction of NHS spending is determined more by history than an objective and current assessment of the disease burden of the population and the potential for particular interventions to relieve that burden. Redirecting resources to prevention and early diagnosis or rebalancing spend between different diseases could yield important productivity improvements.

The following section describes how SNCCG is applying this guidance to achieve the National challenge:

Pathway reviews

Reviews of care pathways during 2014-16 include the following clinical specialities:

- **Rheumatology** - to ensure compliance with best practice models of care and seek to provide rheumatology services in the community, including the transfer of new drug infusions, where clinically appropriate.
- **Community Injections service** – to provide services in the community at equal quality but better value.
- **Trauma & Orthopaedics (T&O)** - a review of T&O was undertaken by the Royal College of Surgeons (RCS) during 2013. Although the review was limited in clear points of action, we recognise the need to review and simplify the primary care pathway for orthopaedics.

36 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226835/procurement_development_programme_for_NHS.pdf

37 http://www.monitor.gov.uk/sites/default/files/publications/ClosingTheGap091013.pdf

- Review MSK services
- Review current Orthopaedic pathways to provide good care, patient satisfaction and conservative management, where appropriate
- Work with NNCCG and NCCG to ensure the current service provider of orthopaedic triage (NCHC) is able to work towards delivery of a high quality service that is fit for purpose.
- Redesign pathways for patients presenting to primary care with hip, knee or shoulder pain.
- Work with PH to ensure all clinical referral policies for hip and knee arthroplasty are amended to include conservative management initiatives prior to referral for surgery.

- **Gastroenterology** – to increase patient satisfaction and to ensure care and conservative management is provided in line with NICE guidelines.
- **Ophthalmology**
  - **Glaucoma** – review services in the community.
  - **Cataract Service** – implement a full cataract pre and post operative service and one-stop service for cataract surgery
- **Aural Microsuctioning** – following a pilot in primary care a full evaluation will be undertaken to assess future options for procurement.
- **Oncology** (led by NCCG)

Patient flows

Discharge Planning

- To contract specific minimum standards in discharge planning and transparent reporting of all delays and reasons for delay
- To ensure practices have typed discharge letters within 48 hours of discharge to enable the correct clinical care

Daily consultant ward round for all patients in an acute bed and inter-Consultant discharges

- To improve clinical care of patients while admitted to an acute hospital and to standardise discharge processes across the week

Seven day working

Seven day working will be an ongoing work streams with NNUHFT during 2014/15 to agree an implementation and action plan based contractual obligations and clinical standards set out in by the NHS Seven Days a Week Forum review[38].

[38] http://www.england.nhs.uk/wp-content/uploads/2013/12/forum-summary-report.pdf

Refine prior approval and thresholds

SNCCG will work with PH and other Norfolk & Waveney CCGs to ensure the latest best practice is in place for clinical effectiveness and prior approval.

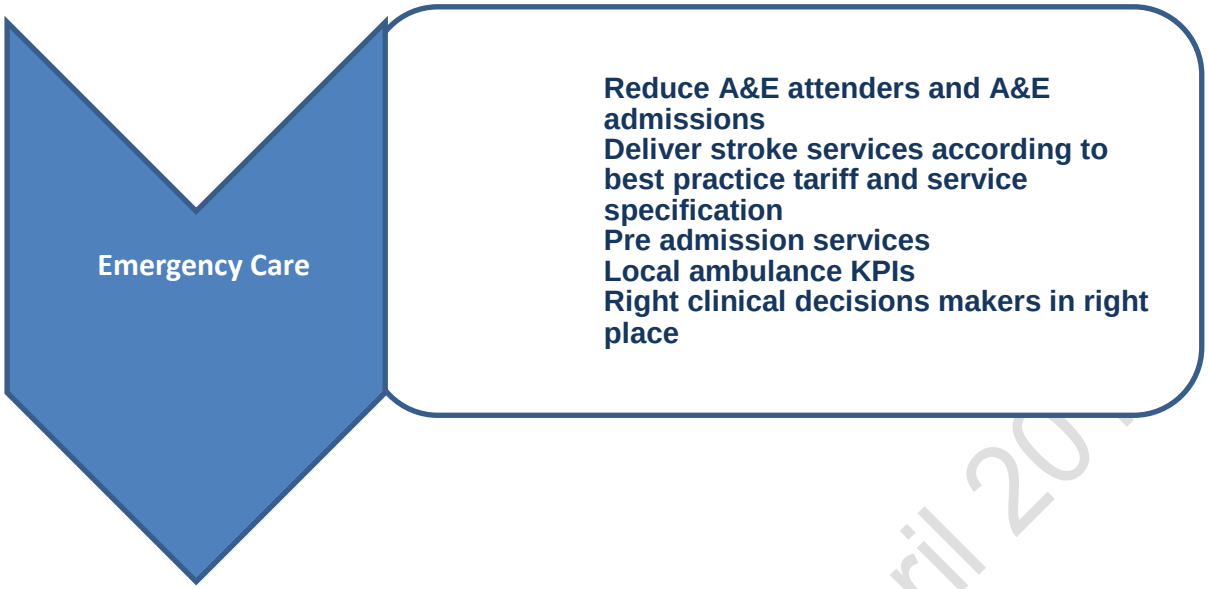
Tier 3 Weight Management Services

The SNCCG draft weight management strategy identifies the need for adult Tier 3 weight management services to be provided more locally. The CCG will therefore seek to develop and commission a service in 2014/15.

QIPP Savings for Planned Care Workstream

PROJECT TITLE	CCG LEAD NAME	PROJECT START DATE	ACTIVITY IMPACT START DATE	Net QIPP Saving	Proposed KPI or Metric
Full Year Effect of initiatives From 13/14				257	
Prescribing for Quality and Safety	Debbie Oades	01/02/2014	01/06/2013	1250	Financial performance against the plan
Pathology Re-procurement	Jim Barker		01/04/2014	619	Financial performance of the contract
Age-related macular degeneration and other eye conditions	Debbie Oades	01/08/2013	01/04/2014	550	Financial performance against the plan
Contract levers and compliance	Debbie Oades	01/09/2013	01/04/2014	350	Actual savings realised on WSH Contract
Lower Limb	Anne Moates	01/08/2013	01/07/2013	245	replacement
Upper Limb	Anne Moates	01/08/2013	01/07/2013	116	Reduction in shoulder operations
Cataracts	Anne Moates	01/08/2013	01/07/2013	95	Reduction in new and follow up ophthalmology appointments
Prior Approval	Louise Browning	01/04/2013	01/07/2013	60	Actual monitoring
Cancer	Debbie Oades	01/03/2014	01/10/2014	52	Reduction in Inpatient and day case admissions
Various Initiative £50k or Less				169	
			TOTAL	3763	
Potential initiatives					
Various Initiative £50k or Less		01/10/2013	01/12/2014	20	
			TOTAL	20	

Emergency and Urgent Care



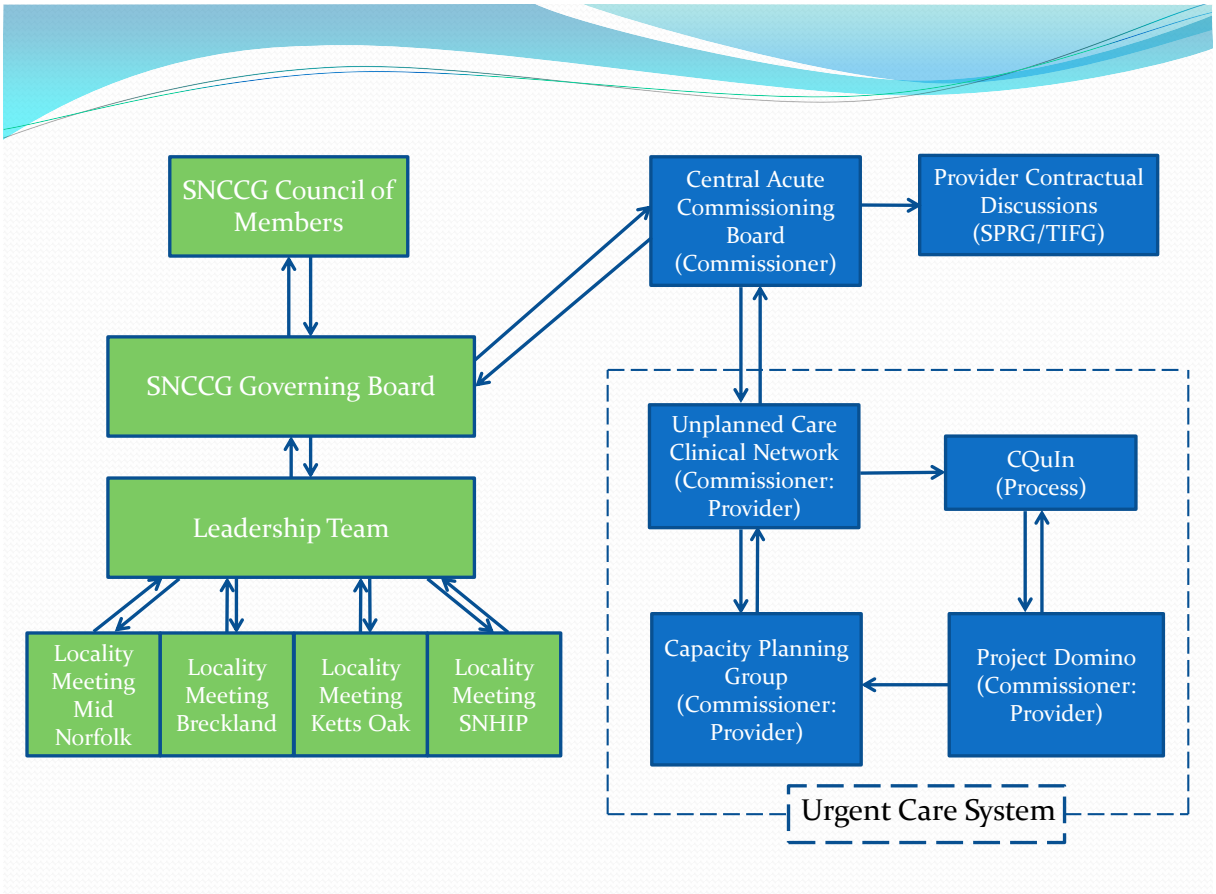
Whilst the CCG's number of non elective admissions is fewer than the national average and growth rate slower, SNCCG has identified that work to improve the commissioning of emergency and urgent care services is of vital importance to reduce expenditure and the need for treatment in secondary care.

	SNCCG rate against national average
GP referral rates	Higher
Growth trend for GP referral rates	Lower
Number of non elective admissions	Fewer
Growth rate for non elective admissions	Higher at >7% (national average 7%)

SNCCG recognise the need to collaborate on matters of urgent and emergency care and are active members of the Central Norfolk Unplanned Care Network (CNUCN).

The CNUCN is the senior strategic CCG Commissioner/Provider clinical/managerial interface that addresses the delivery of an effective 24/7 urgent and emergency care system for the health community in response to current system pressures, and in line with national guidance and local need.

Within the Urgent Care landscape the CNUCN sits between the Capacity Planning Group, and the ACB (as described in the diagram overleaf). The formation of these groups encourages vital and clear two way discussion to occur from the CCG integrated Commissioning Board through senior Provider management down to the operational frontline, and most importantly back again. This ensures that commissioning initiatives have the best opportunity to succeed in the most efficient way.



Working groups of the CNUCN have been coordinated under the heading *'Project Domino'*.

'Project Domino' has seen the urgent care pathway broken into its component parts and then into associated work streams i.e. from the patients home to hospital (blue workstream), from the front door of the hospital to the back door (red), supporting patients coming out of hospital and keeping them at home (green), additional service commissioning (purple).

The following items represent the commissioning achievements of this group:

- Expanding Ambulance Paramedic Skills
- Planning for the A&E refurbishment due to start in 2014/15
- Planning for a clinical decision unit and Acute point of care testing to become core business in 2014/15
- Community IV service
- Community Rapid Response Teams
- Community Matron Acute Pull-out service
- Home Based Therapy Service
- An integrated clinical Directory of Services
- System Operations Centre

The Group has also been instrumental in the distribution of the National fund for winter resilience which has seen the commissioning of the following services:

- A primary care led Urgent Care Unit within the A&E
- Community Early Supported Discharge Team

- Additional Community beds
- Supporting the county councils Norfolk 1st Response service
- Employing Ambulance trust Hospital Ambulance Liaison Officers (HALO)
- Care home GP support packages
- Weekend Social Worker Scheme
- Community Discharge Co-ordinators
- Acute Discharge lounge facility

The nature of urgent and emergency care is such that these initiatives are part of a rolling programme of development that is not exclusive to 2013/14 and will continue into 2014/15 and 2015/16. The evaluation of these initiatives will govern which are commissioned as ongoing core services in the future.

Urgent and Emergency Care Activity

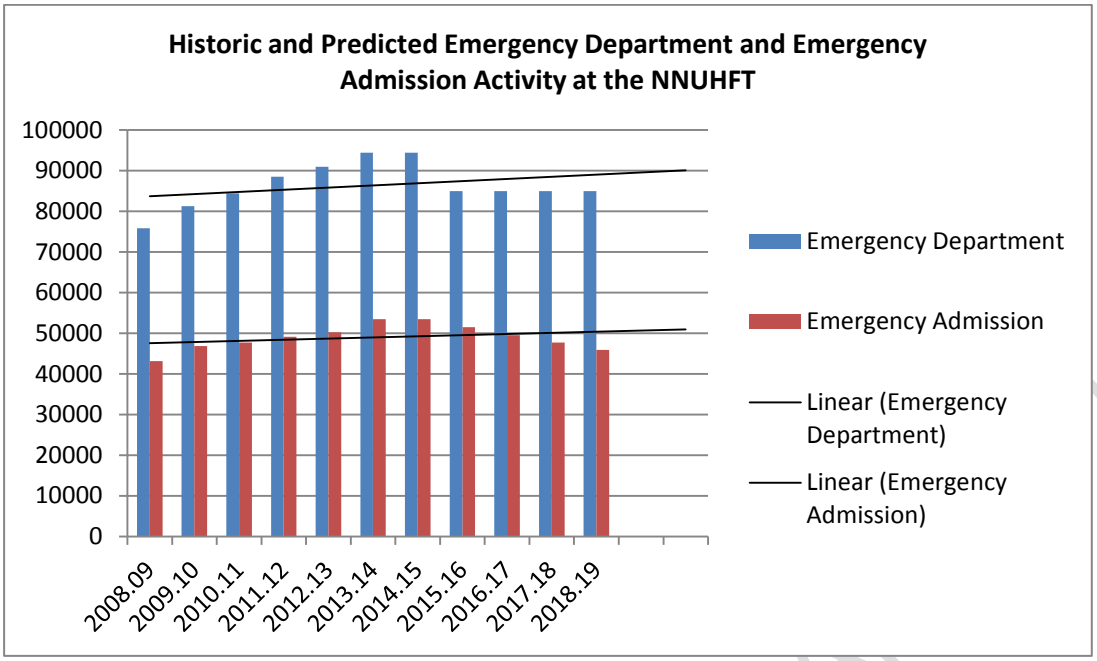
While it is without question that our emergency services are stretched, it is also understood that urgent and emergency activity in SNCCG, NNCCG and NCCG is not unusually high.

Both rates of A&E attendance and Emergency Admissions to the two Acute Trusts that serve SNCCG patients are below National standardised rates per head of 1,000 population. These rates are also lower than those of CCG areas with similar demography such as Devon, Cornwall, Somerset, and Cumbria. This is undoubtedly due to the higher number of GP's per 1,000 population in Norfolk and the good level of access our patients have to Primary and Community care.

Nevertheless, A&E attendances and Emergency Admissions have been rising at a rate higher than the National equivalent, particularly into NNUHFT in the 2013/14 year, and this needs to be halted. This has been particularly felt in the areas of General Medicine and Medicine for the Elderly. With this in mind SNCCG are actively exploring services that offer an alternative to A&E compliment Acute front door services alleviating the need for admission. For example SNCCG continue to support the delivery of a primary care led department within A&E, as well as commissioning a pre-admission assessment unit at NNUHFT and extending diagnostic capabilities in the community such that patients may be 'pre-streamed' prior to referral to Acute hospital admission. In this way SNCCG expect to level off the current rise in unscheduled activity in 2014/15 and see a reduction going into 2015/16 and beyond.

Patient flows

The following diagram details the current growth trend in Type 1 A&E and overall emergency admission activity at NNUHFT, SNCCG's primary provider of Acute services:



What initiatives will SNCCG undertake to tackle these health challenges?

Reducing A&E attenders and A&E admissions

A&E attendance followed by zero length of stay (LOS)

- Data has been forwarded to GP Practices for them to review and SNCCG will pursue opportunities for cost savings,
- Review of GP triage and direct access Magnetic Resonance Imaging (MRI) / Point of care blood testing pilot,
- Signposting from A&E to urgent outpatients clinics to avoid duplicate charges for same day A&E attendance and outpatient attendance,
- Reduce levels of cardiac emergency admissions in particular - this has been identified as a potential QIPP saving area and a range of initial data has been gathered to enable a review of admissions,
- Review and discharge redesign for 14 days+ stay patients in order to review and redesign current discharge protocols to ensure maximum integration and ensure the most efficient process,
- Maintain current performance levels on non-elective admissions.
- Continue with the implementation of the Frequently Attenders CQUIN being delivered by the NSFT, with a view to reducing A&E attendance for a core cohort of frequently attending patients and to ensure learning from this and the further development of mental health hospital liaison services is fully explored.

Admission ratio from Accident & Emergency (A&E)

- To maintain the rates of admission from A&E to expected levels and not allow process or targets to distort admission need

Stroke services

It is well recognised that significant improvements in Stroke prevention and care are required across NHS England (Midlands & East) to maximise reduction in morbidity and mortality.

This includes identification of patients at risk, prompt recognition and action on symptoms, effective management of transient ischaemic attacks (TIA) and access to Thrombolysis. SNCCG continues to work collaboratively with NHS England on ensuring high quality stroke services are provided at centres of excellence and will directly reduce the incidence of Stroke and its associated morbidity and mortality. SNCCG will continue work to close the gap between the currently commissioned Stroke service and the Best Practice Service Specification[39]. This will potentially require operational and structural flexibility, but will not attract additional funding outside the best practice tariff.

Pre admission services

SNCCG intend to commission an acute clinical decision making pre-admission service aimed at ensuring that suitable patients are clinically and diagnostically assessed prior to admission in line with National guidance and recommendations made in the 2012 Department of Health (DH) Emergency Care Intensive Support Team report.

SNCCG are also intending to commission:

- An increase in the availability of telephone advice and same day and next day clinic appointments for patients requiring urgent consultant opinion,
- Emergency outpatient tariff at NNUHFT for Emergency Ambulatory Sensitive Conditions (EASC) and improvement of community management of Ambulatory Care Sensitive Conditions (ACSC) conditions through improved community diagnostics and access to NNUHFT diagnostics prior to, or place of admissions. An agreed number of Acute Medical Unit (AMU) beds will be re-commissioned to operate in an emergency clinic-type system relying more on trolleys and point of care testing than is currently the case. In terms of rationalising and achieving this approach, we will seek to systematically apply the Institute of Innovation's 2010 Directory of Emergency Ambulatory Care and Implementation of Emergency Ambulatory Care documents.

Right clinical decision makers in the right place

SNCCG will seek to implement the following initiative over the next 1-2 years:

- Direct access to emergency x-rays for suspected small fractures to enable GPs to directly refer to x-ray when they suspect a small fracture
- Urgent Care/Walk in service for SNCCG
- Improved access to urgent care services for the South Norfolk population

Ambulance Activity and KPIs

Recently there has been much media interest in the performance of the EEAST, the agency that serves the population of South Norfolk CCG. It is undeniable that EEAST self-reported data shows that patients living within our rural boundaries are currently at a disadvantage when compared to the service provided to patients living in neighbouring and more urban areas.

39 http://www.bhhsnetwork.nhs.uk/userfiles/file/Stroke/120629%20NHS%20Midlands%20East%20Stroke%20Service%20Specification%20v3%200%20(3).pdf

Response times against all national standards have been poor throughout the 2013/14 financial year. Red2 and A19 performance is the worst in England and there is variation in performance across CCGs. EEAST is meeting standards for some CCGs in some months; whereas performance is well below standard in other CCGs, particularly in rural Norfolk and Suffolk. Green response times are frequently not met.

While SNCCG accept the challenges of delivering an equitable standard of care between rural and urban geographies, it does not accept the current service gap. As such SNCCG have been, and continue to be, active members of the Commissioning Consortium and have strongly lobbied for CCG level KPIs to be introduced into the contract that will be made publicly available and will enable the CCG to ensure performance improvement through operational and contractual actions and aligned to an agreed trajectory.

EEAST are of course aware of the imperative need to address the inequity of service to the population that it serves and have been fully engaged and open about the challenges they face by sharing the results of their Clinical Capacity Review which has underlined a lack of overall numbers and skill mix within their workforce.
There have, however, been a number of areas of improvement including fleet and vehicle management; staff recruitment and induction; staff support; and the audit processes. In a recent visit the CQC noted improvements since their previous visit in February 2013, including: staff engagement; complaints processes; staff sickness (reduced from 12% to 6%); and engagement with MPs and councillors. Trust performance had improved against some, limited clinical quality indicators for cardiac and stroke patients, and for patients treated without the need to convey. Additionally it should be noted that delays in handing patients over at hospital have improved at the NNUHFT more than anywhere else in the region and this has led to hundreds of SNCCG patients receiving ambulance led care more quickly this year than last.

Primary Care

The role of primary care is recognised as a key player in the urgent care system. Similarly building a robust and capable out of hospital sector is a crucial factor in building seven day working. SNCCG does not directly commission General Practice or Pharmacy Services we are however committed to collaborative working with the Area Team.

Examples of this include the potential to use community pharmacy in the out of hours system

SNCCG does commission Out of Hours and 111 services and the Provider of these is heavily involved in both the Urgent Care Network and Capacity Planning Meetings.

QIPP Savings for Emergency and Urgent Care Workstream

PROJECT TITLE	CCG LEAD NAME	PROJECT START DATE	ACTIVITY IMPACT START DATE	Net QIPP Saving	Proposed KPI or Metric
Full Year Effect of initiatives From 13/14		01/04/2013	01/04/2013	142	
Potential initiatives					
Pre-admission assessment	Jim Barker	01/04/2013	01/01/2015	65	Reduction in emergency admissions
CDU Assessment	Jim Barker	01/04/2013	01/01/2015	55	Reduction in emergency admissions
Urgent Care Unit	Jim Barker	01/04/2013	01/01/2015	20	Reduction in A&E attendances
			TOTAL	140	

Mental Health (MH) & Learning Disabilities (LD)

Norfolk is driving forward the implementation of payment and pricing systems, implementing the National Dementia Strategy, the Local Joint Dementia Strategy and undertaking the Prime Minister's "Call for Action" in making Dementia a priority area locally.

MH Parity of Esteem

The CCG is fully committed to ensuring an equal focus on improving MH as physical health and that patients with MH problems do not suffer inequalities as a result.

The CCG's overarching aims for MH services are that:

MH provision will be open and accessible to all people who need it regardless of their age and the diagnosis and severity of their MH condition

No MH service user should need to be returned to their GP for onward referral for another MH service

MH and learning disability services are integrated with the wider health and social system and which support the recognition that people's MH should be seen as part of their overall physical and mental wellbeing.

This will apply to all people regardless of their age including those marginalised from society

Plans to reduce the gap in life expectancy for people with severe mental illness

The gap between life expectancy in patients with a mental illness and the general population has widened in recent times. The higher death rate associated with mental illness has focused on the elevated risk of suicide, whereas most of the risk can be attributed to physical illness such as cardiovascular and respiratory diseases and cancer (80% of deaths). Studies suggest that, nationally, the gap in life expectancy in people with mental illness could be as high as 20 years for males and 15 for females.

What initiatives will SNCCG undertake to tackle MH?

Address impact and harms of drug and alcohol use

- Working with Public Health to reduce the harms and impact of drug and alcohol use and specifically focussing on reducing drug and alcohol hospital related admissions.

Re-commission IAPT

- Re-commissioning of IAPT, developing this into wider Primary Care focused provision to mild to moderate MH needs – refocusing this to be a wider MH wellbeing service,
- Improving access and quality of support,
- Enabling psychological support for people with long term physical health conditions.

NSFT strategy delivery

- SNCCG will closely monitor NSFT Strategy implementation ensuring that this supports and further improves services to patients in South Norfolk and does not have a detrimental impact on care,
- We will also ensure NSFT is fully integrated with the 111 service,
- We will work with NSFT to:
    - further develop and embed cluster pathways within MH services with a view to moving towards payment and pricing systems,
    - pilot and consider the results of patient transport for MH patients,
    - evaluate the effectiveness of the Frequently Admitted Patients (FAP) scheme as part of the aim to reduce A&E attendances for a core cohort of individuals.
    - explore options and solutions for the effective delivery of Section 136 suites, ensuring collaborative approaches are taken with Norfolk Constabulary.
    - consider which elements of service are and need to be delivered on a seven day service basis, ensuring that the service complies with the 10 seven day clinical service standards by 2016.
    - ensure NSFT works as a core member of the appropriate urgent care partnerships and as part of Project Domino.

Identify and support dementia

- SNCCG will improve the identification and management of Dementia and develop a specific Dementia strategy that incorporates roles and responsibilities of Primary Care, the related elements of Integrated Care approaches, secondary care MH services, care homes and Continuing Health Care (CHC).

Primary care MH focus

- Ensure a recovery focus is embedded within MH services and that a whole systems approach to meeting MH needs taking into account wider resources and services that are in place to help meet people needs.
- Implementation of new primary care focused IAPT service.

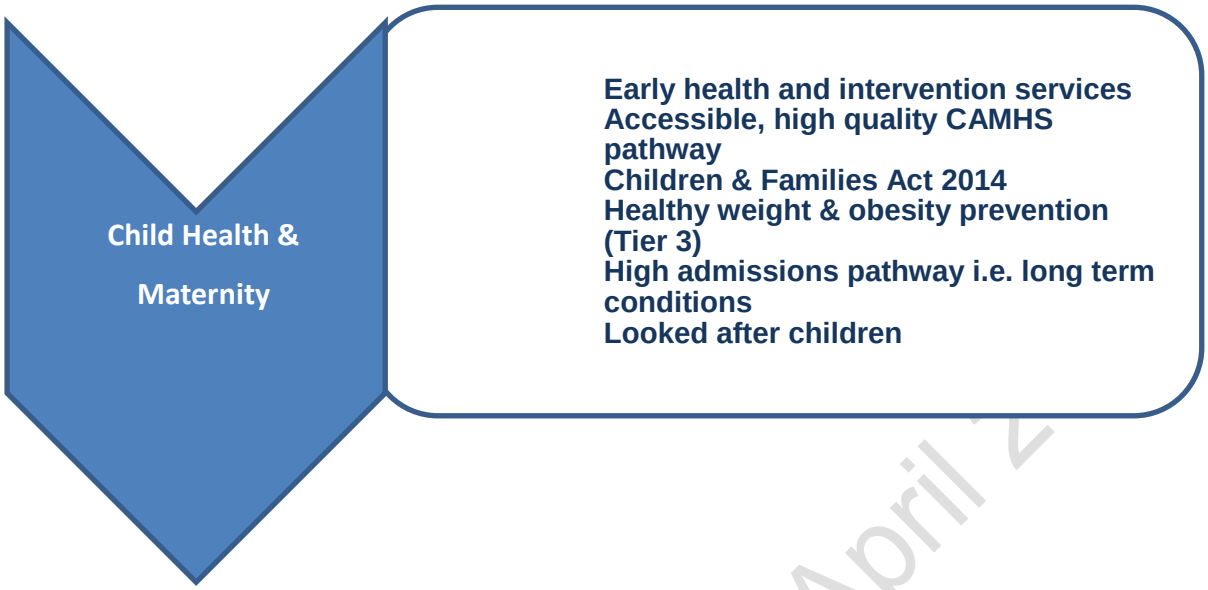
Other

- To further develop Child and Adolescent MH Services (CAMHS) developing seamless pathways of support for children with MH needs and improving service quality and waiting times.
- To review Autistic Spectrum Disorder (ASD) pathways.
- To develop cluster pathways, ensuring within this that the needs of adults with Attention Deficit Hyperactivity Disorder (ADHD) are fully considered and that effective transitional arrangement with CAMHS are in place.
- To further develop Eating Disorder Pathways and re-commission services.
- To review the evidence base of the Mindfulness Pilot and consider future options.
- To review MH 1/3rd sector contracts ensuring that these work with and add value to wider system provision.
- To further define the services provided to the Thetford area and consider future commissioning approaches to these.

QIPP Saving for MH and LD Workstream

PROJECT TITLE	CCG LEAD NAME	PROJECT START DATE	ACTIVITY IMPACT START DATE	Net QIPP Saving	Proposed KPI or Metric
Potential initiatives					
3rd Sector Contract Reviews	Rob Cooper	01/12/2013	01/04/2014	12	Financial performance against the plan
Dementia	Anne-Louise Schofield	01/09/2013	01/04/2014	80	Reduction in emergency admissions over 75s for patients diagnosed with dementia
Drug and Alcohol	Anne-Louise Schofield	01/10/2013	01/04/2014	40	Reduction in emergency admissions for drug and alcohol misuse
			Total	120	

Child Health & Maternity



The SNCCG Child Health & Maternity workstream covers the commissioning of a wide variety of healthcare services but also crosses over into areas of prevention, working with Public Health (PH) and Norfolk County Council colleagues. This collaborative work influences the shape of services and the long term outcomes whilst seeking to reduce inequalities in access and provision.

The CCG's local health profiles highlight that, although children in SNCCG are comparably in good health, obesity in younger children although within the national average range remains a priority for SNCCG. South Norfolk CCG is within the national average range for obesity at year 6, however the Breckland District Council area of the South Norfolk CCG area is at the lower end of this national average range. Tackling obesity and increasing children's physical activity is a joint responsibility between CCGs, Public Health and NHS England.

The South Norfolk CCG Health Profile also identifies smoking in pregnancy as a risk area.

What initiatives will SNCCG undertake to tackle these issues?

Early health and intervention services

- **Same day telephone advice service for children (health professionals)** The CCG will undertake a cost benefit analysis of the current level of service and consider increasing the availability of the telephone advice service. The service will offer advice to GPs to help avoid unnecessary admissions and where possibly offer urgent outpatient appointments as an alternative.

- **Children's Community Nursing Team (CCNT)** Following the expansion of CCNT in 2013/14, the CCG will consider the development of the following services identified in the original NCHC CCNT business case:

- Administration of chemotherapy
- Management of syringe drivers
- Sub-cutaneous granulocyte-colony stimulating factor (G-CSF)
- Plastics and burns dressings
- 24/7 telephone cover
- IV antibiotics for cystic fibrosis and oncology patients

- **Equity of services** – The CCG will work with West Norfolk and West Suffolk CCGs to ensure that children's community services provided across South Norfolk (including Thetford and Diss) are equitable.

CAMHS

- Ensure there is an accessible, high quality CAMHS pathway in place,
- Develop further a common CAMHS offer for children and young people (for targeted and specialist CAMHS),
- Strengthen support and advice for Primary Care and other staff working in universal settings,
- Improve access to joint/integrated CAMHS pathways of care and treatment (for targeted and specialist CAMHS),
- Systematically implement and report approved routine outcome measures across targeted and specialist CAMHS,
- Assess the future of the Intensive Support Team (IST).

Children and Family's Act 2014

In line with National initiatives, the CCG will develop integrated community health pathways for children with special needs which are cost effective and responsive to the needs of this vulnerable group of young people, including providing more care in the community.

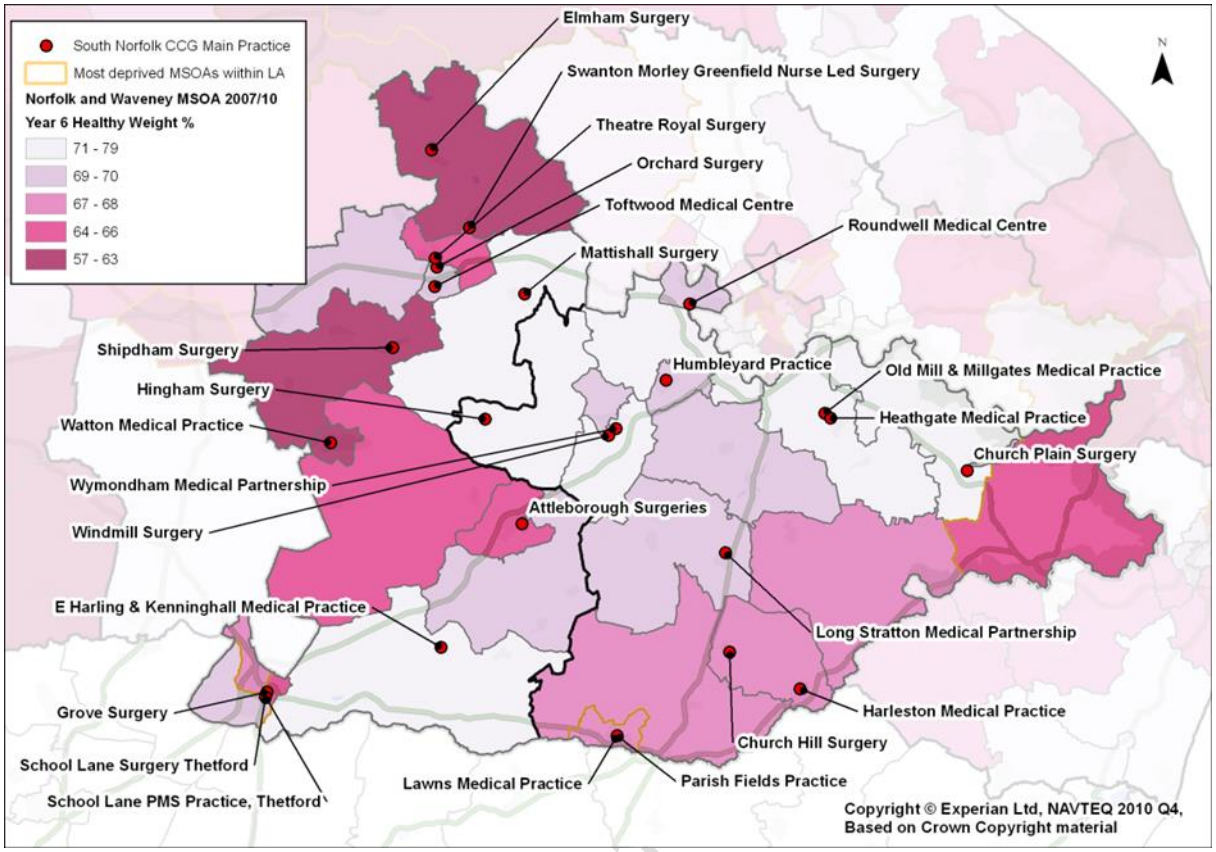
SNCCG will ensure compliance with Health Education and Care Plans related to Special Educational Needs and Disability (SEND) legislation and the implementation of children's personal health budgets.

We will take this forward through the development of joint commissioning arrangements with NCC and effective engagement within the county wide implementation board.

Health weight and obesity prevention

SNCCG had identified that targeted obesity and prevention services for children are vital for the long term health of our population.

The map overleaf illustrates the healthy weight % for Year 6 across South Norfolk:



The CCG will work with Public Health to ensure that support and services are available to children and their families at a Tier 2 level (prevention, lifestyle and education) intervention and clarify the pathways for Tier 3 weight management services.

High admissions pathways (i.e. LTCs)

The CCG is considering the outcomes of the review of the high admission pathways for children's LTCs identifying and implementing pathway improvements and/or potential avoidance options (by starting treatment earlier in Primary Care). The high admission pathways are:

- Asthma/wheezy child
- Bronchiolitis
- Feverishness illness
- Gastroenteritis (diarrhoea and vomiting)
- Head injury (accidental)
- Abdominal pain

Looked after children (LAC)

We will improve outcomes for LACs by working with providers and Children's Services to ensure appropriate services are in place. SNCCG will also look to commission Health Assessments for LACs.

Other Initiatives

Child Health

- The CCG will support the pathway redesign of the Community Continence Service to improve current service provision,
- To continue the development of integrated pathways for Community Healthcare Services for Children with a Disability and/or Additional Healthcare needs (DASH Service Specification),
- SNCCG are leading on the development of an all age non-complex wheelchair specification, which will include services for those aged 36 months and above,
- A new service specification for the Chronic Fatigue Syndrome (CFS)/ Myalgic Encephalopathy (ME) pathway has already been developed in 2013/14 and will be implemented in 2014/15,
- SNCCG will work with the Children's Complex Cases Panel and the Child Health and Maternity Commissioning Board to further develop pathways for children with continuing healthcare needs and for children who need joint funded packages of care with NCC Social Care.

Maternity

- SNCCG will ensure joint working is in place across primary care, midwifery, health visiting and MH services to ensure early and effective support to expectant and new parents with MH needs.
- SNCCG will negotiate a new maternity service specification and performance dashboard with NNUHFT in collaboration with wider Norfolk CCGs. SNCCG will aim to ensure that this specification enables early identification of parental risk factors including MH, substance misuse, smoking and maternal obesity.

Fertility Services

- SNCCG, as part of a collaborative commissioning agreement, will complete the retendering exercise for level 3 specialist fertility services in 2014/15 and will review level 2 service provision.

Workforce

The CCG will work to ensure that providers have an appropriate, capable and sustainable workforce. The commissioning of local services will need a workforce fit for purpose, as we change the shape of services and where necessary move them closer to patients' homes.

The local workforce will need to be highly flexible to respond to changes in how we deliver healthcare. As services across health and social care become more aligned and are delivered in more flexible ways in the community, providers and commissioners must work towards easing the transfer of staff between different employers and ensure they can minimise cost and maximise efficiencies where the workforce overlaps.

The CCG will commission services that are appropriately skilled and competent in providing high quality and safe services for patients, however we are particularly aware of the requirement to carefully plan how we can align the capacity of our primary care workforce with the needs of supporting integrated working.

Staff Satisfaction

The people who work for us are a very valuable resource and it is important that the CCG has a good understanding of staff satisfaction. In order to ensure this will be undertaking a staff satisfaction survey in June and this will inform our organisational development plan.

The areas that we are interested in are:

- Staff opinion of the CCG leadership
- That CCG leadership consult with staff on issues that affect them
- That staff believe the CCG has a strategic plan which will deliver its vision
- That manager and staff relationships are constructive
- That good performance is recognised and poor performance is managed well

Research and Innovation

Health research is essential to continually improve health outcomes and the effectiveness of health services for patients. There is an expectation that the UK will be the first research-led health service in the world. Searching for and applying innovative approaches to deliver health care must be an integral part of the way the NHS does business. Doing this consistently and comprehensively will dramatically improve the quality of care and service for patients (Health Wealth and Innovation 2012).

The Health and Social Care Act reflects these commitments and places a clear duty on the Secretary of State, NHS England and CCGs to promote research and champion innovation.

Research

In line with the research commitments, SNCCG accepted responsibility for hosting the Norfolk & Suffolk Primary & Community Care Research Office, on behalf of all CCGs across Norfolk & Waveney in April 13. Patient and clinical involvement in research across SNCCG is strong. The CCG has a statutory duty to promote research including:

- Participation in research
- Supporting research and using research evidence
- Proactive engagement with local partners
- Meeting treatment costs for patients taking part in research (including any Excess Treatment Costs[40])

In line with the research duty the CCG will:

- Agree a plan to enhance the research culture of the CCG-addressing leadership, education, use of evidence and partnership.
- Ensure provider contracts are fit for purpose in relation to the Research Governance Framework, Clinical Research Network (CRN) targets, and Quality Account arrangements.
- Chair the Norfolk and Suffolk Primary and Community Care Research Steering Group which oversees arrangement for Research Delivery through the Norfolk and Suffolk Primary and Community Care Research Office. This group has a mandate to agree strategic direction for research across Norfolk and Suffolk. The Research office supports the Research Design, Research Assurance, Study Delivery and Patient involvement in research across CCGs, academic organisations, primary and community Care providers and will deliver an agreed work plan[41]

[40] Where patient care is being provided which differs from the normal, standard, treatment for that condition (either an experimental treatment or a service in a different location from where it would normally be given) the difference between the total Treatment Costs and the costs of the "standard alternative" (if any) can be termed the *Excess Element of Treatment Costs* (or just "**Excess Treatment Cost**"), but is nonetheless part of the Treatment Cost, not a Service Support or R&D cost. *DH HSG(97)32*

[41] \\inf-fs-1-v1\snccg\Departmental Documents\R&D\R&D Policies & Corporate Docs\Workplan\Workplan updated Feb13.docx

- Through CRN involvement: continue to support the establishment and development of the CRN; represent the interests of patients, commissioners, and primary care providers; work with CRN partners to support the delivery of the National Institute of Health Research (NIHR) performance framework and agree models of funding for enhanced patient and clinical involvement in research.
- Fully implement the research cost policy with NHS England, and Public Health England including agreeing processes for managing appropriate research treatment costs for provider organisations to ensure provider trusts identify research savings and reinvest these in new studies and where appropriate review provider business cases for additional research treatment funding.
- Build on the CCG leadership recommendation to enhance research dissemination particularly through GP education routes. A new research dissemination process will be developed and agreed by CCG leadership.
- Work with R&D to identify a research priority for a commissioned research call out for preparation of a national research grant application (Research for Patient Benefit Grant) to include a systematic review to feed into commissioning programmes.
- Engage locally with the University of East Anglia and other academic bodies.

Innovation

The CCG recognises the importance of the three stages of the innovation agenda – invention, adoption and diffusion and has a statutory duty to champion innovation and the adoption of innovation including:

- Setting out the CCG approach to innovation
- Ensure strong leadership and accountability for innovation within our organisation
- Being an active partner in the local Academic Health Science Network (AHSN).

In line with the innovation duty the CCG will:

- Increase its understanding of opportunities for innovation by joining and working with the East Anglian Innovation Hub.
- Work in collaboration with the Academic Health Science Network (AHSN) to support the delivery of innovation, adoption and spread of evidence for Diabetes, Dementia and Chronic Disease Management.
- For 2014-16, the CCG will work with the Research Office and AHSN to develop a post that will support increased involvement in the adoption and spread of evidence for the CCG/AHSN priority areas.
- Through CCG officer time contribute to the delivery by AHSN working Groups
- Deliver the EPaCCS innovation Project which aims to do the following: develop an options appraisal for an electronic EoL register for SNCCG, engage with stakeholders, agree a pilot area with the GPs involved and work with them on how the register will be implemented, establish robust governance arrangements. The EPOC project was funded from the Innovation fund with the support of the AHSN.
- Use the collaborations such as AHSN that were developed through the EPaCCS Project to identify funding streams for the FFT Early Adoption Wave project which aims to develop a set of quality indicators and dash board for community care providers (fractured neck of femur rehabilitation pathway) using the work of Kings Fund and CQC and align patient data within these core indicators.
- Review and strengthen CCG leadership and CCG innovation plansthrough the Norfolk and Waveney CCG Chief Officers meetings support the cross CCG representation by West Norfolk CCG on the AHSN Partnership

Implementation and Delivery of the Plan

SNCCG has implemented a project management approach to its commissioning programme which will be further developed in 2014/15.

All proposed commissioning initiatives require sign off by the CCG Leadership Team with the joint clinical and management sponsors required to identify at the outset clear benefits in terms of improved patient outcomes, access, experience and/or reduced cost against which projects will be measured. Projects also have to demonstrate use of a relevant evidence base and plans for patient/public engagement and robust evaluation in order to get project approval.

SNCCG Leadership Team will monitor delivery of the programme above regularly during 2014-16 using this methodology.

QIPP Governance

To ensure achievement of the QIPP target a number of systems and process have been established. Each QIPP project has a project charter and plan that is signed off by the Senior Management Team, which comprises Chief Officer, Chief Operating Officer, Chief Finance Officer, Director of Quality and Patient Safety and Head of Governance and Strategy.

Each identified QIPP project is monitored and RAG-rated with timescales and the savings clearly recorded.

A live QIPP Working document provides detailed information on each project broken down further by clinical work-stream areas and detailing pro-rated savings to be made during 2013-14. QIPP projects are monitored and reviewed at a number of meetings to provide the necessary rigour and assurance of delivery.

The CCG has appointed a QIPP Programme Director who manages and oversees achievement of QIPP. There are a number of stages in which challenge of QIPP can be undertaken.

The QIPP Programme Director oversees a weekly QIPP meeting which is attended by the CCG's Commissioning Team, Clinical Workstream Leads as well as a Business Intelligence analyst.

The purpose of these meetings is to ensure that projects are consistently monitored and reviewed, identifying any matters that will impact on the timescales and achievability of each project. Risks are flagged and where appropriate the RAG rating amended.

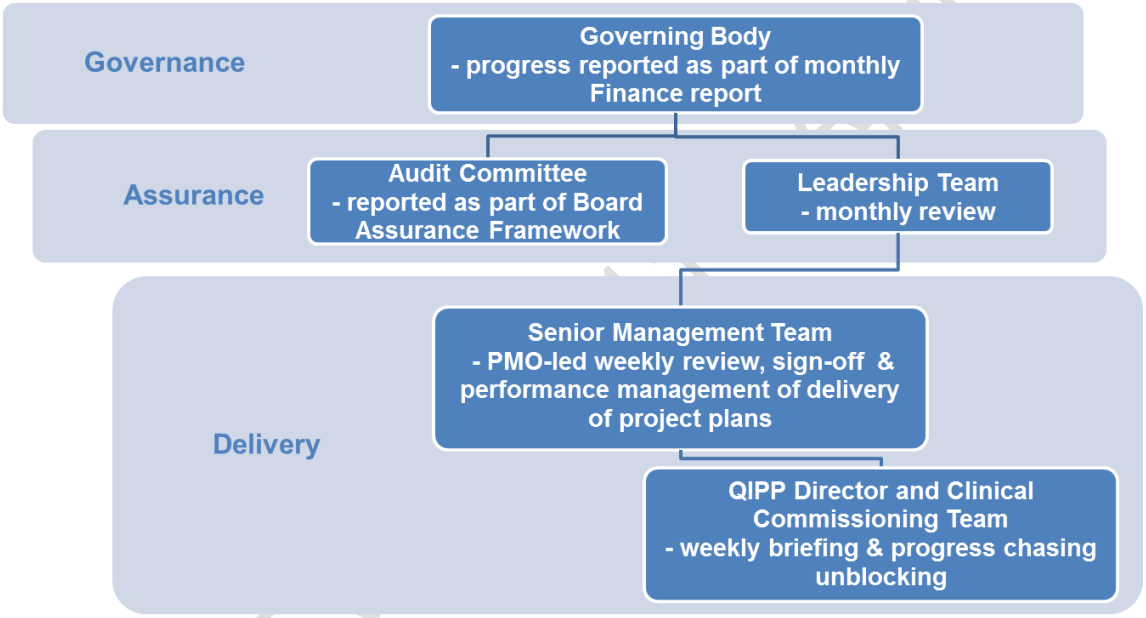
In addition, a key aspect of the weekly meeting is the development of new QIPP initiatives. Each new initiative is assessed for quality based on the deliverability of savings and quality. The meeting ensures that there is detailed clinical challenge around existing plans and potential new projects.

A further review and assessment of QIPP delivery is then undertaken at the weekly Senior Management Team Meeting, at which any new initiatives are approved.

Where a project is identified as liable to miss savings and/or deadline a rectification plan will be produced by the commissioning team, with the aim to ensure that it is brought back on target. The robustness of the rectification plan is tested and challenged at all stages throughout the process.

A monthly Executive Leadership Meeting including Senior Management Team and Clinical Governing Body members further reviews QIPP initiatives and receives an overview of QIPP delivery. This meeting provides an opportunity for the rigour of the QIPP plan to be tested and challenged by members who include elected Governing Body members. This meeting provides a further chance for broad clinical and managerial input and an opportunity to test robustness of plans.

At monthly Governing Body meetings QIPP plans and initiatives are reported and reviewed enabling discussion about QIPP delivery and management and further challenge is provided by the Governing Body lay members.



Summary operating plan

Our summary operating plan and summary QIPP plan is contained in the accompanying Excel file.

Financial Plan

Introduction and Context

The purpose of this 2-year Financial Plan is to underpin the delivery of NHS South Norfolk Clinical Commissioning Group's (SNCCG) Operational Plan 2014-16, by establishing a robust, flexible and sustainable financial environment within which to operate. The plan will enable the local health and social care system to develop within the context of the anticipated economic and political climate, providing a financial framework for collaborative working and integration.

The policy context within which SNCCG will deliver this plan is the settling down of the new system architecture (CCG's, CSU's, Area Team's etc.) but still in the midst of the toughest financial constraints ever experienced by the NHS, with £20bn savings to be identified and delivered between 2011 and 2016. The Quality, Innovation, Productivity and Prevention (QIPP) agenda is the response to this national funding gap.

SNCCG is one of five CCGs emerging from the NHS Norfolk and Waveney PCT cluster and although the predecessor PCT consistently delivered its required financial surpluses, in terms of legacy for the successor CCGs, the PCT used non-recurrent measures in 2012/13 to balance its financial plans. SNCCG's share of this funding gap was £5m and together with other funding pressures planned and unplanned for, meant the SNCCG itself required the benefit of non-recurrent measures to deliver its required financial surplus in 2013/14,

The achievement of savings is becoming more difficult as easier transactional savings have already been made or are being exhausted over the two years of this financial plan. This, therefore, requires the focus of QIPP delivery to move more quickly to transformational change, requiring a level of collaboration and integration with other organisations not previously experienced.

2013/14

The CCG allocation for 2013/14 saw net growth of 2.3%. However, there existed considerable uncertainty regarding the CCGs programme cost resource during the year as the process to align funding to contracted activity, following the transfer of commissioning responsibility for specialised services to NHS England, was only completed in October 2013. Additionally, the four Norfolk CCGs undertook a similar exercise to align funding transferred from Norfolk PCT to contractual liabilities, which was completed in December. The net impact of these reviews is that South Norfolk CCG's programme cost resource was reduced by £2.3m from that planned.

As a result of these reviews, after reporting month 6 finances, SNCCG was requested to prepare a Financial Recovery Plan to provide assurance to NHS England regarding how it would improve its month six forecast outturn position and demonstrate achievement of the required 1% surplus position for 2013/14. It was also requested to demonstrate how it would achieve the planning requirements for 2014/15 given the change in the month six reported outturn position. SNCCG largely planned and delivered the 1% surplus by managing down non-recurrent costs, such as Continuing Healthcare (CHC) Restitution, and utilising all available contingencies.

NHS England have required CCGs to manage the processes to settle the cost of CHC Restitution claims – claims from individuals who have funded their own care or those of a

family member, who believe that the NHS should have funded the care. This process is on-going and is forecast to be completed by 31st March 2015. Clarity regarding the accounting treatment of these costs was only received in March 2014 when NHS England confirmed their accounting responsibility for a cohort of the cases that were sufficiently advanced at 31st March 2013 to allow Norfolk PCT to provide for those costs as determined by International Account Standard (IAS) 37 – *Provisions, Contingent Liabilities and Contingent Assets.* CCGs are required to meet the costs of all other claims and at the beginning of the year South Norfolk CCG anticipated the cost of settling these costs to be £3.7m, although at the end of the year the cost to be incurred by South Norfolk CCG was anticipated to be in the region of £1.0m.

A limited risk-share agreement is in place between the five Norfolk and Waveney CCGs so that individual CCGs should not be exposed to financial risk as a result of incurring excessive costs for individual high cost packages and other significant costs. During 2013/14, SNCCG received £1.1m from neighbouring CCGs under the terms of the risk-share agreement, largely as a result of additional high cost packages put in place for patients requiring neuro-rehabilitation and continuing healthcare.

Despite the uncertainties existing in the CCG's first year of existence, the CCG is on course to deliver its required surplus of £2.3m. This financial performance was achieved by a combination of robust contract management, together with realisation of benefits from locally derived QIPP schemes. Additional costs due to higher than planned acute activity and other cost pressures were mitigated by contingencies that would otherwise have been invested in programme services.

2014/15 and 2015/16

South Norfolk CCG (SNCCG)'s 2-year Operational Plan (Table 1) anticipates the delivery of required financial 1% surplus in 2014/15 and 2015/16. The Plan includes realistic estimates of provider contracts not signed by 31st March 2014.

The financial plan assumes that the required 2.5% Transformational Funds will be spent non-recurrently in 14/15 and 15/16 to support system-wide integration, reduce pressure on the emergency care system and deliver other system provider benefits on a spend-to-save basis. Of this 1% will be spent to support the Better Care Fund. The Plan allows for a contingency of 0.5%, as required by the NHS England Planning requirements.

The planning requirements set out a number of Financial Key Performance Indicators (Table 2). All KPIs meet the requirements of NHS England. The underlying position describes the recurrent planned financial position of the CCG. The decrease in the underlying position reflects the CCG's planned recurrent delivery of QIPP mitigated by an increasing amount deployed non-recurrently of funds derived from the application of the 70% marginal rate credit on non-elective activity.

The CCG planned to spend £5.580m on its running costs during 2013/14, reflecting the cap of £25 per head of population. This running cost allocation funds staff costs, the costs of clinical engagement, the costs of commissioning support services delivered by North and East London CSU, as well as establishment and other costs. SNCCG did not spend its full allocation during 2013/14, largely as a result of delays in recruiting staff in the early part of the financial year and the underspend partially mitigated programme overspends. In 2014/15, the allocation increases marginally to £5.610m but due to the anticipated

population increase this now represents a per capita allocation of £24.41. The running cost allocation is reduced by 10% in 2015/16 so the available £5.055m represents a per capita allocation of £21.78. SNCCG anticipates absorbing this funding reduction using the 20% efficiency savings committed by North and East London CSU when it took over the running of Anglia CSU prior to April 2014. Additionally, the CCG will mitigate cost pressures by reducing its reliance on non-substantive contractors.

Table 1 – Financial Plan

Financial Position

Revenue Resource Limit

£ 000	2013/14	2014/15	2015/16
Recurrent	241,761	247,036	255,783
Non-Recurrent	1,727	2,348	2,495
Total	243,488	249,384	258,278

Income and Expenditure

Acute	126,129	126,230	125,460
Mental Health	19,999	20,151	20,649
Community	27,185	27,459	26,875
Continuing Care	19,746	18,659	18,148
Primary Care	40,732	42,871	43,645
Other Programme	1,669	4,663	13,656
Total Programme Costs	**235,458**	**240,033**	**248,433**
Running Costs	5,326	5,610	5,055
Contingency	361	1,247	2,207
Total Costs	**241,145**	**246,889**	**255,695**

£ 000	2013/14	2014/15	2015/16
Surplus/(Deficit) In-Year Movement	976	152	88
Surplus/(Deficit) Cumulative	2,343	2,495	2,583
Surplus/(Deficit) %	0.96%	1.00%	1.00%

One key issue that Norfolk CCGs need to address during 2014/15 is the requirement to develop evidence-based demand management plans funded by the marginal rate 70% threshold deduction. The processes inherited from Norfolk PCT were opaque and SNCCG is working with other Norfolk CCGs and providers, through the urgent care network, to improve the transparency and efficacy of these schemes. Norfolk PCT had used marginal rate credit to fund recurrent expenditure and these, though subject to review, are forecast to continue. Due to 2013/14 unexpected increases in emergency admissions the amount of marginal rate credit requiring investment has increased but is yet to be agreed with providers. SNCCG has provided for an additional £1.4m to mitigate these costs.

GPIT income and expenditure are not yet confirmed and so are excluded from this financial plan.

Table 2 – Financial Key Performance Indicators

£ 000	2013/14	2014/15	2015/16
Net Risk/Headroom		-	-
Risk Adjusted Surplus/(Deficit) Cumulative		2,495	2,583
Risk Adjusted Surplus/(Deficit) %		1.00%	1.00%
Risk Adjusted Surplus/(Deficit) (RAG)		GREEN	GREEN
Underlying position - Surplus/ (Deficit) Cumulative	9,103	7,882	7,282
Underlying position - Surplus/ (Deficit) %	3.77%	3.19%	2.85%
Underlying position (RAG)	GREEN	GREEN	GREEN
Contingency	361	1,247	2,207
Contingency %	0.1%	0.5%	0.9%
Contingency (RAG)		GREEN	GREEN
Notified Running Cost Allocation	5,580	5,610	5,055
Running Cost	5,326	5,610	5,055
Under / (Overspend)	254	0	0
Running Costs (RAG)	GREEN	GREEN	GREEN
Population Size (000)	228	230	232
Spend per head (£)	23.41	24.41	21.78

The Key Planning assumptions used by SNCCG to forecast the cost and volume of the services it commissions are set out in Table 3.

Table 3 – Key Planning Assumptions

	2014/15	2015/16
Notified Allocation Change (£'000)	5,896	8,894
Notified Allocation Change (%)	2.18%	1.44%
Tariff Change - Acute (%)	-1.20%	-1.10%
Tariff Change - Non Acute (%)	-1.80%	-1.10%
Demographic Growth (%)	0.99%	0.99%
Non Demographic Growth - Acute (%)	2.50%	2.50%
Non Demographic Growth - CHC (%)	9.60%	6.60%
Non Demographic Growth - Prescribing (%)	2.50%	2.50%
Non Demographic Growth - Other Non Acute (%)	0.50%	1.00%

Tariff assumptions are as per DH guidance. The acute tariff is adjusted in 2014/15 to allow for 0.3% of service developments allowed by NHS England and Monitor to reflect the costs to providers of implementing the recommendations of the Francis Report and the Keogh Review. A further 0.3% adjustment is included to reflect the increased costs of the Clinical Negligence Scheme for Trusts (CNST).

Demographic Growth assumptions are as per ONS 2012 LSOA population assumptions for South Norfolk and Breckland districts.

The Non-Demographic Growth assumptions for acute activity is based on historical trends to 2012/13. The majority (85%) of the acute activity commissioned by SNCCG is delivered by NNUHFT and the activity increases observed in 2013/14 are higher than historical trends. Evidence suggests that there are a number of contributing factors to this increase including the impact of the transfer to NHS England of responsibility for commissioning specialised services. The observed growth is faster than that seen at other acute providers in the East of England and the month-on-month figures suggest a growth rate reverting to historical trends.

The Non-Demographic Growth assumption for Continuing Healthcare has been based on recommendations made by Public Health in a July 2013 report entitled "Long Term Projections of Continuing Healthcare Provision for Norfolk CCGs". The recommendation was that South Norfolk CCG should plan for an annual 2.6% increase in the provision of CHC reflecting the increase in age-specific disease prevalence in its population. Additional growth is anticipated in 2014/15 (8%) and 2015/16 (5%) to reflect a short-term expectation that there remains a backlog of demand to be addressed, as well as to reflect the impact of a reducing attrition rate seen in 2013/14.

The assumption regarding non-demographic growth pressures in prescribing expenditure is based on advice from Anglia CSU in respect of their "horizon-scanning" for anticipated changes in activity due to NICE implementation and guidance changes.

The Norfolk system has historically been largely successful in mitigating the impact of demographic growth pressures on non-acute care though there is recognition that the ageing population will bring increasing pressures on the out of hospital care system.

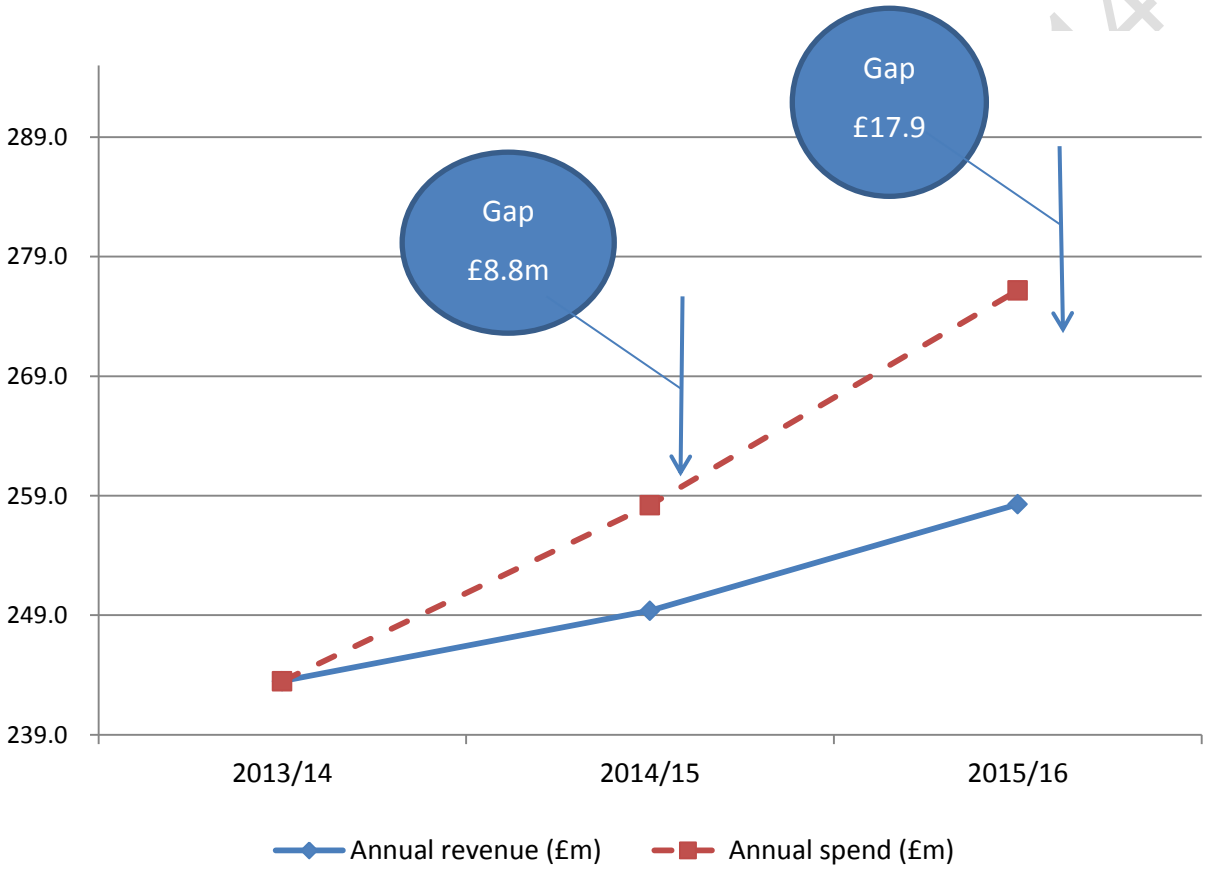
Other recurrent and non-recurrent pressures for 2014/15 include a £2.8m allowance for the cost to agree contracts with the CCGs main providers, together with an additional £0.5m costs relating to the rebasing of Integrated Community Equipment Store funding between Norfolk CCGs and Norfolk County Council, as well as other sundry developments

In 2015/16, SNCCG has forecast an additional cost pressure of £0.700m in respect of an enhanced IAPT service currently being procured, together with a potential liability for costs once the cluster-based Mental Health Payment System is implemented.

Also in 2015/16 the CCG has forecast a contribution of £10.2m (£5.0m net of the additional planned allocation of s256 monies in 2015/16). This sum is yet to be agreed with Norfolk County Council and represents a "worse-case" assumption of the costs required to protect social care services in Norfolk.

QIPP

The QIPP savings required to deliver the CCG's 2-year Financial Plan are effectively bridging the gap of doing nothing and seeing the costs of healthcare increase in price and volume. This known as the QIPP challenge and for SNCCG the challenge is to deliver £8.8m of savings in 2014/15 and a further £9.1m of savings in 2015/16.



The planned QIPP savings are challenging, at 3.54% for 2014/15 and 3.51% for 2015/16. They largely build on work commencing in 2013/14 to:

- mitigate acute activity by specific contractual levers and by engagement practices to reduce variation in referral activity;
- deliver planned savings following implementation of new pathology contract from Norfolk; leverage the primary care investment of £5 per head to improving care for the over 75 years old cohort of patients by reducing acute admissions for that age group;
- reduce the cost of Continuing Healthcare by market engagement (Care Homes) and improved management of new and existing cases;
- mitigate the cost of prescribing by eliminating variation across practices and clinical area.

Additionally, during 2014/15 SNCCG anticipates some return from its Better Care Fund collaboration with Norfolk County Council, together with Norwich and North Norfolk CCGs. In the first half of the year, the planning and PMO functions of the BCF will ensure that adult social care will become more aligned to the health agenda and that out of hospital health services, including mental health, will be reviewed to ensure improved focus on mitigating pressures on acute emergency activity. SNCCG anticipates that the benefits from this collaboration will begin to be noticed financially in Q4 2014/15, if not sooner.

The QIPP savings will be delivered by six workstreams (Table 4) based on where the intervention will be undertaken as opposed to where the savings will be achieved. For instance, the majority of QIPP interventions in the community are predicated on avoiding hospital admissions.

Table 4 – QIPP Workstreams

Workstream	14/15 £m	15/16 £m
Mental Health	132	-
Out of Hospital / Better Care Fund	2,816	2,907
Planned Care	3,323	2,038
Primary care	574	575
Unplanned Care	282	-
Finance and Contracting	711	1,537
Unidentified QIPP	996	2,000
Grand Total	**8,834**	**9,057**

Key Risks and Mitigations

The risks to the CCG's financial forecasts are generated in the areas that are not within the control of SNCCG but need to be managed to ensure financial sustainability. These include:

- Commissioning arrangements with external providers. The CCG has made allowance for tariff uplift for acute and non-acute activity as per national guidance. However, an increase in prevalence or activity pressures in excess of the demographic and non-demographic growth assumptions will lead to unexpected demand and activity.
- Inflation assumptions, particularly around high cost drugs and technology and equipment costs may be understated.
- Continuing Healthcare costs rising. The CCG has seen increasing demand for continuing healthcare costs for a number of years as a result of policy changes and an increasingly aged population. In 2013/14 it was noted that the duration of packages was increasing significantly contributing to greater than planned costs. If these trends continue or increase this will cause greater pressure on the CCG's finances.
- Reduction on management capacity due to the requirements to meeting national targets for a 10% reduction in running costs could impact on the CCGs ability to achieve the

savings and transformation necessary to meet statutory targets. The CCGs new CSU provider North and East London CSU has committed to delivering efficiencies totalling 20% over three years which will go some significant way to addressing this risk.

- Non-delivery of QIPP

- The CCG has entered into a limited risk share agreement with its four neighbouring Norfolk and Waveney CCGs, largely around the cost of individual high cost packages (costing greater than £100k per annum). SNCCG benefitted from this arrangement in 2013/14 but there is no reason to expect that this will continue and the CCG will incur part of the cost of additional high cost packages of care delivered in neighbouring CCGs

- For 2015/16 the financial arrangements anticipated under the Better Care Fund are to be agreed with Norfolk County Council. The challenge is significant to protect social care services and deliver more from greater integration and it is possible that the assumptions of savings included in the financial plan will not be met in full or will be met later than planned. Robust project management and planning during 2014/15 will mitigate against that risk on delivery of QIPP

SNCCG has planned for a contingency of £1.2m being the 0.5% of Resource required by NHS England. Additionally, the CCG will not commit its remaining non-recurrent funds until it is confident that risks will be absorbed by the planned contingency.

Balance Sheet Issues

SNCCG is forecasting a cash balance of £1.95m at the end of both 2014/15 and 2015/16, which is in excess of anticipated maximum cash balance requirements set out by NHS England of 1.75% of the final month's cash drawdown, or £0.250m whichever is the higher. This is because the CCG hosts the Norfolk and Suffolk Primary & Community Care Research Office, which receives donor funds in advance of expenditure. These funds, represented as deferred income in the financial statements of the CCG are forecast to be £1.7m at 31st March 2014. NHS England has authorised SNCCG to hold these excess funds because they are not derived from the funding allocation available to the CCG. The CCGs planned Income and Expenditure does not included revenue or expenditure for the hosted organisation, though this will be reflected in SNCCG's statutory accounts.

Summary

SNCCG recognises that the transformational change necessary to achieve the level of savings required needs a whole system integrated approach. The development of the Better Care Fund, if properly implemented, will be the primary method by which the CCGs statutory financial obligations will be delivered from 2015/16 onwards. As a result it is key that the foundation stones for this fund are put in place during 2014/15.

The risks to delivery of the CCG financial plan are significant but are mitigated either by the contingency or by other non-recurrent expenditure as yet uncommitted.

***Appendix 1* – SNCCG, NNCCG & NCCG Strategic 'Plan on a Page'**

STRATEGIC PLAN ON A PAGE

VISION - improvement in our populations' health and well-being through affordable, integrated, individualised, high quality, health and care. Available to all that need it and primarily delivered through integrated community primary care teams

Ensuring that patients, the public and their carers will be fully included in all aspects of service design and change

SYSTEM VALUES & PRINCIPLES

- Our health and care system is in this together
- All care is delivered in, or near patients' home wherever clinically safe to do so. After acute care, re-ablement and support to get patients back to their own home or community
- A universal expectation that ALL services are based upon best evidence, are high quality, personalised and delivered with respect and compassionate personalised approach
- Clinicians and senior managers work together to lead from the front to make change happen and maintain momentum
- We maximise value by seeking the best outcomes for every pound spent
- We have a positive mind-set about the challenge – 'we can, we must, we will'
- We work collaboratively with our colleagues to build trust, the mind-set is one of 'this is about patients not organisational boundaries'

SYSTEM GOALS

- **GOAL 1** Continuously improve the quality and safety of health and care
- **GOAL 2** Improve the health and well-being of the people of South Norfolk, Norwich and North Norfolk
- **GOAL 3** Collectively manage resources effectively, responsibly and ethically, delivering VFM
- **GOAL 4** Fully integrate health & social care services working in full partnership with primary care localities, to support people to remain safe & well in their own homes
- **GOAL 5** Reduce unwarranted variation in care
- **GOAL 6** Develop the necessary underpinning architecture for innovation and effective future services

OBJECTIVES

- **Objective 1** Further improve unplanned admission rates and remain in lower quartile
- **Objective 2** Reduce all avoidable hospital deaths
- **Objective 3** Improvement in patient experience both in and out of hospital
- **Objective 4** Public health indicators improve to better than England average
- **Objective 5** Maintain financial balance, deliver statutory duties
- **Objective 6** Community health and care teams delivering integrated services in localities
- **Objective 7** All patients who need it, have access to high quality and appropriate care 7 days per week
- **Objective 8** All services at better than England average on the Atlas of Variation

Utilising all available technology to support transformation in care

INTERVENTIONS

- **Intervention 1** Development of primary care
- **Intervention 2** Implementation of integrated community care teams, working across boundaries (based on primary care locality footprints)
- **Intervention 3** Proactive use of predictive modelling and risk stratification
- **Intervention 4** Easy to access, seven day health and social care provision for people with complex health and care needs
- **Intervention 5** Enable independence, self care and
- **Intervention 6** Improved support for people with
- **Intervention 7** Deliver major redesign of urgent
- **Intervention 8** Ensuring effective end of life
- **Intervention 9** Ensuring effective workforce planning,

SHARED GOVERNANCE ARRANGEMENTS

QUALITY, INNOVATION, PRODUCTIVITY & PREVENTION

Appendix 2

18 week RTT waiting times for non-urgent consultant-led treatment

Operational Standards	Threshold (2014/15)	Method of Measurement (2014/15)	Consequence of breach	Timing of application of consequence	Applicable Service Category
% of admitted Service Users starting treatment within a maximum of 18 weeks from Referral	Operating standard of 90% at specialty level (as reported on UNIFY)	Review of monthly Service Quality Performance Report	Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £400 in respect of each excess breach above that threshold	Monthly	Services to which 18 Weeks applies
% of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral	Operating standard of 95% at specialty level (as reported on UNIFY)	Review of monthly Service Quality Performance Report	Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £100 in respect of each excess breach above that threshold	Monthly	Services to which 18 Weeks applies
Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral	Operating standard of 92% at specialty level (as reported on UNIFY)	Review of monthly Service Quality Performance Report	Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £100 in respect of each excess breach above that threshold	Monthly	Services to which 18 Weeks applies

Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

PUBLIC

NHS Great Yarmouth and Waveney Clinical Commissioning Group

2 Year Operational Plan

4 April 2014

Better Health, Better Care, Better Value

Introduction to the 2 Year Operational Plan

This plan contains the following elements:-

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Links to Five Year Strategy

As set out in our Five Year Strategy, NHS Great Yarmouth and Waveney Clinical Commissioning Group (NHSGYWCCG) has an ambitious and transformational vision to develop an integrated care system to cover all of our population. This is in conjunction with Norfolk and Suffolk County Councils, Great Yarmouth Borough Council (GYBC) and Waveney District Council (WDC), together with NHS England. Our ambition, shared with all of our local system partners, is to create a single public service provider organisation with full citizen design and 'buy in' – one that is sustainable and affordable, and which delivers flexible and high quality services for our population.

Our vision can be described as: By 2018/19 the citizens of Great Yarmouth and Waveney will receive their health and social care, and some district/borough services, from a cohesive Integrated Care System (ICS) acting as a single provider of services. The ICS will be user focused, delivering high quality and safe services with an orientation to innovate and develop new methods delivering better care based on the ideas and ambitions of professionals and the feedback of users. Because it is operating in a coordinated way, eliminating inefficiency and waste, and striving for more effective delivery methods it will be using resources optimally and constituent member organisations will be in financial balance and able to invest in further improvements.

Our shared vision has been the result of intense dialogue with our partners and stakeholders – ensuring that all of our commissioner and provider strategies are complementary, and has culminated in letters of intent to work together being signed by our commissioning partners. This includes detailed discussions over many months with our Clinical Executive Committee (CEC) and retained GPs. The plans have also been discussed with our member practices.

It is essential that we have strong alignment with and engagement from, our partners in the Norfolk and Suffolk Health and Wellbeing Boards (HWBs). To this end, we have maintained close dialogue with our partners to ensure that our direction of travel and strategic intentions are recognised and supported by both HWBs. We are pleased that our strong vision around integration has been commended by colleagues in both county councils and that our vision is strongly referenced in the Better Care Fund (BCF) plans for both Norfolk and Suffolk.

We have ensured that we engage throughout the iterative stages of the formation of this system-wide strategy with our commissioning partners, with our main providers, with other stakeholders and with the public. The strategy aligns with our vision of an ICS and discussions have taken place in a number of different settings. These include:

- presentations to our Great Yarmouth and Waveney System Leadership Partnership (GYWSLP) in November 2013 and January 2014
- presentation of the ICS model to our engagement event on 19 December 2013. Partners signed up to our vision at this event
- presentation to the Council of Members on 29 January 2014, together with discussion about the principles of integration at the previous meeting
- detailed discussions about the principles of integration and our five year system-wide vision with the Senior Programme Board of the ICS, at meetings in December 2013 and January 2014
- we are also planning public engagement events, to follow on from a successful public engagement event with integration as its main theme earlier in 2013. Key to this was the 'Big Listen' in March 2014.

Our commissioning intentions for 2014/15, published in September 2013, were aimed at beginning the contractual moves necessary to support the delivery of the CCG's (Clinical Commissioning Group) overall strategy. Whilst pan system collaborative working to an agreed vision has been in place informally for some time, the commissioning intentions began to specify actions expected from providers and to begin to shift the structural make-up of the system.

The high level intentions of the commissioning intentions document included:

- creating well-being, not just delivery of health care
- stimulating prevention and early treatment
- a focus on the whole population
- provision of care at home or in local communities wherever possible
- driving integration, across the whole public sector, not just health
- achieving the best use of total resources available for local citizens
- sharing benefits and risks with commissioning partners and providers
- achieving the benefits of vertical integration
- removing perverse incentives for providers.

The above aims were targeted in the commissioning intentions with the beginning of greater use of outcomes required, an assumption of quality equal to best practice and the statement that all contracts would be progressively tested for value for money.

The specific intentions highlighted included:

- a requirement wherever possible that providers would create single operational management structures between them
- the creation of an out of hospital team
- investment in primary care
- seven day services should be the intention in all areas of activity but with specific focus on out of hospital care and discharge from secondary care
- an expectation that budgets would be pooled with partner commissioners (subsequently the BCF requirements were published in line with and supporting CCG intentions)
- some movement from Payment by Results tariffs in specified areas
- transformational and different pathways of care in some conditions and disease areas e.g. respiratory care, asthma, epilepsy, diabetes, falls management, palliative care, discharge management, bed management
- implementation of the Children and Families Bill in September 2014.

Our vision and commissioning intentions have been designed and developed to ensure that the resultant outcomes are high quality and sustainable and complement NHS England's characteristics of future health and care systems. Future commissioning intentions will be based on the above principles with the intention of achieving an integrated care system and joint commissioning with partner commissioners.

Establishing the Integrated Care System (ICS) during 2014/15 and 2015/16

NHSGYWCCG is delighted to have been awarded Early Adopter status for seven day services, which is an essential component of our integrated vision, which was commended by the national team of NHS Improving Quality (NHS IQ) for its clarity. Coupled with our work with seven day services, we will work to identify which pathways may be amenable to a move away from tariff, and towards costed packages of care for certain high risk members of our population or people living within some of the more deprived wards in our area. We have been offered help by NHS IQ with this financial modelling.

This work will help us identify the initial coverage of our ICS – during the first year of 2014/15 probably around a selected number of pathways where we will combine budgets between the commissioners, streamline management and co-locate teams. We will evaluate the success and impact of this work during 2014/15 and expand on the number of combined pathways and budgets during 2015/16. We will also look to rationalise the use of estate between the partners. The development of the ICS is likely to require both staff and public consultation with regards to some elements.

Our vision for an ICS will bring about some significant changes to the way in which our system is currently configured. These changes will enable integration to proceed at pace, increasing the quality of what we commission and provide for our residents and patients. It will also ensure the sustainability of our providers (including primary care) moving forwards and maximise efficiency. It will also enable us to address the requirement to contain emergency activity and free up resources for the transfer into the BCF in 2015/16 and beyond. The way in which we will bring about these changes is described later in this plan.

There is a clear agreement between the members of the GYWSLP that the formation of the ICS depends upon major cultural and system change. We need to build on the significant integration of systems and teams that has already taken place, and on the opportunities for pooling budgets and whole system redesign offered by the BCF. Whilst organisational and structural change will be an eventual outcome of the ICS further down the line (probably beyond the timescale of this plan) the focus of work in the next two years is as described in this section. Integration is our overarching principle and flows throughout the other content of this plan also.

We are working with our providers in acute and community health to foster a strategic alliance between James Paget University Hospitals NHS Foundation Trust (JPUH) and East Coast Community Healthcare (ECCH). We plan that JPUH will retain its provision of a full service District General Hospital, but drawing on the opportunities for a networked approach with Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH) wherever appropriate, in order to ensure highest standards of clinical safety, but also ensure sustainability of services. We remain very clear that the relative isolation of some of our residents means we need strong local services. We are also pleased that our mental health provider, Norfolk and Suffolk NHS Foundation Trust (NSFT), is moving towards a more localised model of care, with a semi-autonomous team in Great Yarmouth and Waveney (GYW), with its own budget. This will aid both integration and better access to mental health services.

At the same time, we are working with our primary care providers for them to develop strategic alliances. This may be in the form of a local GYW federation of primary care that promotes informal resource sharing arrangements between practices, including mobilising seven day working. We also are in early discussions with Gorleston practices, exploring options to develop an innovative scheme to locate primary care on the JPUH site, providing integrated front line care to patients attending as emergencies, diverting demand from traditional A&E services and reducing cost. This is also guided by the implications of the Keogh Report on urgent care, and how the co-location of urgent care services on the JPUH site may be beneficial to patient care. There will also be provision of services by ECCH within JPUH to move forward towards an integrated provision model.

We have a very productive relationship with our public health colleagues, with a strong emphasis on prevention. This will necessitate reviewing the emphasis of public health interventions, for example increasing exercise initiatives to help increase mobility and prevent falls.

Strategic clinical networks

We maintain our links with the strategic clinical networks, as well as continuing to develop both local networks within GYW and engaging actively in regional networks such as the Norfolk and Waveney Stroke Network, and as we move our ambitious improvement plans forward, we will bear in mind the help that the Clinical Senate could offer us in providing an external senior clinical opinion should this be beneficial.

Current State

Financial position

NHSGYWCCG financial planning underpins the organisation's strategic and operational plans. In a challenging financial environment the CCG is using available resource effectively to deliver financial sustainability creating efficiencies through collaborative working and integration.

In its first year of operation the CCG is forecasting achievement of its required 1% surplus. This has been within an ever changing environment, not just financially but also as a result of the financial risks transition and the changes to direct commissioning have created for the system and the CCG.

The 2013/14 Quality, Innovation, Productivity, Prevention (QIPP) target has been a challenge and the CCG has recognised this in its use of an element of reserves to mitigate the risk of non-achievement of savings to support the outturn position. The CCG has also recognised that this is a non-recurrent solution and robust plans are being put in place to achieve future QIPP targets.

The delivery of increased quality and productivity within the CCG's limited allocated resources is the key challenge for the organisation going forward. QIPP schemes will be embedded in order to maintain the future financial sustainability of the CCG and the Great Yarmouth and Waveney health system.

The CCG financial plans have been developed, taking account of Everyone Counts: Planning For Patients 2014/15 – 2018/19, the CCG's Commissioning Intentions for 2014/15, the CCG Plan on a Page and 5 year strategy along with discussions within the CCG and with other local stakeholders.

NHSGYWCCG's strategy for a financially sustainable ICS providing quality care to the Great Yarmouth and Waveney population through increasing the efficiency and effectiveness of services, a vision shared by our commissioning partners, is supported by our financial planning.

The financial plans developed have been designed to ensure that all resources are allocated appropriately to deliver the CCG's performance targets and QIPP plans and the impact of these have been discussed and agreed with our partners and providers.

The Opportunities - Integration and QIPP

Financial planning clearly indicates that whilst we predict a continual rise in expenditure each year there is insufficient growth in resources to match this. To enable us to balance our books, we must improve the productivity and cost efficiency of our health services and how we commission them to ensure we develop our opportunities to maximum advantage so we can achieve our savings target.

The level of savings required in the next five years represents a huge challenge for the CCG and its membership practices. Savings made to date have taken advantage of transactional efficiencies within the system, future savings will only be found through transformational change.

Transformational change includes doing things differently, in different settings, in different ways, contracting with different providers. These changes will be based in more primary prevention achieving care earlier, more effectively and encouraging patients to be more involved in their treatment.

We can also improve care through integration, removing unnecessary intervention by multiple agencies. By reducing transactional costs and unnecessary overheads we will also explore changing funding mechanisms to remove perverse incentives.

Later in the plan, we set out a number of headline initiatives. These support our integration vision, together with having impact in terms of helping to reduce capacity and ensure good health outcomes.

In order to achieve financial balance and a national required 1% surplus every year, we have already developed a QIPP plan. The plan is also supported by a high level summary of the key initiatives and QIPP schemes outlined in this plan, including expected savings and key performance indicators (KPIs). We have also produced a delivery and resources map, giving a helicopter view of our work over year one of this plan. A year two plan will be produced of 2014/15 progresses. Both of these documents appear at the end of the plan.

We are continuing to develop, build on and monitor these plans to ensure the required savings are made securing the foundations for a sustainable future.

The CCG will need to release significant savings each year in order to balance its income and expenditure. As a result the only source of investment is from our non-recurrent reserves and unless recurrent resource is freed up from divestment the only type of investment available is non-recurrent.

This means that the initiatives that will have the highest priority for investment are those which will lead to an overall saving on healthcare expenditure. In addition it may also be possible to make further investments from services which we decommission.

Health and Care System – Partnership Working

The QIPP savings targets are those that must be achieved by the CCG, however it is the local system as a whole who are responsible for ensuring that savings targets are met.

Working with other local organisations is the key to how these savings will be made and the CCG will continue to work with its local partners through the GYWSLP and other forums to review current activity and continue to develop work streams to ensure our QIPP opportunities are met.

The BCF is a vehicle for closer integration between health and social care and this will be a key tool for ensuring close working relationships and understanding of efficiencies that can be made across the whole system. By using the BCF to support health and social care services to work more closely together current services and value for money will be improved.

Financial risks are enumerated in the later section of this plan, Delivery Mechanisms.

Financial planning, including QIPP savings and investments, needs to ensure a healthy recurrent underlying financial position. In the current climate, making savings as part of an efficiency driven and collaborative approach and taking account of any transactional savings to help balance the annual financial position, is crucial. Prioritising non-recurrent funds strategically to pump prime invest to save projects that will have a return on investment in future years that is greater than cost is key.

Vital to service planning in the future will be not only what we provide and where, but what we no longer provide, either in a particular setting or at all. An integral part of the financial plans is to achieve the potential reduction in hospital activity. What we must drive, in collaboration with our partners, is a radical transformation of how services are provided which will enable public funds to be used more cost effectively, across all sectors.

The local health system will only remain financially sustainable through integration and collaborative commissioning, through working closely with providers and ensuring that future decisions are made for the benefit of the local system.

Our Population

The current population of GYWCCG is 233,342 (GP registered population), with about 60% in the 16-64 age group and 24% over 65 years of age. Over the next 20 years, it is likely to see numbers of older people increase significantly, with children and the working age population increasing less

significantly. However, there are some significant new housing developments planned across our two main towns of Lowestoft and Great Yarmouth, together with some of the villages. The population forecast is estimated as 248,028 in 2020. The population projections used for this 2 year plan are shown in Appendix 4.

The Joint Strategic Needs Assessment (JSNA) informs us that the health of people in Great Yarmouth is generally worse than the England average; deprivation is higher than average and about 4,400 children live in poverty (22% of children in Waveney live in poverty and Great Yarmouth has a higher rate of poverty than the Norfolk average (17.8%)).

Great Yarmouth and Waveney are the 54th and 115th deprived districts in England respectively with 28 Lower Super Output Areas (LSOAs) in the most deprived quintile in England.

GYWCCG has 5 practices in the most deprived quintile in England and 7 practices in the most deprived 10 in Norfolk and Waveney.

Life expectancy for both men and women in Great Yarmouth is lower than the England average. In Waveney, the life expectancy for women is higher than the England average.

The life expectancy gap between the most deprived and the least deprived areas is 9.5 years for men and 5.3 years for women in Great Yarmouth and it is 5.9 years for men and 5.3 years for women in Waveney.

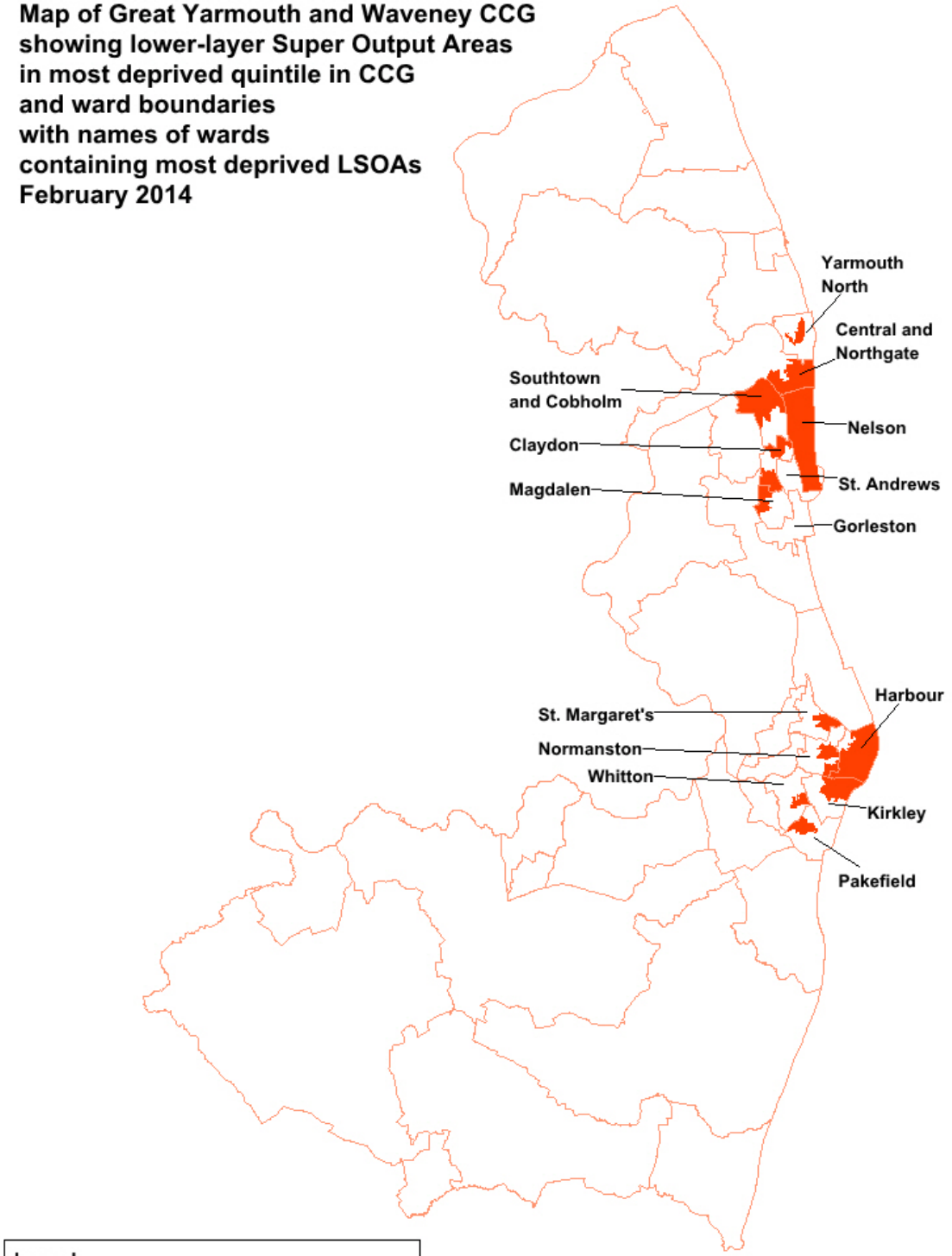
Over the last 10 years, all-cause mortality rates have fallen in both Great Yarmouth and Waveney. The early death rate from heart disease and stroke has fallen.

In Year 6, 22.1% of Great Yarmouth children are classified as obese, worse than the average for England. In Waveney, in Year 6, 18.3% of children are classified as obese. Levels of teenage pregnancy, GCSE attainment, breast feeding and smoking in pregnancy are worse than the England average in both Great Yarmouth and Waveney.

The estimated levels of adult obesity in Great Yarmouth and Waveney are worse than the England average.

The map overleaf shows the areas of deprivation in Great Yarmouth and Waveney. We will focus our interventions in these areas and work towards reducing health inequalities and improve equity towards access and services in these areas.

Map of Great Yarmouth and Waveney CCG showing lower-layer Super Output Areas in most deprived quintile in CCG and ward boundaries with names of wards containing most deprived LSOAs February 2014



Priorities for Prevention, Reducing Inequalities and Improving Health

Our priorities will include the reduction of smoking levels, especially in pregnancy, and reducing obesity, diabetes and alcohol related harm, improving perinatal mental health, and to ensure that every child has the best start in life.

Public Health have identified these priority areas and we will work closely with their programme leads to implement their health improvement and harm reduction initiatives.

Public Health tobacco control and smoking cessation services will further develop the GP Local Enhanced Services for smoking cessation and agree local targets. We will help run Alcohol Brief Intervention Courses aimed at GPs, practice nurses and primary healthcare staff and also train them to ensure Making Every Contact Count.

NHS Health Checks is a Public Health mandatory service and we will work towards greater uptake of these checks in hard to reach populations and help them access a range of lifestyle change services.

We will also support the Health Trainer Service in delivering health improvement through behaviour change amongst the most deprived and vulnerable population groups with an overarching aim to reduce health inequalities.

The 5-19 years Healthy Child Programme (HCP) including School Nursing Service, the mandatory National Child Measurement Programme (NCMP) and the Healthy Child Programme 0-5 years are the main Public Health programmes that work towards ensuring that every child has the best start in life.

We will try to implement the National Audit Office recommendations to increase the prescribing of drugs to control blood pressure and increase the prescribing of drugs to reduce cholesterol. We will also work with Public Health to see if we can increase the capacity of smoking cessation services.

Inequality in outcomes should be reduced through reducing circulatory, cancer and respiratory deaths, by prevention strategies at all levels:

Primordial prevention – Improve wider determinants of health:

- improve the environment
- increase educational attainment
- deliver relevant training
- increase employment
- reduce children in poverty
- support for families suffering family breakdown due to bereavement of domestic abuse.

Primary prevention – Health improvement:

- reduce low birth weight births
- increase breastfeeding
- improve diet – reduce the consumption of salt, saturated fats and trans fats
- reduce smoking
- increase exercise and physical activity
- reduce harmful alcohol intake
- emotional well-being of looked after children.

Secondary prevention and Healthcare:

- identify those at risk of disease earlier – screening programmes, health checks and primary care registers
- manage those on disease registers as well as possible

- optimum management of diagnosed cases
- systematically address any inequality in prescribing
- address any inequities in access and provision of services

Tertiary prevention:

- optimise management of home care and rehabilitation
- partnership working between health (primary, secondary and tertiary care), social services and voluntary, commercial sector

Other Cardiovascular disease groups

We are mindful of the absolute requirement to deliver this challenging programme of change and improvement. As we consider implementation, focus becomes of significant importance. We have therefore prioritised our approach, informed by population data, clinical advice and input (via our clinical leads groups and clinical executive committee) and the expert opinions of our staff. We have borne in mind the clear conclusion of Little's Law in a project environment, a reduction in work in progress results in more output overall. We have therefore chosen for the next 12 to 18 months to focus on the projects mentioned in this plan. We recognise that this means that some diseases, for example some aspects of cardiovascular disease, may not get the level of focus that diabetes and respiratory services are receiving. While, for example, the diabetes service improvements will improve cardiovascular outcomes, this clear focus will allow us to deliver improvements and then move on to focus on other areas.

Outcome Ambitions

Ambition 1: Potential Years Life Lost (PYLL) from causes considered amenable to healthcare

The table below shows the actual number of people and standardised rate per 100,000 of population under age 75 who die from conditions which could respond to early treatments.

Year	Actual or Assumption	Count	Rate	% Reduction
2009/10	Actual	5476	2055	
2010/11	Actual	5624	2086	1.5%
2011/12	Actual	5508	2092	0.3%
2012/13	Actual	5982	2281	9.0%
2013/14	Assumption		2281	0.0%
2014/15	Assumption		2208	-3.2%
2015/16	Assumption		2137	-3.2%
2016/17	Assumption		2068	-3.2%
2017/18	Assumption		2001	-3.2%
2018/19	Assumption		1936	-3.2%

About: This indicator measures potentially how many years of life are lost from conditions that could respond to early treatment. This includes conditions such as Cancer, Epilepsy, Diabetes and Aids which if treated early enough could extend life.

Our ambition: GYWCCG is aiming to reduce the number of deaths each year by 3.2% to 1,936 by 2018/19. To do this we are doing a number of things to reduce premature mortality from the major causes of death: cardiovascular disease, respiratory disease, and cancer by preventive measures like smoking cessation and reducing prevalence of smoking, increasing physical activity and reducing obesity, early detection and prompt treatment of these conditions.

Ambition 2: Health-related quality of life for people with Long Term Conditions:

The table shows a weighted count of all responses from people with a long term condition (average EQ-5D score). The rate is a nationally standardised rate.

Year	Actual or Assumption	Count	Rate	% Reduction
2011/12	Actual	1571	71.1	
2012/13	Actual	1537	72.7	1.60%
2013/14	Assumption		72.7	0.00%
2014/15	Assumption		73.1	0.55%
2015/16	Assumption		73.5	0.55%
2016/17	Assumption		73.9	0.55%
2017/18	Assumption		74.3	0.55%
2018/19	Assumption		74.7	0.55%

About: This indicator measures responses to the national GP Patient Survey section Managing Your Health which asks if people have a long term condition and what that condition is. People are also asked if, in the last six months, they have had enough support from local services or organisations. There is also a question on how confident you are that you can manage your own health followed by statements around mobility, self-care, usual activities, pain/discomfort and anxiety/depression.

Our ambition: GYWCCG is aiming to make a 0.55% improvement year on year on the response from people with long term conditions. To do this we plan to improve patient education in self-management, and work towards integration of services for people with long term conditions.

Ambition 3: Avoidable emergency admissions

The rate shows a nationally standardised rate of avoidable emergency admissions per 100,000 of the population.

Year	Actual or Assumption	Rate	% Reduction
2009/10	Actual	1,818.4	
2010/11	Actual	1,906.8	4.86%
2011/12	Actual	1,963.0	2.94%
2012/13	Actual	1,869.5	-4.76%
2013/14	Assumption	1,869.5	0.00%
2014/15	Assumption	1,850.8	-1.00%
2015/16	Assumption	1,832.3	-1.00%
2016/17	Assumption	1,814.0	-1.00%
2017/18	Assumption	1,795.9	-1.00%
2018/19	Assumption	1,777.9	-1.00%

About: This indicator measures the number of emergency admissions that could be avoided for conditions such as asthma, diabetes and epilepsy amongst adults and children. If these conditions were managed appropriately then an emergency admission would not be necessary.

Our ambition: GYWCCG is aiming to make a 1% improvement year on year in the number of emergency admissions for these conditions. To do this we will put in place programmes for more systematic and proactive management of chronic disease, integration of services so that care in the community is optimised, and patient empowerment to help them manage their illnesses better.

Ambition 5: Patient experience of hospital care

The rate shows the average of negative responses to 15 questions on patient experience of hospital care by 100 patients.

Year	Actual or Assumption	Rate	% Reduction
2012/13	Actual	147.4	
2013/14	Assumption	147.4	0.0%
2014/15	Assumption	145.9	-1.0%
2015/16	Assumption	144.4	-1.0%
2016/17	Assumption	143.0	-1.0%
2017/18	Assumption	141.6	-1.0%
2018/19	Assumption	140.2	-1.0%

About: This indicator uses information from the national inpatient survey which looks at access and waiting; safe, high-quality co-ordinated care; better information, more choice; building closer relationships; clean, friendly and comfortable place to be. CCGs can monitor this indicator throughout the year by using the monthly friends and family results.

Our ambition: GYWCCG is aiming to make a 1% improvement year on year in the proportion of people having a positive experience of hospital care. To do this we are working with our providers in improving the care they provide and learn from the friends and family test results.

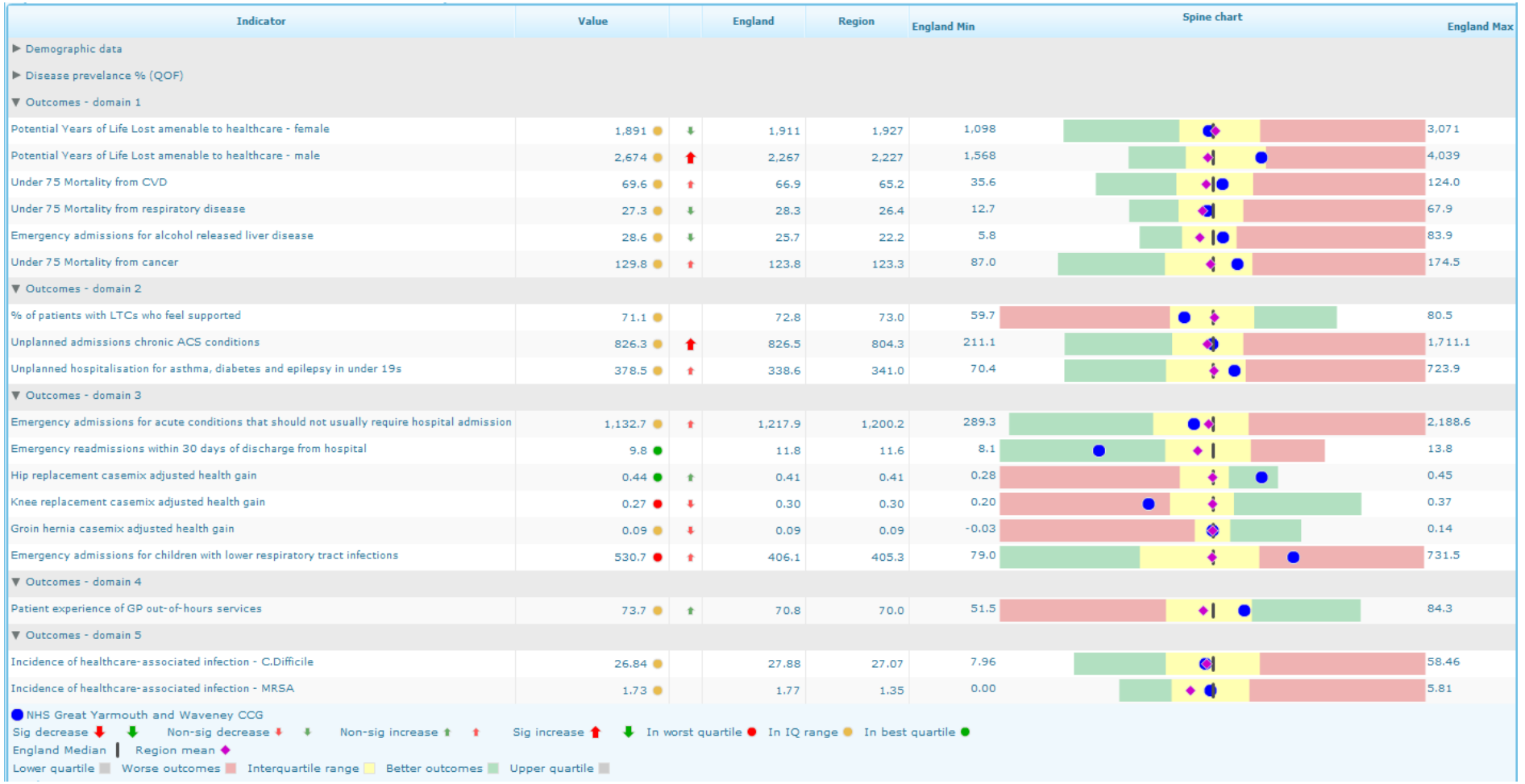
Ambition 6: Patient experience of primary care

The rate shows the average of negative responses to 15 questions on patient experience of primary care by 100 patients.

Year	Actual or Assumption	Rate	% Reduction
2012/13	Actual	4.5	
2013/14	Assumption	4.5	0.0%
2014/15	Assumption	4.5	0.0%
2015/16	Assumption	4.5	0.0%
2016/17	Assumption	4.5	0.0%
2017/18	Assumption	4.5	0.0%
2018/19	Assumption	4.5	0.0%

About: This indicator looks at responses to the national GP Patient Survey around satisfaction with GP services, GP out of hours services and dental services.

Our ambition: NHSGYWCCG already performs well on this indicator and is aiming to continue the current good work and good relationship with general practice to keep its current position nationally.



Indicator	Value		England	Region	England Min	Spine chart	England Max
▶ Demographic data							
▶ Disease prevelance % (QOF)							
▼ Outcomes - domain 1							
Potential Years of Life Lost amenable to healthcare - female	1,891	↓	1,911	1,927	1,098		3,071
Potential Years of Life Lost amenable to healthcare - male	2,674	↑	2,267	2,227	1,568		4,039
Under 75 Mortality from CVD	69.6	↑	66.9	65.2	35.6		124.0
Under 75 Mortality from respiratory disease	27.3	↓	28.3	26.4	12.7		67.9
Emergency admissions for alcohol released liver disease	28.6	↓	25.7	22.2	5.8		83.9
Under 75 Mortality from cancer	129.8	↑	123.8	123.3	87.0		174.5
▼ Outcomes - domain 2							
% of patients with LTCs who feel supported	71.1		72.8	73.0	59.7		80.5
Unplanned admissions chronic ACS conditions	826.3	↑	826.5	804.3	211.1		1,711.1
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	378.5	↑	338.6	341.0	70.4		723.9
▼ Outcomes - domain 3							
Emergency admissions for acute conditions that should not usually require hospital admission	1,132.7	↑	1,217.9	1,200.2	289.3		2,188.6
Emergency readmissions within 30 days of discharge from hospital	9.8		11.8	11.6	8.1		13.8
Hip replacement casemix adjusted health gain	0.44	↑	0.41	0.41	0.28		0.45
Knee replacement casemix adjusted health gain	0.27	↓	0.30	0.30	0.20		0.37
Groin hernia casemix adjusted health gain	0.09	↓	0.09	0.09	-0.03		0.14
Emergency admissions for children with lower respiratory tract infections	530.7	↑	406.1	405.3	79.0		731.5
▼ Outcomes - domain 4							
Patient experience of GP out-of-hours services	73.7	↑	70.8	70.0	51.5		84.3
▼ Outcomes - domain 5							
Incidence of healthcare-associated infection - C.Difficile	26.84		27.88	27.07	7.96		58.46
Incidence of healthcare-associated infection - MRSA	1.73		1.77	1.35	0.00		5.81

The spine chart shows the position of our CCG compared with the region and England for various indicators linked to the five NHS Outcomes Framework.

The areas for us to work on are:
Reduction in potential years of life lost, particularly for males
Reducing unplanned admissions for chronic Ambulatory Care Sensitive (ACS) conditions
Emergency admissions for children with lower respiratory tract infections

Contracting for 2014/15 and Performance Management

GYWCCG will continue to contract using the standard NHS contract in 2014/15 for all providers of healthcare services. Regular meetings are held with all major providers, reviewing aspects of performance in relation to clinical quality, national and local standards and financial positions. Where contracts are coming to an end, decisions on the future of these services will be taken through the CCG Governing Body, and procurement processes put in place as appropriate.

The contracting round is in progress and plans will be updated in the light of contractual agreements made.

Meeting the standards of the NHS Constitution is important to us, and we cover below how we will maintain and increase vigilance with regards to 18 week performance, which has been challenging during 2013/14.

A database of all Healthcare contracts has been established and all contracts have been reviewed for 'value for money'. A workplan for service reviews during 2014 is being developed as well as a map of where contracts sit within the ICS model. This will enable us to identify opportunities for joint contracting with our partners, minimising duplication and establishing where new models of care need to be contracted for. The BCF will be an excellent vehicle to facilitate this.

An Improving Access to Psychological Therapies (IAPT) procurement is underway with the other Norfolk CCGs, with an anticipated start date of April 2015. We are also considering a procurement of specialist palliative care beds which will take place during 2014/15, effective April 2015.

We will continue to be an active member of the East of England Ambulance consortium for Emergency Ambulances. A regular Great Yarmouth and Waveney locality meeting has recently been set up which enables clinicians from both the CCG and Ambulance Service to engage in service issues and redesign.

Our Operating Plan submission via Unify on 14 February showed our targets for improvement in 2014/15 against each of our performance indicators.

We show below the current progress against performance indicators and our plans for maintaining or improving performance in 2014/15.

Performance in 2013/14 was as shown below.

Domain 3: Helping people to recover from episodes of ill health or following injury

CB_A10 emergency readmissions within 30 days of discharge from hospital will be reported nationally using the HES dataset. In order in monitor in year performance the CCG has built an in-house model. The output from the model shows that re-admissions are an increasing problem for the CCG with four out of the seven calculated months having a higher re-admission rate than 2012/13.

To understand this issue further the CCG information team has analysed the data in more detail. Some of the highlights from this are that for 2013/14 78% of emergency re-admissions have JPUH as both the hospital of the original admission and re-admission. Of this 78% approximately 30% present at the hospital with the same primary diagnosis as their original admission. Converting this to admission volumes the estimated full year impact is that there will be circa 650 re-admissions at JPUH with the same primary diagnosis. Short stay admissions appear to generate more emergency re-admissions with 80% of the 650 re-admissions having an original length of stay of between 0-2 days.

The CCG is working closely with JPUH to understand and reduce readmissions.

Domain 4: Ensuring that people have a positive experience of care

Friends and Family Test. For November, the JPUH inpatient Friends and Family Test score equalled the year high score of 78 with A&E scores also continuing to score highly. Combining these scores gives an overall performance of 73 which matches the year high score seen in May 2013. Although independently both the inpatient and A&E scores are higher than the individual scores for May both months can achieve the same combined score due to the mix of patients across both activity types. Friends and Family Test has been extended within JPUH recently to include children's ward and maternity services.

Domain 5: Treating and caring for people in a safe environment and protecting them from harm

The CCG has seen continued over-performance for indicator CB_A16 the number of clostridium difficile (C-diff) infections throughout 2013/14 although December cases were below the monthly plan. As at the 16 January 2014 excluding appeal cases the CCG has reached its ceiling of 50 C-diff cases.

Referral to Treatment (RTT) Targets

Admitted RTT Performance: November 2013

The CCG has been working with JPUH to improve performance and has formally raised its concerns about disappointing progress by means of a contract query issued in February 2014. We have required refreshed detailed plans setting out a trajectory for achievement.

Incomplete Pathway RTT Performance: November 2013

During 2013/14 JPUH failed to meet the waiting times for treating patients within 18 weeks from referral at a Trust level as well as individual specialty levels. The Trust developed a trajectory to recover the situation, however, this was not achieved in year. A new plan has been developed to achieve the targets in the early part of the financial year 2014/15. To ensure this plan is delivered and the Trust continues to meet the required standards, there will be fortnightly meetings between the CCG Director of Contracting and the JPUH Director of Operations. At these meetings, the milestones of the action plan will be monitored, together with a detailed review of the numbers of patients waiting by length of wait. This is to ensure patients are being booked in order, and to act as an early warning for potential increases in activity. Formal monitoring will also take place as part of the monthly Contract Performance Meeting and any non-achievement of targets will be subject to the conditions within the NHS Standard Contract.

National publically available November RTT performance data were published on the 16 January 2014. Upon downloading the November dataset the CCG noticed an error with the data which causes the published CCG performance against the CB_B03 incomplete pathway target to be incorrect. The incomplete pathway data incorrectly allocates 2,211 pathways to the CCG. This error has been raised with NHS England with the CCG now waiting for confirmation on how this will be corrected. These pathways have a significant impact on the CCGs performance moving November performance from 94.7% to 96.3% which moves the CCG from the 78th ranked CCG in England (out of 210) to the 20th ranked CCG in England. For reference at the start of the financial year before the back log clearance started the CCG were ranked 193rd. The November data show the positive impact the back log clearance at JPUH has made with only ENT missing the target at specialty level for the CCG patients.

A&E 4 Hour Waits

CB_B05 requires the number of patients spending four hours or less in A&E to be at least 95% of the total number of patients attending A&E. When comparing performance across the East Anglia Area Team (LAT), performance at JPUH continues to be one of the strongest performers in the region with performance of 97.1% in February 2014.

Cancer Waiting Time Targets

Year to date all cancer targets are achieving their performance targets. However, the recent performance trend for cancer 31 day subsequent surgery treatment (CB_B09) does cause the CCG a risk. Performance from April to January 2014 was 94.4% against the target of 94.0%. Target misses in September, November and December 2013 were caused by breaches at NNUH with capacity cited as the reason for the breaches.

Most of the breaches occurred within the skin pathway, the vast majority due to the exceptional rise in demand for sentinel lymph node biopsies. The NNUH service was initially set up to deliver 50 cases across all CCGs compared with a forecast outturn of 178 cases for 2013/14. All patients that are beyond the 31 day threshold have been offered 'To Come In' dates and prioritised in line with clinical need and the Cancer Waiting Times Policy.

If performance in this metric continues to be an issue at NNUH then there is a risk that CCG performance will dip below the 94% threshold. NNUH have reported that December performance was back on track but validated performance information will not be available to the CCG until 6 February 2014.

Ambulance Response and Handover/Clearance Performance

February data show the calls resulting in an emergency response arriving within 8 minutes for Red 1 category calls achieved the 75% target but the Red 2 category calls narrowly missed the target with 74.5% performance. However, year to date performance remains strong with performance for Red 1 = 84.0% (Target = 75%) and Red 2 = 76.0% (Target = 75%).

A19 performance for February just achieved the 95% response time target with performance of 95.1%. This means the target has been achieved in 6 of the last 7 months but lower performance levels between April and July 2013 means that Year to Date (YTD) performance is 94.7%. The CCG are expecting this target to be a challenge over the next few months while the ambulance service continue to alter their response approach to provide more two man vehicles that are able to transport a patient onwards instead of a rapid response one man vehicle.

YTD activity variance to contract continues to remain at circa 2% over plan and 0.3% above 2013/14 levels. In the GYW area throughout February 2014 the ambulance service continued to see pressure of higher than expected levels of dispatches via 111 services. For February 19.1% of total ambulance dispatches came via a 111 service compared to 18.1% for February 2013. Integrated Care 24 (IC24) the GYW 111 service provider has seen its percentage of 111 triages receiving an ambulance dispatch increase to 10.5% for February from 7.7% in November 2013, 9.2% in December 2013, and 9.7% in January 2014. To help address this issue IC24 have altered their dispatch process and all Green 2 calls will now be assessed by a clinical supervisor before dispatch.

The CCG is a co- commissioner of the East of England Ambulance Service NHS Trust (EEAST) along with 18 other CCGs. EEAST has had performance challenges over a number of months particularly in responding to the most urgent 'red' cases and as a result they have had significant changes of staff at board level. The CCG consortium has called for EEAST to transform its services and asked for plans to meet standards at Trust and CCG level within the next year. This is likely to require significant investment on a non-recurrent basis to modernise fleet and equipment as well as developing and delivering a programme to train around 400 paramedics over the next two years. The CCG will continue to work closely with the lead commissioners as well as continuing to work with EEAST at a local CCG level.

Improving Access to Psychological Therapies (IAPT)

IAPT performance information is now available up to December 2013. Compared to previous monthly volumes this shows there was a dip in access rates in December 2013 due to the Christmas holiday

period. This dip is also visible in prior years' actual activity and was built in to the original profiling for the 2013/14 plan. However, the recovery trajectory in place assumed an equal number of attendances over each of the remaining months which means access has now slipped further behind the 13% target. If activity volumes remain consistent with the rest of the year then forecast outturn for 2013/14 is 12.1%. Although this is below the 13.0% target it is an increase compared to the 2012/13 outturn value of 8.8%. The CCG has noticed some small movements between the contractual monthly reporting files in the numbers or referrals and access numbers reported by NSFT. The CCG has asked NSFT to explain these movements and although not a significant number depending on the reason for the movement the access numbers and referrals may increase. In addition to the drop in access rates in December there was a significant increase in recovery rate performance. December recovery rate was 65% and it was the first time during 2013/14 that the rate was above the 50% target. The increase in recovery rate and drop in access rates highlights how the two indicators are linked and makes it difficult for a provider to achieve both targets at the same time.

Key Performance Indicators (KPIs) for Long Term Conditions (LTCs)

Long term conditions are monitored through the appropriate project and programme boards.

KPIs utilised will fall under the following broad headings:

- monitoring of appropriateness of prescribing and overall costs
- improvements in Quality Outcomes Framework performance indicators
- monitoring of activity in both primary and secondary care, with an anticipated reduction in secondary care activity
- improvements in patient satisfaction.

Cardiac:

- primary care Heart Failure Care Bundle has been implemented within all practices as part of QOF Quality Premium
- medicines management through the Eclipse system is being regularly monitored by all practices and regular review and monitoring by the NHSGYWCCG prescribing lead

Respiratory:

- primary care chronic obstructive pulmonary disease (COPD) care bundle has been implemented within all practices as part of QOF QP
- COPD training for primary care utilising specialist expertise to standardise and improve care across GYW, ie spirometry, nebuliser technique
- primary care patient information leaflet developed for COPD patients to promote self-management
- secondary, primary and community care integrated clinical speciality group established for all respiratory care.

Specialised services concentrated in centres of excellence

The CCG will work closely with providers and local specialist commissioners to review local volume to ensure local patient pathways meet the specified clinical standards.

Annex	Measure	2014/15 Target	Baseline Data
A	E.A.1: Potential years of life lost (PYLL) from causes considered amenable to healthcare	CCG Com Template	2012/13 FY = 2281
	E.A.2: Health-related quality of life for people with long-term conditions: Average EQ-5D score.	CCG Com Template	2012/13 FY = 72.7
	E.A.3: IAPT Roll-Out: Access to psychological therapies.	15%	2013/14 FOT = 11.3%
	E.A.4: Composite measure on emergency admissions. Avoidable admissions per 100,000 population.	CCG Com Template	2012/13 FY = 1869.5
	E.A.5: Patient experience of hospital care: average number of negative responses to 15 questions by 100 patients from national inpatient survey.	CCG Com Template	2012/13 FY = 147.4
	E.A.6: Friends and Family Test	Improving the proportion of positive recommendations to friends and family test score. TBC how positive and negative responses will be combined to form an indicator.	2013/14 month 9 A&E = 60 2013/14 month 9 Inpatient = 75
	E.A.7.i-ii Composite indicator comprised of i) GP Services ii) GP Out of Hours: average number of negative responses per 100 patients from GP patient survey	CCG Com Template	2012/13 FY = 4.5
	E.A.8: Hospital deaths attributable to problems in care	tbc in autumn 2015	
	E.A.9: Improving the reporting of medication-related safety incidents	Same as E.A.6	Same as E.A.6
	E.A.S.1: Estimated diagnosis rate for people with dementia	67%	
	E.A.S.2: IAPT Recovery Rate	50%	2013/14 month 9 = 45.2%
	E.A.S.3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services		
	E.A.S.4: Healthcare acquired infection (HCAI) measure (MRSA)	0	2013/14 month 9 = 2
	E.A.S.5: Healthcare acquired infection (HCAI) measure (C-diff infections)	tbc: ceiling not yet provided	2013/14 month 9 = 47
B	E.B.1-3: Referral to Treatment pathways	E.B.1 = 90%. E.B.2 = 95%. E.B.3 = 92%	2013/14 month 8: E.B.1= 85.0%, E.B.2 = 98.7% and E.B.3 = 93.8%.
	E.B.4: Diagnostic test waiting times	<1%	2013/14 month 8 = 0.37%

Annex	Measure	2014/15 Target	Baseline Data
B	E.B.5: A&E waiting time - total time in the A&E department	95%	2013/14 month 10 = 94.4%
	E.B.6-7: Cancer 2 week waits	93%	2013/14 month 8 = 97.4% and 97.7%
	E.B.8-11: Cancer day 31 waits	E.B.8 = 96%. E.B.9 and E.B.11 = 94%. E.B.10 = 98%	2013/14 month 8: E.B.8 = 98.1%. E.B.9 = 95.0%. E.B.10 = 100.0%. E.B.11 = 98.6%.
	E.B.12-14: Cancer 62 day waits	E.B.12 = 85%. E.B.13 = 90%. E.B.14 = no standard in place	2013/14 month 8: E.B.12 = 88.4%. E.B.13 = 98.3%.
	E.B.15.i: Ambulance clinical quality – Category A (Red 1) 8 minute response time	75.0%	2013/14 month 9 = 83.8%
	E.B.15.ii: Ambulance clinical quality – Category A (Red 2) 8 minute response time	75.0%	2013/14 month 9 = 76.0%
	E.B.16: Ambulance clinical quality - Category A 19 minute transportation time: % of calls resulting in an ambulance vehicle arriving at the scene of the incident within 19mins	95.0%	2013/14 month 9 = 94.5%
	E.B.S.1: Mixed Sex Accommodation (MSA) Breaches	0	2013/14 month 10 = 2
	E.B.S.2: Cancelled Operations: all patients who have operations cancelled, on or after the day of admissions for non-clinical reasons to be offered another binding date within 28 days	Reduction in cancellations	
	E.B.S.3: Mental Health Measure – Care Programme Approach (CPA). Proportion of those patients on CPA discharged from inpatient care who are followed up with 7 days.	95.0%	2013/14 month 9 = 100%
	E.B.S.4: Number of 52 week Referral to Treatment Pathways. No patient should have to wait longer than 52 weeks.	0	2013/14 month 8 = 0
	E.B.S.5: Trolley waits in A&E: instances of 12 hour trolley waits.	0	
	E.B.S.6: Urgent operations cancelled for a second time	0	
	E.B.S.7: Ambulance handover time: 30mins and 60mins	Reduction in delays	

Annex	Measure	2014/15 Target	Baseline Data
C	E.C.1-3: Elective finished first consultant episodes (FFCEs)	Unify2 submitted activity plans	
	E.C.4: Non-elective FFCEs (First Finished Consultant Episode)		
	E.C.5: All first outpatient attendances		
	E.C.6: All Subsequent Outpatient Attendances (consultant led)		
	E.C.7-8: A&E Attendances		
	E.C.9: GP Written Referrals		
	E.C.10: Other Referrals for first Outpatient Appointment		
	E.C.11 : Total Referrals		
	E.C.12: First Outpatient Attendances following GP Referrals		

Headline Initiatives

We have an ambitious and transformational set of plans and initiatives which will help us to achieve better integrated care commissioning and provision for our population, whilst ensuring the ongoing sustainability of the GYW system. The schedule below outlines a number of schemes, which have been/will be subject to normal governance processes around clinical review, financial robustness etc. The schemes include those which are still in course of full work up. All the expected costs and outputs from the schemes are being triangulated with our overall finance and activity projections.

Additionally, we will also ensure that 'business as usual' is maintained. This will ensure that work around areas such as prescribing efficiencies, which has reaped savings, continue. The headline initiatives, as outlined below, should not be seen as the totality of our commissioning activities.

Commissioning for Prevention

We have used the 5 steps in the framework for commissioning prevention to identify and plan initiatives to improve the health of our population and reduce inequalities.

1. Analyse the most important health problems at population level.

   Using the JSNA and the Commissioning for Value pack, we have identified that our population has significantly greater rates of years of life lost due to premature mortality for COPD, lower respiratory infections, gastrointestinal diseases and trauma/injuries.

   We have significantly high elective and non-elective admissions for people with cancer, circulatory and respiratory diseases. Currently the prevalence of diabetes is not significantly high, but with high levels of obesity in our population, the projections show a significantly high increase in diabetes prevalence over the coming years.

2. Working together with partners and the community, set common goals or priorities.

3. Identify high-impact prevention programmes focused on the top causes of premature mortality and chronic disability.

   We will prioritise integration of respiratory services to improve the health of patients with respiratory illnesses and reduce hospital admissions by improving care in the community, early diagnosis and interventions and work towards reduction in the smoking prevalence.

   We are developing a scheme whereby the amount of specialist support and training available to primary care around improved management for patients with diabetes is increased. We are drawing on the specialisms available within our acute provider and making them more readily accessible to primary care. We are also working with Public Health to reduce the prevalence of smoking and obesity in our population, particularly in areas of more deprivation.

4. We are addressing the growing demographic pressures around the needs of carers, and also for the increasing prevalence of dementia. We will continue to build an integrated support model, where every unpaid carer:

   - is recognised and supported as an expert care partner
   - enabled to enjoy a life outside caring
   - should not be financially disadvantaged
   - feels mentally and physically well; treated with dignity.

   Recognising that the number of people living with dementia is set to rise significantly in line with our ageing CCG population, we will strive as part of our intended integrated care system to deliver

diagnosed dementia care services through an integrated pathway, which encourages independence and supports wellbeing of patients and carers.

5. Plan the resource profile needed to deliver prevention goals.

   Our colleagues in Norfolk and Suffolk County Councils have a strong drive to increase prevention of ill health and dependency on social care services. We plan to develop BCF schemes for 2015-16 that build on the prevention agenda.

6. Measure impact and experiment rapidly.

   See operating plan outcome and process measures above.

   We will try to implement the National Audit Office (NAO) recommendations to increase the prescribing of drugs to control blood pressure and increase the prescribing of drugs to reduce cholesterol. We will also work with Public Health to see if we can increase the capacity of smoking cessation services.

   Additionally, we need to maintain and increase our focus on children's services. We have linked our ambitions of three of the outcome ambitions, as shown below.

Outcome ambition 1:
Reduce child deaths (mortality rates for children 0-14 years in England have moved from average to one of the worst in Europe).

Outcome ambition 2:
Children's and families Bill 2014-access to a local offer, personal budget and education and health plan.

Outcome ambition 3:
To reduce the number of children attending hospital with asthma (currently 75% of hospital admissions for children with asthma could have been prevented in primary care).

It is important that our headline schemes, provide appropriate coverage of the characteristics of transformational change and quality outcome indicators.

Research and Innovation

Health research is essential to continually improve health outcomes and the effectiveness of health services for patients. There is an expectation that the UK will be the first research-led health service in the world. Searching for and applying innovative approaches to deliver health care must be an integral part of the way the NHS does business. Doing this consistently and comprehensively will dramatically improve the quality of care and service for patients (Health Wealth and Innovation 2012).

The new Health and Social Care Act reflects these commitments and places a clear duty on the Secretary of State, the NHS England and CCGs to promote research and champion innovation.

a) Research

In line with the research commitments, NHSGYWCCG supports South Norfolk CCG as host of the Norfolk and Suffolk Primary and Community Care Research Office, on behalf of all CCGs across Norfolk and Waveney and has signed up to Memorandum of Understanding. Patient and clinical involvement in research across the CCG is growing and the CCG's statutory duty to promote research includes:

- increasing participation in research
- supporting research and using research evidence
- proactive engagement with local partners
- meeting treatment costs for patients taking part in research (including any Excess Treatment Costs[1]).

In line with the research duty NHSGYWCCG will:

- through a Department of Health funded (NIHR/Ashridge) research leadership course, support the Director of Clinical Transformation and the Norfolk and Suffolk Primary and Community Care Research Team in agreeing a plan to enhance the research culture of the CCG - addressing leadership, education, use of evidence and partnership and patient participation
- ensure provider contracts are fit for purpose in relation to the Research Governance Framework, Clinical Research Network (CRN) targets, and Quality Account arrangements
- review the CCG support given to the GP Research Champion and agree arrangements for the role to link into the governing body and relevant committees
- through its Executive Research Lead support the Norfolk and Suffolk Primary and Community Care Research Steering Group which oversees arrangement for Research Delivery through the Norfolk and Suffolk Primary and Community Care Research Office. This group has a mandate to agree strategic direction for research across Norfolk and Suffolk. The Research office supports the Research Design, Research Assurance, Study Delivery and Patient involvement in research across CCGs, academic organisations, primary and community Care providers and will deliver an agreed work plan \\inf-fs-1-v1\snccg\Departmental Documents\R&D\R&D Policies & Corporate Docs\Work plan\Workplan updated Feb13.docx
- through representation on the CRN-Eastern Partnership Board support the establishment and development of the CRN; represent the interests of patients, commissioners, and primary care providers; work with CRN partners to support the delivery of the National Institute of Health Research (NIHR) performance framework and agree models of funding for enhanced patient and clinical involvement in research
- fully implement the research cost policy with NHS England and Public Health England including agreeing processes for managing appropriate research treatment costs for provider organisations to ensure provider trusts identify research savings and reinvest these in new studies and where appropriate review full provider business cases for study specific research treatment funding from CCGs
- enhance research dissemination particularly through GP Education routes and through the CCG Research Champion. A new research dissemination process will be agreed with CCG leadership, Governing Body and Norfolk and Suffolk Primary and Community Care Research Office
- using Research Capability Funding the CCG will identify a commissioning priority for a commissioned call out. Academics will be commissioned to develop a research proposal for submission to Research for Patient Benefit programme. The systematic review generated to support this research submission will be fed into commissioning programmes.

We will also work together with all our local stakeholders to explore how we might start to build a wider collaboration on research and development for the benefit of the patients and clinicians of GYW. At present the research links between Primary, Secondary, Community, and Mental Health providers are distant and somewhat siloed. We will draw these groups together and jointly explore how we might further the research agenda to the benefit both of our patients access to research, but also to the benefit of our organisations.

[1] Where patient care is being provided which differs from the normal, standard, treatment for that condition (either an experimental treatment or a service in a different location from where it would normally be given) the difference between the total Treatment Costs and the costs of the "standard alternative" (if any) can be termed the *Excess Element of Treatment Costs* (or just "**Excess Treatment Cost**"), but is nonetheless part of the Treatment Cost, not a Service Support or R&D cost. *DH HSG(97)32*

b) Innovation

GYWCCG recognises the importance of the three stages of the innovation agenda – invention, adoption and diffusion and has a statutory duty to champion innovation and the adoption of innovation including:

- setting out the CCG approach to innovation
- ensure strong leadership and accountability for innovation within our organisation
- being an active partner in the local Academic Health Science Network

In line with the innovation duty the CCG will:

- work in collaboration with the Academic Health Science Network (AHSN) to support the delivery of innovation, adoption and spread of evidence for Diabetes, Dementia and Chronic Disease Management
- for 2014 to 2016, the CCG will work with the Research Office and AHSN to develop a post that will support increased involvement in the adoption and spread of evidence for the CCG/AHSN priority areas
- through CCG officer time contribute to the delivery by AHSN working Groups
- use collaborations such as AHSN to identify funding streams for early adoption projects
- review and strengthen CCG leadership and CCG innovation plans
- through the Norfolk and Waveney CCG Chief Officers meetings support the cross CCG representation by West Norfolk CCG on the AHSN Partnership

The 6 Characteristics of Transformational Change

1. A completely new approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.
2. Wide primary care, provided at scale.
3. A modern model of integrated care.
4. Access to the highest quality urgent and emergency care.
5. A step-change in the productivity of elective care.
6. Specialised services concentrated in centres of excellence.

The 7 outcome ambitions

1. Securing additional years of life for the people of England with treatable mental and physical health conditions.
2. Improving the health related quality of life of the 15 million plus people with one or more long-term condition, including mental health conditions.
3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community outside of hospital.
4. Increasing the proportion of older people living independently at home following discharge from hospital.
5. Increasing the number of people having a positive experience of hospital care.
6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

The 3 key measures

A. Improving health.
B. Reducing health inequalities.
C. Parity of Esteem.

In the table below, we cross reference our headline initiatives to show coverage of the indicators above.

Scheme number	Scheme description	Transformational change						Quality outcome indicator							Key measures		
		1	2	3	4	5	6	1	2	3	4	5	6	7	A	B	C
1.	Develop an integrated health and social care model of palliative care			✓	✓				✓	✓			✓				
2.	Cancer care			✓	✓			✓	✓	✓			✓				
3.	Parity of self-esteem for mental health														✓		✓
4.	Support for people with mental health problems	✓							✓								✓
5.	Reducing the 20 year gap in life expectancy for people with severe mental illness		✓						✓				✓			✓	
6.	Review the dual diagnosis service provided by Access Community Trust in Waveney and assess how this should be delivered across GYW in 2015/16		✓						✓								✓
7.	Developing good access to general practice and community services, especially mental health services		✓						✓						✓	✓	✓
8.	Improving Health Related Quality of life for LTCs		✓						✓								
9.	Long Term Conditions – Respiratory		✓						✓				✓				
10.	Gorleston (and further) Connected Care																
11.	Reducing time in hospital through out of hospital care		✓	✓	✓					✓	✓		✓				
12.	Children and Families Bill	✓							✓						✓		
13.	Childhood obesity		✓												✓		
14.	Perinatal Mental Health Service																
15.	Children's palliative care and bereavement services for children/young people who die unexpectedly																
16.	Falls Management			✓						✓	✓	✓	✓				
17.	Rapid Admission Avoidance Car (RAAC)			✓	✓								✓				
18.	Prescribing initiatives																
19.	Ophthalmology				✓				✓			✓					
20.	Eye Clinic Liaison Officer Service	✓		✓					✓								
21.	Dermatology Secondary Care Revision					✓			✓			✓					

Scheme number	Scheme description	Transformational change						Quality outcome indicator							Key measures		
		1	2	3	4	5	6	1	2	3	4	5	6	7	A	B	C
22.	Trauma and Orthopaedics					✓						✓		✓			
23.	Non-routine Treatments and Treatment Thresholds					✓						✓	✓	✓			
24.	Leg Ulcers		✓						✓				✓				
25.	Orthotics			✓									✓				
26.	Services for limbless persons												✓				
27.	Podiatry											✓	✓				

Clinical and Public Engagement/Experience

Clinical and membership engagement

Clinical engagement is critical and essential to achieving NHSGYWCCG's strategic goals and outcome objectives. Clinicians provide frontline services to our staff and patient and public engagement cannot proceed without agreement for developments being achieved with local clinicians first. We have a host of examples of clinical and membership engagement in action already across Great Yarmouth and Waveney.

NHSGYWCCG is a membership organisation, meaning that all practice staff are members of NHSGYWCCG. This has its own specific challenges both to communicate to, and engage with our membership. Our quarterly members meeting led by the Chief Executive and Chair of the CCG facilitates this relationship. NHSGYWCCG sees practices playing a full part in our activities as vital to our success, crucially providing the unique clinical view on which clinical commissioning is founded.

However, we also focus closely on frontline staff, from receptionists and medical secretaries to administrators and managers. They too have clear views and an ambassadorial role to play. So engagement work from formal consultations to service shifts always encompass clinical and operational engagement, most recently though our ongoing work in developing the Out of Hospital Team. NHSGYWCCG has a 'gate keeping' role to ensure the relevance of information flow to clinical audiences and that they do not become overwhelmed by the volume of briefs.

We recognise the need to establish systems to secure two–way accountability between members. We are aiming for excellence in our engagement with member practices, and are developing a strong system of peer support and co-production. This is an area where we are beginning to deliver significant cultural and behaviour change. We have embedded this concept in our 'principles of clinical transformation', which says as a value that we will 'systematically foster strong and mature relationships between clinicians from all sectors and organisations. We will develop a culture of responsibility both for and to each other for the quality of care we commission and deliver. We will hold one another to account for patient benefit through honest relationships.

While this will be challenging, we have a well-developed local model of openness and accountability for quality of care and use of NHS resource in our approach to prescribing and medicines management. Practice data has been shared across the area for some years and clinicians are used to seeing their data and their colleagues' data presented in a comparative style. We are seeking expand this approach beyond prescribing to other areas of quality and commissioning focus in 2014/15, underpinning it with an explicit outlier policy which makes it clear that our initial approach is supportive and formative, rather than punitive or contractual. Finally this cultural change is supported through the sharing of our Practice Charter. This is a set of 'rules for engagement' which lays out what practices can expect from the Board, and the Board from practices, and how practices interact as a unified body. This has been shared with all practices, along with a summary of our Constitution, and we have worked closely with our Local Medical Committee (LMC) on this document and our Constitution.

Clinical and membership engagement in action in NHSGYWCCG

The work of our Clinical Executive Committee

Our Clinical Executive Committee (CEC), led by the Chair of NHSGYWCCG, reports to the NHSGYWCCG Governing Body as a formal subcommittee. This committee ensures clinical input into all areas of our work, promoting clinical engagement and acting as a governance structure to make sure there is clinical input into new and existing services which reflect best practice and value for money. Its membership includes clinicians.

Seeking member practices views

Our GP practices in Great Yarmouth and Waveney are all Members of NHSGYWCCG, and critical to our success. We're focused on member practices being closely involved in decision making and we've published our Practice Charter. We have strong GP and practice manager representation on our CEC and on the CCG's Governing Body. Alongside this we have our regular GYW Clinical Leads Forum, where a representative from every practice attends, and our monthly PTL (Protected Time for Learning) sessions, plus our practice manager meetings and a range of regular informal practice visits.

We have ten retained GPs and two retained Nurses working with us in NHSGYWCCG. This is a tremendously valuable resource to help us with commissioning decision making, and being clear on our commissioning intentions going forward.

CCG members are involved in quality priority setting in NHSGYWCCG Plans

We met with all our Clinical Leads across GYW to identify and agree our commissioning priorities and intentions for 2014/15 and beyond. We recognise the need to engage with member practices to help them understand the quality challenge in both primary and secondary care to develop an appropriate response for our population and our area, and to translate that into real action and real quality improvement.

Member practices involved in decision making processes

Our clinical leads meetings are fully representative; each practice sends a GP to these meetings and in addition there is a lead practice manager from both of our main geographical areas at each meeting, Great Yarmouth and Waveney. These groups guide strategic development prioritisation, and practical implementation of pathway redesign, and meeting the QIPP challenge via system transformation. Retained GPs inform this process through the programme boards and specific work areas. Our CEC includes representation from GPs across the patch and is the delegated authority for decision making from Governing Body. Thus clinical leadership is not only accountable at Governing Body level, but involved at executive level in all spending decisions, monitoring delivery of the QIPP challenge and priority setting for each commissioning year. The CCG Governing Body includes member practice representation at clinical and managerial level leads strategic planning for the CCG, with extensive clinical involvement in decision making.

Some examples of member practices being involved in decision making include when our Clinical Leads met recently, led by our Director of Clinical Transformation, to agree NHSGYWCCG's commissioning priorities. We have approved new care pathways in Neurology, Urology and Cardiology, where clinicians were directly involved in planning and designing pathway change to deliver direct benefits to patients.

Member practices understand at a high level our local plan and priorities

Our clinical leads groups have been involved in shaping and approving our overall strategic plans at both a health system and Programme Board level. Specifically, the Urgent Care Strategy and Frail Elderly Strategy were both discussed in detail at the clinical leads groups, and amended in the light of clinical leads feedback prior to their presentation to the CEC. In addition, in the planned care arena, our overall approach to the QIPP challenge was developed through discussion with the clinical leads, informing our 'excellent GP, not specialist GP' ethos when addressing our high volume specialities of dermatology and ophthalmology.

Member practices receive timely information to inform their involvement in NHSGYWCCG planning and monitoring delivery of those plans

Practice level data are sent to all 25 of our member practices on a monthly basis. We also use PTL meetings and Clinical Leads forums to share more specific data.

Systems are in place to sustain two–way accountability between members

We recognise that this is an area for significant cultural and behaviour change. While this will be challenging, we have a well-developed local model of openness and accountability for quality of care and use of NHS resource in our approach to prescribing and medicines management. Unblinded practice data has been shared across the area for some years and clinicians are used to seeing their data and their colleagues' data presented in a comparative style. We will seek to expend this approach beyond prescribing to other areas of quality and commissioning focus, underpinning it with an explicit outlier policy which makes it clear that our initial approach is supportive and formative, rather than punitive or contractual. Finally this cultural change is supported through sharing our Practice Charter.

Effective and transformational Programme Boards

Our five Programme Boards plus related workstreams like Primary Care and Prescribing have extensive clinical engagement from a wide range of providers and are actively influencing commissioning intentions, with service user representation. These Boards are led by clinicians and they are developing locally sensitive clinical pathways which reflect clinical and cost effectiveness and will ensure the delivery of our local QIPP challenge.

Working with Healthwatch

NHSGYWCCG works very closely with our two local Healthwatch organisations, Healthwatch Norfolk and Healthwatch Suffolk.

Our Chief Executive has regular meetings with the Chief Executives of both Healthwatch organisations to keep them informed of the work of the CCG and give them the opportunity to make sure that they are involved.

Both organisations are represented on our Patient and Public Experience Group who have helped to develop the Big Listen event during the first week in March 2014. Healthwatch representatives also took part in the visits and will help to ensure that the feedback from the event is used to improve patient experience of healthcare.

Healthwatch representatives sit on a number of our Programme Boards and they also took part in both of our consultation development groups. They helped to shape the consultation documents for the Lowestoft Consultation and the consultation on the future of adult and dementia mental health services provided by NSFT.

NHSGYWCCG holds a patient, carer and community event twice a year where we engage the public in our strategy and commissioning intentions and both Healthwatch organisations are represented at these events.

Improving access for minority groups

There are a range of seldom heard or minority groups in our community. NHSGYWCCG will make sure all external communications are inclusive and take place through a range of channels that reach all groups, taking into consideration all barriers to communication, including language and access to computers. We are committed to engaging with patients, carers and the public in all stages of the commissioning cycle. This is essential and will make sure we always develop innovative, patient-

centred services. As commissioners, we will make sure that the views of patients and the public are listened to, heard and acted upon. We are particularly focused on accessing seldom heard and vulnerable groups, namely:

Key seldom heard groups in GYW:

- Migrant Workers
- Gypsy, Traveller and Roma communities
- Looked After Children
- Individuals within the criminal justice system
- Asylum seekers and refugees
- Black and Minority Ethnic (BME) Groups
- People with Learning Disabilities
- People with long-term mental health problems.
- Lesbian, Gay, Bisexual and Transgender people
- Homeless and insecurely housed people

In 2009, the former Primary Care Trust commissioned a full research project from the University of East Anglia on these groups, and the findings of this report continue to inform our engagement work with these communities today. The report sets out the blueprint for engagement with these groups and also gives a database of contacts within these categories. It was supported by the appointment of a dedicated Health Visitor for seldom heard groups in ECCH, who continues to be a key contact for NHSGYWCCG's work. Along with the other Norfolk CCGs we are working alongside the newly-formed Norfolk Equality and Diversity council who will act as one voice for all individuals and communities covered by the Equality Act 2010 and will hold us and other public sector organisations to account for our work in this area.

Along with the other Norfolk CCGs we are joint members of INTRAN which is a multi-agency partnership providing language services throughout the Eastern region.

Citizenship and Engagement

Patients are the focus of all we do in NHSGYWCCG. Across, the CCG there is active patient, carers, service user and public engagement. Commissioning Programme Boards include representation from patients, family carers, service users and the public. The views of these groups are regularly sought through Commissioning Programme Boards and wide range engagement events to inform the development of integration and future commissioning intentions. These include public consultations, working alongside our patient groups in our 25 GP practices, working with Healthwatch and our local Health Scrutiny Committees. NHSGYWCCG has listened to what they have said and included their views in strategic and operational planning including the CCG's overall approach to the BCF. We have developed plans across the two years of the operational plan.

Patients, carers and our local community have all been involved in helping to develop our five year vision for healthcare in GYW. During 2013 we held two public events with patients, carers and community members.

Some of the key themes from these workshops have been woven into our five year strategic plan:

- co-ordinated health care and social care
- support for the family/carer
- more education required for patients
- better communication between GPs and the hospital
- 24/7 access
- clinicians available at weekends to enable discharge
- do not want multiple assessments

- ‘walking sign posts’ like the Gorleston Connected Care initiative and our Community Advocates
- joint health and social care plans, owned by the patients which include goals, support and key workers
- integration will work and support Carers if services are seven days a week

We will need to develop habits of flexibility, compromise, transparency, honesty, engagement and listening to our customers and patients. In order to deliver better outcomes and greater efficiencies there needs to be more integrated approach to service provision. This includes all organisations working more closely across organisational and professional boundaries and changing staff behaviours to encourage system and whole team working. This is underpinned by a passionate belief that we are doing the right thing.

We have a programme in place to ensure that we engage with our patients and public about the design of our services going forward. This includes a programme of events such as a public participation forum which will be meeting next on 7 April 2014; our Patient and Public Experience Group meeting which will be meeting next on 14 May 2014 and our Patient, Carer and Community events.

Year 1: 2014/15

The Big Listen Event: The NHSGYWCCG ‘Big Listen’ event took place in the first week of March 2014, from Monday 3 March to Friday 7 March. During this event, 132 CCG staff, plus patients, carers and staff from other partner organisations, visited healthcare providers across GYW in primary, secondary, emergency and nursing home providers.

The purpose of The Big Listen was to:

- observe the everyday experience of patients and carers in our local health system
- learn what matters to them
- understand how we can work together with our partners and health and social care to improve their every day experience
- focus on ‘first impressions’ of our health services everyday.

We believe this event is one of the first of its kind in NHS England. The results will be independently assessed and a full action plan developed with our providers through our PPEG, which reports directly to the CCG’s Governing body.

To complement this, we will offer all staff in primary care the opportunity to visit NHSGYWCCG and learn about the work of a new Clinical Commissioning Group. This was a key learning point from practice visits by **all** CCG staff in 2012.

Community Advocates Working with Voluntary Norfolk: We will evaluate the Connected Care pilot of Community Advocates in Gorleston, and begin to implement a larger advocate and befriending team for patients with long term conditions across the borough of Great Yarmouth. Cost £45k.

We will work with Waveney District Council and Community Action Suffolk to develop a similar pilot project for Community Advocates in Kirkley, Lowestoft. Cost £50k.

Mental health insight work In 2013: NHSGYWCCG completed a substantial market research insight project with clients and service users of local mental health services, both statutory and third sector. This was the first time such a substantial piece of work has been led locally with this group of patiens by the Commisisoning organisation. We will use the learning from this to develop and implement a full action plan with primary, secondary and voluntary sector providers in response to the powerful voices heard through this research.

Public Consultation: To ensure we meet our duty as commissioners to participate effectively in the commissioning process to ensure service meets the needs of local people, we are committed to publicly consulting with our patients, public, carers and partners when we anticipate substantial service changes being required. This will promote transparency in all we do as commissioners. To this end we continue in 2014/15 with the implementation of service changes following our public consulation on the reconfiguration of services in Lowestoft. We have just launched our public consultation on the future on adult and dementia mental health services provided by NSFT in GYW. We are also planning more consultations in a number of areas including around the future provision of care through our community hospitals and the local walk-in centre in Great Yarmouth.

Launch of a website for young people and social media: We will launch a new section of our website for young people, designed by two CCG apprentices based on the responses received from the Great Yarmouth Youth Advisory Board who recently surveyed 360 young people. Results were that the young people wanted a one stop place where they could find out the information they needed. This will support our accessible website designed with the public in mind and receiving over 2,000 hits per calendar month. We will continue to actively develop our Facebook Page and use Twitter to get in touch with our wider population. Public meetings during February and March 2014 in support of our mental health services consultation will actively use Twitter.

Friends and Family Test: We will continue to actively monitor the feedback from this important measure of patient and visitor satisfaction, and work with providers who are new to this test to ensure we monitor their progress, through our PPEG.

Empower patients through co-production: Empowering patients means doing much more to give control to patients through the extension of choice and the provision of high quality information to support decisions, plus insightful listening methods. It also means doing more to make sure the views of patients and communities are built into everything we do, through the local Health and Wellbeing Boards and through Healthwatch to champion patients' interests at all levels of the system. Within NHSGYWCCG this means continuing to build on relationships that already exist with Health Overview Scrutiny Committees (HOSCs) and Healthwatch. We will use the Transforming Participation in Health and Social Care guidance to assess our progress so far, and evaluate our ambitious plans for the future.

Patient experience: What we expect from all our providers: Our PPEG, and our Patient Participation Group (PPG) Forum both report to our Governing Body and work together to evaluate how well our providers are monitoring the experience of patients. This work and our bi-annual community events will help to shape new models of care and inform our system-wide integration plans. We will also have expectations of providers about listening to and hearing patients in our contracts for the first time. This will deliver a patient experience of holistic care which is joined up for them in one single package.

So monitoring our patients' experience is critical and we will use the following methods to do so:

- use of real time feedback eg SMS texting, kiosks, Patient Experience Trackers, Facebook, Twitter, Website, PPG Forum Real Time Reporting, Friends and Family Test
- patient feedback websites
- patient and practice surveys and PPG Forum
- patient experience groups (Patient Advisory Group, PPEG and PPG Forum)
- complaints, Patient Advice and Liaison Service (PALS) and Serious Incidents (Sis)
- monitored through the Quality and Patient Safety Committees and Quality Incident Reporting (QIRs)
- regular planned and unannounced visits to care providers with a focus on quality and patient safety, including The Big Listen
- 'Deep Dives' by Board on specific quality issues
- regular reports eg Care Quality Commission, Monitor.

When we are monitoring information, we will always focus on four key questions:

1. Do we have the data we need to make intelligent commissioning decisions?
2. Do we understand what the data is telling us?
3. What are the implications of using this data in commissioning?
4. Do we have mechanisms in place to make sure we can change commissioning decisions in response to the intelligence?

Through our contracts with providers, we will put this patient-centred intelligence to good use and ensure this feedback is included in contracts, and regularly monitored with clear outcomes.

Year 2: 2015/16

The Big Listen: We plan to repeat this event, using the learning from Year 1 to spread the reach and robustness of this exercise. We will also assess providers' progress from year 1.

Insight work: Commission market research insight work with our seldom heard and vulnerable groups, and black and minority ethnic (BME) communities.

Year 3 to 5

We will continue to:

- value the patient voice, and develop a culture that listens, hears, and uses these insights to inform commissioning and service transformation
- harvest the experience and views of local clinicians – built on patient stories – about services, and systematise these to provide a rich resource to improve the design and delivery of patient care
- gather the views of our population about our priorities and plans using a wider range of engagement exercises and methodologies than just consultation, seeking greater involvement throughout the process
- nurture our relationship with member practices
- be dedicated to making sure we effectively engage, consult and feedback, communicating clearly about how we are investing tax payers' money, as the pressure on money to buy services in NHS finances becomes tighter and commissioning decisions more difficult.

Seven Day Services

Within NHSGYWCCG we fully support the ambition that “every community in England should be able to access urgent and emergency care services and their supporting diagnostic services delivered in a way that meets clinical standards seven days a week” as articulated by Sir Bruce Keogh following the recent NHS seven day service review. The Forum he chaired also believed that patients’ experiences of care are particularly affected at weekends by a lack of integration across all health settings and with social care services and our aim is to address this by enhancing access to health and social care services over the weekend.

As a system we already have many examples of where seven day services have been embraced and where improvements have already been made for our patients but we also acknowledge that we do not provide seven day services across the board and we have gaps. As a system we are committed to identifying key focus areas where we can get best quality outcomes by addressing these gaps.

Early Adopter Bid

We recognise that we have more to do to fully work through the implications of our proposed integration and seven day working models. With this in mind in October 2013 JPUH and NHSGYWCCG submitted a bid with and on behalf of our health and social care partners across the Great Yarmouth and Waveney system to become an ”early adopter” for Seven Day Service Transformation Improvement Programme (SDSTIP). Our bid, outlined in Appendix 2, was successful and we received the following positive comments from the panel as part of the selection process, “strong patient involvement, very clear vision, strategy and engagement, single organisations, single system approach and valuable new learning”.

A key theme throughout our bid was that of integrated working, using the system based approach to promote integrated management, where professionals work together seven days a week across organisational boundaries and have immediate access to other parts of the integrated care system to provide a seamless service to users, clients and patients.

Shared Pledges

Our four shared pledges below within the seven day services bid also reinforce our commitment to an integrated care system.

- **ONE team** working for the benefit of the patient irrespective of organisational boundaries.
- **ONE** integrated care system, working together as one.
- **ONE shared vision** receiving the same high quality, safe care seven days a week.
- **ONE commitment** and determination to make sustainable whole system change a reality.

Implementation and commitment to these pledges will allow our patients, clients and service users to receive seamless interaction with different health and social care professionals any day of the week.

As a system we have radical ambitions to move away from traditional commissioning and provider models, changing funding flows with new ways of working seven days a week and if we truly work to the pledges above we believe we have the ability to move at scale and pace.

We also have many examples of where seven day services have been embraced and where significant improvements have already been made for our patients and we must build on these and share any valuable learning.

We recognise we have more work to do to fully work through the implications of our proposed integration and seven day working models and have recently set up whole system Steering Committee to lead this whole system approach to seven day services. Members will be accountable to their respective organisations and the GYW System ICS board to deliver rapid progress towards seven day

working. They will ensure a truly coordinated approach with full involvement and collaboration from all partner organisations.

The long-term project will see all organisations which provide health and social care in Great Yarmouth and Waveney work closely together to provide more joined up, integrated services, which offer equal levels of care every day of the week. Our initial focus will be on the areas that support reduction in urgent and emergency care admissions. These are admissions avoidance, unplanned care with a focus on diagnostic services and discharge. Our "Out of Hospital Strategy" will see social care and healthcare staff working together across seven days providing a 24/7 service that supports unnecessary admissions at weekends and also facilitates timely discharge by having the right care staff available to do assessments and care at all times not just Monday to Friday.

We have been working with all our partners over the last few months to agree our focus areas around seven day services and how best to move forward, including agreeing the outcomes we wish to achieve.

The JPUH are committed to extending seven day services where they will make the most difference in terms of quality and results to the patent in terms of early diagnosis. They have already identified a number of areas within diagnostic services were they will be expanding opening hours over 7 days. They will be submitting a seven day service action plan as part of their contract with the CCG. They are well aware of their size as a relatively small District General Hospital and have developed strategic alliances with other acute trusts such as the NNUH to ensure they have the capacity in the system to operate some services over seven days ie pathology.

The recent RCP London reports "Hospitals on the edge" and the report of the Future Hospital commission highlight the challenges for how our local services can and should be configured. We will work with our local providers on how patients can be provided with high quality care seven days per week. There are clear links in this thinking to the work that we will be doing together as part of our seven day services pilot site project. We will work from clinical evidence to explore which services are essential for seven day working; how staffing models can be flexed to deliver this, and where wider networking will be necessary to achieve this. We have already engaged in detail on these questions in some clinical areas, with well-developed functioning provider networks delivering seven day generalist and specialist services through collaborative working between for example the JPUH and NNUH in ENT, Cardiology, Vascular Surgery and wider collaborations delivering Telemedicine interventions for our patients in Stroke. This work is encouraging, and we continue to work with our providers to help them establish and develop collaborative and networked approaches which will deliver high quality cost effective solutions to the challenges we face.

A whole system event was held on the 26 January 2014 to give an update to the NHS IQ team on our progress towards seven day services and our approach going forward.

Health and social care partners already work closely, and this opportunity will develop those already strong relationships still further to provide patients with one team, working across boundaries to deliver high quality, safe care seven days a week.

The local acute contract will include the requirement for the JPUH to have an action plan to deliver the 10 clinical standards as part of the seven day service requirements within the service and improvement plan section and is on track to be agreed by the 28 February 2014. The Director of Quality and Safety in GYWCCG is also working with the JPUH to use Commissioning for Quality and Innovation (CQUIN) to capture improvements around the achievement of the clinical standards.

Our Out of Hospital strategy is a key seven day service initiative. This facilitates a move away from traditional bed-based models within acute and community care, to a model that supports people remaining safely at home, wherever possible.

The first Out of Hospital team, to support one of our two main centres of urban population, is effective from April 2014. This is an integrated team of health and social care workers, using shared facilities, increasingly sharing data and with streamlined management. An early example of this is the fact that health and social work teams in Great Yarmouth (Norfolk) will be managed by a leader from Suffolk County Council. We are looking to commission care home capacity in the area, to accommodate those patients who need a period of more intensive input than services at home will be able to provide. We have procured the first set of care home beds to be put to this use and the remit to tender is the requirement that the care homes must be able to admit between 8am and 8pm seven days a week. The Out of Hospital teams will be expanded over the course of the next two years to cover the whole of our area, once we have tested and refined the model.

The Out of Hospital Team (OHT) will be an inter disciplinary team of health and social care professionals for whom the objective of their service will be to provide care at home whenever it is safe, sensible and affordable to do so. The care the team is expected to provide will be organised around the patient, focusing on individual need and empowering independence. It is expected the team will, in the main, provide intensive, short term care, reducing as the patient regains health and independence. Care will be holistic, co-ordinated, responsive and goal focused, using a case management approach.

The OHT will be made up of key health and social care professionals supported by workers able to perform many types of basic nursing, therapeutic and personal care tasks. The shared values and aims underpinning care delivered by the entire OHT will include:

- patient centred care; staff will involve patients and their family and, or carers in the care planning approach
- staff will be sensitive to the needs of family and carers
- care will be provided in patients' usual places if residence only if it is safe and sensible to do so
- the OHT will be easily accessible to patients and their families and, or carers
- the OHT will focus on proactive delivery of care and if a patient is in crises will react rapidly to keep that patient safe in their usual place of residence.

All admissions to beds with care will be through the OHT following assessment by them. Where a patient is admitted to a bed with care the OHT will monitor progress of that patient and agree an expected date of discharge with the Care Home. It is expected that the OHT will provide in-reach therapy support to the Care Home. A bed with care will be able to provide personal care, nursing care, therapeutic intervention and offer medical input, where patients can be cared for in the short term until they can safely return home with support from the out of hospital team.

The OHT will operate 24 hours a day, seven days a week. For all urgent referrals initial assessment by the OHT will be undertaken within two hours of receipt of the referral. Initial assessment for all other referrals will take place on the same day. The response time will be determined by the triage process. Through Multi-Disciplinary Team Meetings and regular patient review, the care package will be kept relevant to the patients' needs and personal aims. Following assessment and on the same day as the assessment, the OHT will organise appropriate care provision for the patient in their place of usual residence or, if necessary, in a bed with care.

The OHT will ensure that, with immediate effect, provision is put in place to keep the patient safe at home until the full care package can be implemented. The full care package will always be implemented within 12 hours of the initial assessment being made.

Quality

How we will respond to the Francis, Berwick and Winterbourne View reports

The learning from the Francis report is at the heart of our commissioning responsibilities; Duty of Candour has been embraced by JPUH who have demonstrated a commitment to transparency to patients where they make mistakes or cause harm to patients. We will work with all of our providers to ensure that this is truly embedded in all practice and that it is replicated within the health economy of GYW.

Open and effective Contract Quality Review Meetings (CQRM) will continue to take place and we will develop the contracts with providers to include comprehensive and relevant opportunities to provide assurance. We will expand on our clinical visit programme to get further assurance about the quality of care being delivered.

Sufficient numbers of staff that have the right skills, attitudes, commitment and motivation is crucial to the delivery of a high quality health service within GYW. All providers will be required to undertake staffing reviews at a minimum frequency of six monthly using relevant and robust patient dependency and acuity tools (where they exist), and where applicable caseload reviews for the clinical workforce such as community nurses and mental health teams. For in-patient services we will require that nurse/midwifery staffing levels (actual and established) are published within each ward on a day by day basis. There will be a requirement for providers to undertake annual training needs analysis reviews, leadership development and ensure succession planning is considered for key and hard to recruit to posts.

We will continue to work with Norfolk and Suffolk County Councils within the Winterbourne View (WV) Steering Group. We are ensuring continued robust monitoring of people with learning disabilities placed in private hospitals out of area or specialist commissioning group commissioned beds regardless of whether they are joint or health funded placements. Within the WV Steering Group each patient is discussed and their management plans are reviewed to ensure progress is being made. Any inappropriately placed patients will be moved by the end of June 2014 and there are robust plans in place to do so.

We continue to submit nationally required progress reports about all of our applicable patients.

Opportunities for us to learn from serious incidents, complaints and never events are of utmost value to us. It is important that we view each of these as opportunities to identify opportunities for improvement but importantly recognise that in many cases, they represent an instance when the health system within GYW has resulted in harm or dissatisfaction with the services that we commission. Serious incidents that are reported by our providers are monitored and reviewed by the Director of Quality and Safety. In addition to this, thematic analysis is undertaken to ascertain the presence of any commonalities within these serious incidents. Never events are scrutinised and discussed at every CQRM, including progress reporting of improvement plans in place to eliminate the instances of such events. There is a zero tolerance of never events by the CCG and contractual action is taken when they occur.

Complaints are sometimes received directly by the CCG about people's experience of services delivered by our providers. Each complaint is investigated and once a response is complete, they are reviewed by the Director of Quality and Safety and signed by the Accountable Officer. However, GYWCCG, where possible, is identifying opportunities to directly contact complainants and offer face to face or telephone resolution meetings. To date these have been successful and are believed to have resolved concerns and improved peoples satisfaction with the process.

Complaints received by the provider, with information about the themes and trends are reported to a varying level. The Contractual requirements will be developed to require providers to report this information to enable a deeper discussion at the CQRMs.

Complaints, serious incidents and never events allow us the opportunity to explore and dive into organisations and services when the information is triangulated. The CCG will further develop processes to undertake further provider reviews and visits if the number (or indeed the absence of) complaints, serious incidents and never events indicate the need to take place.

The reporting of incidents and near misses, regardless of the level of harm incurred, is of vital importance. There are varying levels of reported incidents from provider to provider; this is raised at provider CQRMs and has been escalated to directors of nursing, quality and medical directors as applicable. Improved reporting of medication errors will be prioritised by the CCG; these will include prescribing errors, administration errors and dispensing errors.

NHSGYWCCG encourages the use of Quality Incident Reporting (QIRs) which allow clinicians from organisations including primary care, care homes and well as the main providers to raise concerns about single incidents relating to other such providers of health and social care. These incidents are reviewed singularly and collectively to identify concerns and themes. When this occurs, thematic reviews are undertaken and addressed with the relevant providers. However we encourage people to directly contact other organisations where possible to resolve issues and we recognise that there is a place for both methods of resolving concerns.

Within GYW, we believe that all elements of safety and quality can only truly be delivered if we own safety and quality as a system. Our continuing commitment to patient safety within health and social care means that we can truly make a difference to the lives of our patients by working together and not within our own individual organisations. The pressure ulcer collaborative is a good example of the work that we are currently embarking on to address the high incidence of pressure ulcers within our community. This will extend to falls and indeed to the development of a patient safety health and social care collaborative within GYW. The commitment of the parts of the system is evident and the CCG will lead on ensuring that this commitment results in real positive impacts on outcomes for our population.

As a commissioner, listening to our patients is crucial to understanding what our population need and want. The Big Listen will allow us to 'feel' the experience that people have when using our commissioned services. However we also commit to publically consulting on changes to services to ensure that whilst we continue to commission cost and clinically effective services, it is done with the needs of our population at the heart of our decision making.

Increasing numbers with positive experience of hospital care

The CCG is implementing a programme of listening and observing of the experience of patients and their families when using health services within GYW. The purpose of The Big Listen is to:

- observe and listen to the everyday experience of patients and carers in our local health system in GYW
- learn what matters to them
- understand how we can work together with our partners and health and social care to improve that every day experience
- focus on 'first impressions' of our health services everyday.

This tool gives information about the experience of the service user. It can be used for measuring the effectiveness of employee training, detecting symptoms of effective and ineffective management, monitoring new initiatives and checking consistency of standards across an organisation. The evaluators record the details of their experiences, e.g. condition of the premises; staff conduct and interaction; systems, processes and management.

The outcomes from the event will be used to inform commissioning of health services and enable to development of future events that actively seek out the experiences of our service users, and are not solely reliant on the active feedback mechanisms currently in place.

Complaints

Reviews of the complaints services within the providers will be undertaken by the providers in consultation with the CCG to ensure that all patient and family complaints are treated fairly, timely and effectively with the aim of providing resolution for the complainants and ensuring that they provide a rich opportunity for learning and developing staff and services. Complaints data will be obtained from providers with comprehensive analysis and improvement planning to accompany this. We acknowledge that there will be occasions when the experience of a patient or their family is such that the provider does not meet their expectations; the marker of a safe organisation that it actively seeks the opportunity to gain feedback through complaints and demonstrates that they are keen to learn and improve.

The JPUH regularly receives Patient Stories at Board and the Share Your Care initiative includes involving patients and relatives, as is also the case with the 'Board to Ward' rounds. At the last NHS change day, children from local schools attended the children's ward at the JPUH to experience the ward environment and then presented their findings to the Trust Board in February 2014. The Trust has undertaken a detailed review of complaints including providing a questionnaire to complainants. There is also an associated action plan incorporating learning from Clwyd, Francis, Berwick and Keogh etc. Triangulation from the learning from all of the above plus NHS choices comments, compliments received etc. is undertaken and reported via the Quality SitRep to Board. All external reports have fed into the Trust's Quality Strategy. The delivery of the phased objectives from the Quality Strategy will form part of the Trust's corporate objectives for 14/15 and beyond and will also then filter down into the appraisal objectives of our staff at various levels. Values and behaviours work is also ongoing and relates specifically to issues identified around staff attitude and communication.

Patient Surveys

The CCG will monitor the outcomes from the National Patient Surveys through the Clinical Quality Review Meetings and recognise the value of the Friends and Family tests for patients which provide a timelier indicator of the experience of service users.

National surveys and monthly Friends and Family Test results will be closely monitored through CQRMs and by the CCG's Governing Body. The CCG aspires that the experience of our patients within the local providers is within the national upper quartile.

In terms of the Friends and Family Test, the JPUH has very good response rates and positive scores. Comments recorded by patients are fed back directly to the areas involved and the subsequent actions taken are displayed on 'know how we are doing' boards, presented in a 'You said, we did' style.

Increasing numbers with positive experience of care in community

The national roll out to include community services, mental health and ambulance providers is welcomed and will be closely monitored through CQRMs and by the CCG's Governing Body, as is consistent with the hospital approach. The CCG aspires that the experience of our patients within the local providers is within the national upper quartile. The CCG will work with the providers to seek out varying types of opportunities for service users to complete the survey, such as on-line, post cards, hand held devices, using their own personal devices such as smart phones or through volunteers providing face-to face or telephone support to undertake the questionnaire.

A key priority in JPUH's information about patients with positive experience of hospital care Quality Account is to develop a Patient and Carer Engagement Strategy with the sole purpose of triangulating

this information with the information we have around safety and effectiveness to improve services and specifically patient experience. This is also likely to be one of the Trust's corporate objectives for 14/15 and will also then filter down into the appraisal objectives of our staff at various levels. The Trust is enhancing staffing accordingly via the new management structure. The Patient and Carer Experience (PACE) committee has been strengthened and has an executive chair with wider representation from patient representatives, including governors.

Significant progress towards eliminating avoidable deaths in hospitals

We continue to strive to eliminate avoidable healthcare associated infections for our population. The CCG is leading on this with the development of a system-wide improvement plan for C-diff which is overseen by the CCG's CEC. We recognise that as individual organisations our providers have limited impact to influence this important issue; but as a system we can all own the shared problem and work together to identify areas that require improvement so that our patients can benefit from this regardless of what part of the health service they access.

We continue to work with the JPUH who have developed a comprehensive Unified Mortality Review (UMR) process in order to ensure that mortality reviews are embedded within the organisation and owned by their Trust Board.

Work continues on rolling out the UMR process described in various board reports in the public domain (see attached within the Additional Supporting Evidence at the end of this Operating Plan). The latest mortality information is also included in the Quality SITREP report to the JPUH public Board in January 2014. These reports set out the approach to mortality review, and the Quality Strategy and all the other work in place around safety and quality should support this area. Interpretation of 'avoidable deaths' is covered in one of the attached reports as this has been clarified nationally.

Importance of staff satisfaction

Staff satisfaction is an important indicator of the quality of care provided to patients. The Friends and Family Test for patients has been embraced by the providers within GYW; and the continued development of opportunities to monitor this within the workforce is a priority of the CCG. The GYW geography is such that there is less movement of staff and as such it is vital that the providers in the locality ensure that their staff are supported, developed and have good leadership in order to retain them and remain highly motivated. It is essential that staff providing health services have confidence to both recommend their organisation as an employer and as a provider of health care to their friends and family. As such, in conjunction with the National Staff Survey, the Friends and Family questions for staff is a great reflector of the organisational health of the providers within our locality. The Friends and Family Test has been included within the mandatory CQUINs for 2014/15 and will be further developed to ensure that the feedback received directly influences the provider organisational development plans.

Provider services staff satisfaction

As a commissioner we recognise that staff satisfaction can have a direct impact on the service and quality of care given to the patient and as such we are committed to seeing improvements in staff satisfaction in our provider services staff survey results. As part of next year's CQUIN we have included the family and friends question as part of the core questions in provider staff surveys. We will measure this within our contract performance meeting and will actively reward good results as part of our CQUIN. We are also actively participating in the wider strategic workforce forums with Health Education England and will work with them and our providers to jointly agree where we can make the most difference to staff satisfaction levels.

Safeguarding

GYW sits across two local authorities, Norfolk and Suffolk. As such the CCG is an active participant in the work of the Local Safeguarding Children Boards (LSCBs) and Safeguarding Adult Boards for both counties. GYWCCG recognises our duties within the Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework (2013) and Working Together to Safeguard Children (2013). The CCG's CEC receives quarterly update reports about both safeguarding adults and children. In addition the CCG's risk register is updated each month to ensure safeguarding concerns are given prominence within discussions about risk and safety. The CCG has escalated to the Quality Surveillance Group mechanism and the Care Quality Commission in the event of safeguarding concerns about provider(s).

Safeguarding Children

In particular, GYW leads the Safeguarding Children team as defined within a Memorandum of Understanding between the five Norfolk and Waveney CCGs. We work within a collaborative multiagency approach to safeguarding children and continue to further develop highly effective partnership working across health commissioners and providers but also other agencies such as the Police, Children's Services, Education and Justice. The commitment to continue to improve the safety, health and wellbeing of children is of utmost prominence in the function of the CCG, particularly as there are parts of our locality with significant deprivation and high numbers of children at risk and those with a child protection plan in place. The Director of Quality and Safety remains the executive lead for safeguarding children within the GYWCCG.

The designated professionals are employed by the CCG with the exception of the designated doctor who is employed by one of the community provider organisations. An updated service level agreement (SLA) is in development to ensure robust arrangements are in place for managing the roles and responsibilities. In addition, the five Norfolk CCGs are increasing investment in the designated team to recruit a designated doctor for looked after children.

All providers have safeguarding children executive leads and operational teams in place and the effectiveness of these are monitored through a formal health advisory group that reports to the Norfolk Local Safeguarding Children Board, and to the Health Executive Sub Group of the Suffolk LSCB. Safeguarding risks within commissioning groups and provider organisations are raised and monitored to ensure sufficient mitigation; where required these are escalated to the LSCBs. Formal arrangements are in place with financial contributions made by GYWCCG to the Norfolk and Suffolk Safeguarding Children Boards.

Safeguarding Adults

For adult safeguarding GYWCCG participates within a hosting arrangement within the Norfolk and Waveney CCGs which is underpinned with a Memorandum of Understanding. North Norfolk CCG hosts the service which provides both executive leadership and operational delivery of safeguarding adults. The Director of Quality and Safety remains the executive lead for adult safeguarding within the GYWCCG. Formal arrangements are in place with financial contributions made by GYWCCG to the Norfolk and Suffolk Adult Safeguarding Boards.

Looked After Children and Care Leavers

The CCG is committed to continuing to improve the capacity and quality of health assessments and services for looked after children. We have recruited a Children and Maternity Commissioner with a background in safeguarding children whose role will include identifying areas for improvement within the commissioned activity. In addition, the Care Leavers Strategy will be developed and we will work with providers and other multi agency stakeholders to improve services for care leavers, not just within health but within the whole system. In 2014, GYWCCG will strive to actively recruit a care leaver into an apprenticeship post within the Quality and Safety team.

Designated Professional within Primary Care

Within 2014, the Director of Quality and Safety will work with the Area Team to determine the most appropriate way to allocate investment for a designated professional for primary care. It is anticipated that the new post(s) will work collaboratively with the designated team and adult safeguarding team to ensure an improved support for health providers within primary care.

Compassion in practice implementation

The 6Cs were developed by Nurses, Midwives and Care Staff for Nurses Midwives and Care Staff. They are Care; Compassion; Competence; Communication; Courage; Commitment. However we believe that these are skills, attributes and aspirations that not only are needed by Nurses, Midwives

and Care Staff but indeed by all staff that directly care for patients and also for all staff that support or underpin frontline clinical delivery. All providers within GYW will be required to widen their expectations so that all of their staff own work within the principles of the 6 Cs, whether they are receptionists, doctors, and cleaners, catering staff or medical secretaries. Workforce development strategies, recruitment plans, quality strategies and performance reports will all be required to use the 6 Cs to ensure that their workforce are committed to these principles. The CCG will review our recruitment and appraisal methodology to ensure that principles of the 6 Cs are incorporated within.

System Sustainability, Configurations and Efficiency

This plan is triangulated with our financial and activity planning.

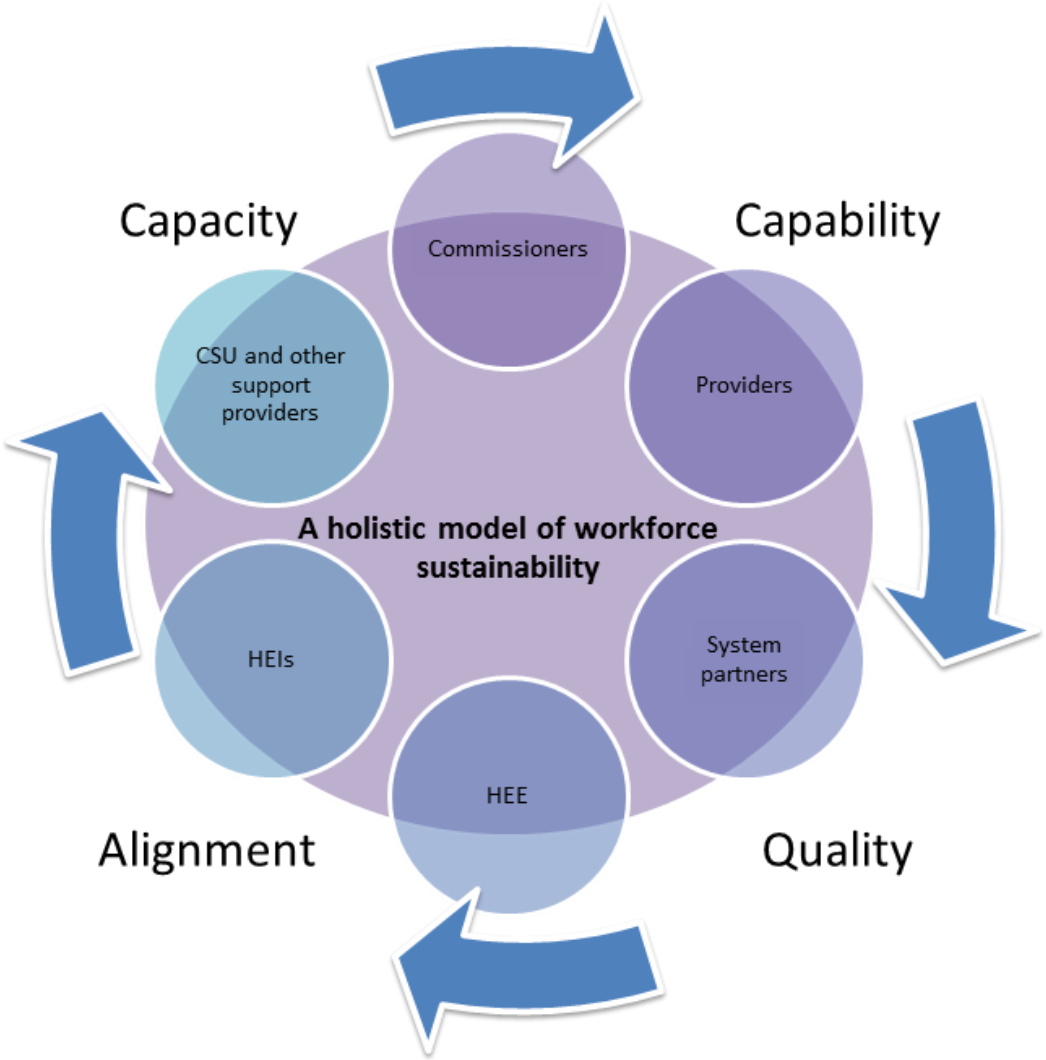
It also supports the metrics contained in the Operational Plan submitted through Unify.

Part of our plans for system sustainability relate to financial sustainability. We will address this by our initiatives to reduce the amount of acute and community capacity in the system, introduce efficient and effective integrated pathways through the vehicle of our ICS and the BCF and pay close attention to transactional savings to maintain our current efficiencies. The schedule in the finance and activity section of this plan shows the extent of these savings.

Our ambitions for a sustainable system can only be underpinned by a sustainable and motivated workforce across the system. We intend to work with Health Education East of England, the Norfolk and Suffolk Workforce Partnership, our system providers and higher educational establishments to ensure that workforce and education plans align with our strategy.

We will hold our key providers to account for staff capacity, capability and for qualitative indicators using outcomes and actions from staff surveys and Friends and Family Tests.

In order to ensure sustainability, we recognise that we also need to maximise the provision of expert support from our commissioning support unit (CSU) and other contracted support service providers and to realise the benefits of sharing resources across the system.



A key element of maintaining a balanced financial position over the next five years is to reduce capacity within the system. This is covered in more detail later in our plan, but includes the decommissioning of hospital capacity and changing the way we provide community based care. We will work with our acute provider to reduce length of stay and reduce the need for inpatient care. Our proposed reduction in community bed capacity involves commissioning care home bed days based close to local communities, together with providing higher acuity community beds within two centres for our population. This represents a step change in the type of care we can offer in terms of greater personalisation, but as part of the changes, we will ensure that we engage with our stakeholders and communities and undertake formal public consultation as necessary. Community bed capacity will be replaced by our innovative out of hospital teams, supported as necessary by additional care home capacity locally. Emergency admissions have reduced during 2013/14 compared to 2012/13 and we plan to build on the fact that our increasingly integrated working between health and social care is starting to manage down demand. Decommissioning capacity will prevent beds freed up by reduced emergency demand being filled, and we also anticipate that the potential to have a strong GP presence at the 'front door' of JPUH will also reduce emergency demand within JPUH.

We also, as a responsible commissioner, are seeking to maximise opportunities for a greener environment with reduced carbon emissions. We will build on the track record of the previous primary care trust (PCT) in this respect, although it must be recognised that as we no longer own our estate, we need to rely on NHS Property Services Limited to help maximise the energy efficiency of our buildings. Our commissioning models, moving care closer to patients home, will also reduce transport costs and thus reduce the carbon footprint.

The estates strategy as described in the last GYWPCT CIAMS report remains intact; however the direction of travel continues to evolve as we incorporated the requirements of the overall integration strategy and the intentions around out of hospital working. Evidence of this can be seen in the continuous improvement of our local buildings in partnership with NHS Property Services and in particular the more recent capital building programme. We also continue to work closely with NHS England around estate to support primary care within GYW and to encourage collocation wherever possible. As a result of the increasing emphasis on whole system working we are more closely involved with housing developments at the planning stage to determine the level of support and the types of services new communities will require. One example of this are plans for significant housing and retail development where there is an opportunity to bring together other embryonic plans within the health system in a cohesive way to ensure that the best possible outcome is achieved for the population. Engagement between all public sector organisations is established and a single estates strategy will emerge from this work to ensure that best use is made of our shared assets and that collocation is achieved at every opportunity. Governance around estates issues is achieved through the multiagency Infrastructure Group meeting which meets monthly.

There is currently an integrated hub – Shrublands – in Great Yarmouth which has achieved colocation of primary care, social care and community health teams. April 2014 will see the first occupants moving into the Kirkley Mill Health centre which will comprise a similar mix of teams initially and looks to enhance the provision of multiple services from that site in the future. This site will also in cooperation with organisations such as the Kirkley Business Association develop a flexible community focus. Sole Bay Health Centre will be open in summer 2014 and will enable the colocation of primary care and community services alongside a pharmacy and potentially dental services within the future.
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NHS Constitution

The way in which we are achieving the metrics within the NHS Constitution is contained within the performance section of this document. Additionally, we have reviewed how we ensure our activities support the more qualitative aspects of the constitution.

NHS Constitution Requirement	In Place	Further Actions Short Term	Long Term Plans
Principles **Comprehensive Service Available to All** **Service Access Based on Clinical Need** **High Standards of Service Delivery** **Patients at the Heart** **Integrated Working** **Better Value in a Sustainable Way** **Accountability**	• The CCG commissions a range of Healthcare Services and monitors delivery to ensure accessibility and decisions are made on a clinical basis. The monitoring of contracts involves considerable review of quality of service. • Clinical Transformation and Integration work put patients at the heart of the commissioning development plans and a focus on better value for money and accountability is achieved through close financial and performance monitoring. • A fully embedded risk management infrastructure is in place with continued focus on key risks and the follow up of mitigation actions to ensure the CCG minimises exposure to unnecessary risk. • The CCG maintains policy, controls and procedures to ensure compliance with statute and best practice across directorates.	• Continuation of local pathway development to meet the 'Out of Hospital' strategy improving • Secure commitment through established planning mechanisms to tackle the locality inequalities in terms of access and quality of health care services and in maintaining a high standard fit for purpose local health service estate through partnership work with NHS Property Services. Work has also started locally to consider the joint use of all public sector estate. (For example in the current project implementation of the Lowestoft Services Reconfiguration project). • Check review dates for Therapeutic Advisory Group and Individual Funding Request policy are met. • Ensure the Patient Safety and Quality Committee include regular review of outcomes from the contract Quality monitoring meetings. Evidenced in the	• Continue ICS development through the mid to long term to realise improvements in efficacy of care pathways, perceived and real improvements in quality and accessibility of care and ensure clarity is built in to the system to support patients accessing continuing healthcare services at the end of their lives ensuring access to palliative care services across the locality. • Develop a forward vision through the ongoing commitment of all public agencies within the GYW locale to ensure effective integrated working is embedded beyond the life of the current Better Care Schemes, building on the commitment and innovative ideas generated at the recent Integration system engagement event. • Bringing together sound clinical based research evidence into pathway redevelopment will ensure the CCG's commissioning of services reaches high standards to

	Resourcing in house and via a commissioning support unit. This includes Freedom of Information and Information Governance specialist advice.	committee's forward agenda. • Ensure QIPP monitoring is maintained and approved Better Care Schemes, are set out in future monitoring plans.	ultimately improve key health indicators for its service population.
NHS Values **Working Together for Patients** **Respect and Dignity** **Commitment to Quality of Care** **Compassion** **Improving lives** **Everyone Counts**	• The CCG is committed to working with patients and regularly uses the outcomes of various feedback mechanisms to inform development and work plans. Pathways involving End of Life (EoL), Mental Health and Vulnerable Patients hold firm the values of respect and dignity. The retained clinician role works to understand the commissioning challenges whilst bringing the real issues patients face on a daily basis into view across all pathway development. • The CCG maintains an accessible website that includes information to engage with all services users.	• EoL Palliative Academy is in place with a clear plan for development work to support the volume, quality and cost implications of the increasing age demographic. • An emphasis on strong and ongoing quality of service monitoring of non NHS and NHS bodies connected with the services commissioned by the CCG is a priority for its Quality and Safety agenda.	• A long term communications and engagement plan is in place to ensure patient feedback informs the CCG work plans for consultations, projects and key developments. This will enable patients ideas and real and perceived views of services commissioned by the CCG to be used to improve services.
Patients and Public – rights and pledges **Access to Health Services** **Quality of Care and Environment** **Nationally Approved Treatments, Drugs and Programmes**	• A range of activities are in place to ensure providers, primary care and CCG members work to ensure access to health services at the point of delivery. Direct involvement in performance and quality contract monitoring provides the CCG with clear information on the degree of	• Complete current co-location of service projects in the area to improve access to health and other public sector services locally. • Consent including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms are being standardised across services to	• Prescribing advice is maintained in line with National Institute for Health and Care Excellence (NICE) and pharmaceutical industry information to ensure accessibility whilst ensuring cost pressures are mitigated. A long term view is taken in supporting public health prevention programmes in relation

Respect, Consent and Confidentiality **Informed Choice** **Involvement in Your HealthCare and in the NHS** **Complaint and Redress**	quality and volumes of services. The CCG retains resource to provide specialist prescribing advice and works with the TAG and IFR process to ensure nationally approved healthcare drugs and treatment services are applied uniformly. The CCG monitors provider policies to ensure patients and their information are handled correctly and continues to support effective complaint and redress procedures.	ensure EoL patients receive the care they consent to. • Service users are provided with a range of useful information regarding the delivery of key services in the Great Yarmouth and Waveney area via the website. The website is continually updated to ensure it is both compliant with statutory requirements to inform and publish information for patients but also provides useful information to enable patients to contact the commissioner whether to provide feedback, request information or make a complaint.	to the use of antibiotics and ensuring system knowledge is maintained. • A long term vision of balanced, low cost and effective commissioning support unit services is in development and procurement and contractual mechanisms will be utilised where opportunities for improvements are required.
Patients and Public - their responsibilities **Contribution to Own Health** **Register with a GP** **Treat Staff with Respect** **Provide Accurate Information** **Keep Appointments** **Follow Course of Treatment** **Participate in Health Programmes** **Organ Donation Position** **Feedback**	• The CCG works closely with Public Health Local Authority partners to ensure commissioning plans address health inequalities and support service users to manage their own health. The CCG provides information to GP practices on courses Protected Time for Learning (PTL), to ensure GPs keep up to date with information on health prevention, developments in healthcare diagnoses and treatment and in effective management of practice healthcare services.	• 'The Big Listen' exercise is where feedback from patients and service users is taken and used to implement changes in pathway redesign, putting patients and their views at the heart of the developments in the commissioning of services. • Communication and engagement work continued to encourage service users to use healthcare services in GYW to promote a prevention approach.	• Outcomes of the NSFT public consultation will be used to work with the mental healthcare provider to ensure improvements in mental healthcare services are achieved whilst ensuring the service platform is managed in terms of efficient use of resources.

Staff rights and pledges **Staff have rewarding worthwhile jobs, are listened to, treated with respect, have the right tools and training and opportunities to develop and progress. Staff rights are upheld to ensure they: work in a good environment, receive fair pay, can be represented, have healthy and safe working conditions, are treated fairly, can progress their complaints and raise concerns.**	• A full suite of mandatory training and additional targeted training courses to meet the needs of the CCG. The CCG commits to ensuring all staff are 100% compliant with their mandatory training requirements as the CCG board and senior management believe this is key to having an effective workforce. • The core HR policies and a Raising Concerns policy is in place.	• Staff contractual terms and conditions are in the process of being reviewed as part of the first year review process. • Health and Safety Workplace Assessments carried out by the specialist have identified a number of key actions to implement over the next 6 months to further embed effective health and safety practices into the running of the CCG at the Beccles HQ. • All staff will have appraisals carried out by the end of the year in line with best practice, to formalise the progress in performance and accountability, however	• Key successes and areas for development highlighted in the recent staff survey are under consideration, informed through discussion at the Staff Involvement Group. • Further HR policy development continues to ensure the CCGs maintains innovative and up to date best practice approaches to support and value staff in the work they do. • Work to develop tenancy arrangements with the landlord of the CCG Beccles site
The NHS will commit to provide: a positive working environment, clear roles, personal development and training access, support and opportunities for staff, engagement, process for internal grievance and encouragement and	• A Staff Involvement Group meets on a regular basis to review key staff items. A Health and Safety Work Action Plan is in place and the resources of a trained and competent external specialist in Health and Safety complements the CCGs resources in this area.	• CCG line management commit to holding regular 1 to 1s and team meetings throughout the year to ensure staff are informed ongoing. • Further policies on Lone Working, Home Working and Flexible Working are in development, with a particular focus on supporting the Continuing Healthcare Team which are the only patient facing service now in operation at the CCG following the recent	• Are ongoing to ensure the CCG maintains fit for purpose accommodation to meet its commissioning needs and the needs of staff.

support in raising concerns.		transition.	
Staff responsibilities **Staff have a duty: to accept professional accountability, take reasonable care of health and safety at work for self and others, work to contract terms, to not discriminate against patients and colleagues, protect the confidentiality of personal information, to be honest in job applications.** **Staff are expected to: maintain high standards of care, take up training and development opportunities, contribute to sustainable improvement of services, raise concerns, involve patients and carers, contribute to a climate of truth, view services from patients viewpoint,**	• An Equality Scheme is established to provide the CCG and its staff with key principles and a platform from which to achieve equality and diversity in all commissioning activities. • A suite of IG policies and guidance documentation is established to ensure the CCG complies with the requirements of the Data Protection Act for both staff and service users and information risk is minimised working within the newly established Patient Confidential Data requirements now in operation across the NHS. • Staff continue to provide key evidence to support the submission of the IG toolkit at level 2 which is a key part of the application for Accredited Safe Haven Status.	• Staff are to receive refreshed terms and conditions to support the current contracts in place through the first year of the CCGs development. • Equality and Diversity Assessment programme is in development to ensure resource is targeted to assess key policies and changes in service development. • Current incident reporting policies, forms and process flow are under review to ensure the CCG has the right processes and controls in place to report incidents effectively. • The CCG seeks to maintain an up to date policy infrastructure with the Audit Committee monitoring progress ongoing. • The CCG is continuing to seek Accredited Safe Haven status to enable it to develop its processes in handling patient confidential data to support commissioning purposes. • A refreshed Sustainability Plan is to be devised to pull together the various thematic approaches to	• The outcomes of the Leadership Development programme in 2014 are to be evidenced in a project on EoL services in terms of how one specific area of healthcare can be developed in an integrated way to secure efficiency and improved services for patients. This work will be used to inform the wider Integrated Care System (ICS) development and consider some of the practical risks and considerations that may be encountered when implementing the ICS approach for specific areas of service.

support patients and colleagues to improve health and wellbeing, contribute to providing fair and equitable services, informing patients on use of Confidential Information, provide appropriate access for healthcare professionals to patient information so long as a legal basis to share exists.		sustainability from Better Care Funded Schemes, QIPP, ICS approaches through to contract monitoring.	

Primary Care

Working with the Commissioners of wider Primary Care

We will support and work with NHS England, the primary care commissioners, to develop relationships to meld national contractual considerations with local needs and specifically the diverse and deprived nature of our population to deliver the structural transformations required by the planning guidance, recognizing their importance to our core strategy. The vision of Primary Care at the heart of an integrated system designed around the needs of patients and focused on geographical areas mapped onto practice populations is the core of our Out of Hospital Team plans, developed with our practices and our providers which we will be implementing in 2014/15.

We will work together with NHS England to explore how to better integrate wider Primary Care and access the untapped talents and capacity of our community pharmacy network. This is an area which we have not yet fully scoped and explored.

We meet NHS England regularly, and will continue to jointly discuss our plans and progress, agreeing joint spheres of action and implementation. We will also continue to share information monthly and ad-hoc regarding quality concerns in our practice provider network, working directly with our members to address quality concerns and assist improvement in concert with the commissioners.

Rethinking the Primary Care Provider Landscape

Working with the Primary Care Commissioners we are supporting our practices as they consider the implications of the challenging climate and the ambitious intent articulated in both the “Call to action” and the Planning guidance.

We are working with the five practices based in Gorleston and Bradwell to help them explore options about how they can meet the challenges of high quality sustainable General Practice, their population’s increased exposure to A&E driven by proximity, and the recruitment challenges which are limiting their development. They have committed to explore working very much more closely together in order to co-locate at a rationalised selection of sites in the area, including possible co-location on the JPUH site, subject to public engagement/consultation as required. This development also explores the phase one Keogh review theme around Urgent Care Centres.

We are also working with a number of practices across our patch to explore the challenges and opportunities they find themselves faced with. We have already seen partnerships merging. We believe that this trend will continue over the coming years and we will end up with fewer, larger practices better scaled to meet the needs of the population.

It is clear that if primary care is to be the foundation of which our integrated care system is based then ensuring that it is robust, providing uniformly high quality services and able to ‘respond to individuals’ needs is vital. We believe that to do this, primary care will need to work more closely together, within the integrated care system, potentially in alliances or federations between neighbouring practices. We have the ambition of supporting the development of larger, stronger, better resourced teams of GPs, nurses and other professionals working from multi-disciplinary healthy living centres in close concert with non-health partners such as benefits officers, community police staff and social care professionals.

Working alongside our colleagues in NHS England, we will also foster closer links with community pharmacy, in terms of how patient centred care can be further developed and community pharmacy services integrated more with both primary and urgent care.

Primary Care at the centre of the delivery network

These changes will underpin our member practices abilities to engage with the ambitious vision for integration held by the citizens and clinical community of GYW.

At the centre of these plans is the idea of a coordinated, 24 hour, seven day per week community response to unplanned health and social care need. Working with our partners in the county councils and community services, we will wrap teams around the populations looked after by practices to respond to their needs in an integrated way, planning their care to keep them at home through earlier collaborative intervention, and receive patients back into the community swiftly when their needs have escalated to the point that they can no longer be met outside a hospital environment. These “Out of Hospital Teams” will be implemented across our area in a phased way starting with our first roll-out in April of 2014. The responsible GP (often for these patients this will be the “named” GP) will work with these multidisciplinary teams to plan and coordinate their care to minimize unplanned care needs – community based multi-disciplinary teams (MDTs) in practices have been trialled locally in 13/14 to provide learning and buy-in on which to base this model.

The plans for the use of the primary care fund have been agreed with our member practices. These support our Out of Hospital strategy, including specific support for primary care in this connection.

Access to Services

The Urgent Care Board was established in 2013 to drive joint plans for managing demand for urgent care services, ensuring patient flow throughout the GYW health and social care system, and ensuring the provision of safe, high quality integrated urgent care.

The board explores opportunities to support the local health and social care system including initiatives to support the local A&E department in ensuring all patients are seen and treated in a safe and timely manner, and initiatives to help keep patients at home through increased social care and therapy support thus avoiding an unnecessary admission to the acute hospital and by supporting patients at home following discharge.

The board consists of representation from all local health, social care, borough and district council partners. The board meets fortnightly, and weekly if there is an operational requirement, so that we can respond quickly to any peaks or operational challenges which may arise. Strategic meetings are held bi-monthly with Chief Executive representation from local partners and voluntary organisation representation to ensure a focussed outcome driven approach to service development.

Workstreams

A number of workstreams have been established which report into the urgent care board. These include:

- **Care Homes/Community Matrons**
  Initiatives include:
  - admission and discharge forms for care home patients
  - urinary tract infection (UTI) pathway for care home patients who have recurrent UTIs
  - opportunities for training days for care home staff
  - alerts processes for community matrons
  - direct admissions for community matrons.

- **Frequent Attenders/Callers**
  Initiatives include:
  - process for sharing frequent attender/caller information at practice multi-disciplinary teams
  - pathways for frequent attenders/callers with complex conditions e.g. dual diagnosis services.

- **Primary Care Support at A&E**
  Initiatives include:
  - Out of Hours GP in A&E

- **A&E/Ambulance Interface**
  Initiatives include:
  - introduction of a Hospital Ambulance Liaison Officer
  - reviewing all A&E attendances via ambulance with same day discharge.

Workstreams will be updated and reviewed regularly in preparation for development of the 2014/15 Integrated Urgent Care Plan.

Access to urgent care for mental health patients

This is being addressed through our Mental Health Programme Board, and includes access to acute inpatient mental health beds currently at Carlton Court and Northgate Hospital. Provision of services in these facilities is currently subject to a full public consultation as part of the NSFT's Service Strategy. No decisions about how access to these services will change in the future will be taken until this process is complete, with decision making expected to start in summer 2014, and delivery thereafter. We expect to develop a full implementation plan following this consultation. There are also our two Section 136 suites, which are included in this public consultation.

The Crisis Resolution and Home Treatment service provides assessment for people in crisis, and our dementia intensive support teams aim to prevent admission of people with dementia by working proactively with patients and their families in a supportive way, closer to home. In Waveney this is supported further by the jointly funded flexible dementia service. There are plans to develop a similar service in Great Yarmouth.

For people who need specialist services, the CCG and NSFT work very closely with the Specialist Commissioning Group to secure appropriate placement, and this also involved all local partner agencies.

Audits

GYWCCG has been undertaking a number of clinical service reviews to support workstream development and inform future integrated urgent care planning. These have all been clinically led using the expertise of retained GPs with management support. Services audited include Admission Prevention Services, Community Matrons, Community Hospitals, District Nursing, Minor Injury Services/Walk-In Centre, and ambulance/A&E activity. Clinical Service Reviews will continue to be a key feature of urgent care service development.

Winter 2013/14

A key role of the Urgent Care Board (UCB) is to develop an integrated plan for the system over winter 2013/14 for GYW, and to provide a forum to support organisations across increased periods of pressure.

For 2013/14 winter funding was utilised to support operational plans for support the system over periods of increased pressure. These included:

- Out of Hours GP in A&E to treat minor attendances
- increased A&E Nursing Staff
- middle grade surgical cover in A&E
- extended social worker cover in the community
- increased social worker capacity in JPUH
- increased therapy support, admission prevention and EIT, including weekend capacity
- rapid admission avoidance car manned by an emergency care practitioner.
- hospital ambulance liaison officer working in A&E to ensure safe, timely handovers from ambulance to A&E
- additional patient transport services over the Christmas period.

GYWCCG has committed the 70% tariff retention funding for 2013/14 on a variety of measures to reduce pressure on A&E services including the following:

- Admission Prevention Service
- Falls Service
- Twilight Nursing
- Community Matrons

- Care Services Improvement Partnership (CSIP) for Beccles, Southwold, Halesworth and Bungay
- Waveney COPD Service.

These services are now in place on a recurrent basis.

Performance

The UCB has developed a local dashboard including all key performance indicators for urgent care services including the A&E 4 hour target, ambulance targets including handover times, length of stay etc. This provides the board with a format for looking at trends, areas of improvement and seeing where initiatives have made a difference to performance.

Standard Operating Procedures between providers have been established particularly between JPUH and EEAST regarding handover processes to ensure achievement of key performance indicators including 4 hour wait, handover times etc.

At all its meetings the board discusses current performance issues including reasons for any drops in performance and actions to be taken to address this.

Following periods of surges in activity, the UCB reviews its escalation plans and processes, and debriefs on possible causes and corrective actions. Learning outcomes are then fed back into the preparation of future Integrated Urgent Care Plans, and any additional workstream development.

The UCB regularly reviews performance of the 111 service highlighting any areas for development.

Pathway work is undertaken to link NHS 111 pathways with local urgent care services e.g. mental health, to ensure quick and smooth transition from 111 into appropriate service settings. These developments will continue to be reviewed and new pathways identified. This work will link into the implementation of the new NHS 111 specification when published.

Urgent Care Services for GYW

Background

For some time there has been much discussion with regard to the implementation of a primary care led service for minor illness based at JPUH. More recently, as part of the CCG's Integrated Urgent Care Plan, a workstream has been established within the Urgent Care Board to explore opportunities for such a service.

With the recent emphasis from NHS England on improving and sustaining the A&E 4 hour standard, EAAST turnaround times, and supporting systems over the winter period we would welcome the opportunity to discuss with the GYWCCG Executive Team options and a proposed model for delivering urgent care in GYW.

Current Situation

It is recognised that in spite of numerous access points for patients presenting with a minor illness and injury, there has been no meaningful reduction in A&E attendances.

Locally we have:

- A&E services at JPUH
- minor injury unit based at Beccles Hospital open 7 days a week, 8am to 8pm
- minor injury services provided at Cutlers Hill Surgery open 5 days a week, 9am to 5pm
- minor injury services provided at Southwold practices open 5 days a week, 8am to 6.30pm

- a Minor Injuries Local Enhanced Service signed up to by the majority of practices – provided 5 days a week during GP opening hours
- minor illness provided by GPs within core hours and contract
- minor illness provided by IC24 Out of Hours service
- Greyfriars Walk-In Centre open 7 days a week, 8am to 8pm.

Equity of access across Great Yarmouth and Waveney is variable and choice is more available in the South rather than the North.

Suggested Model

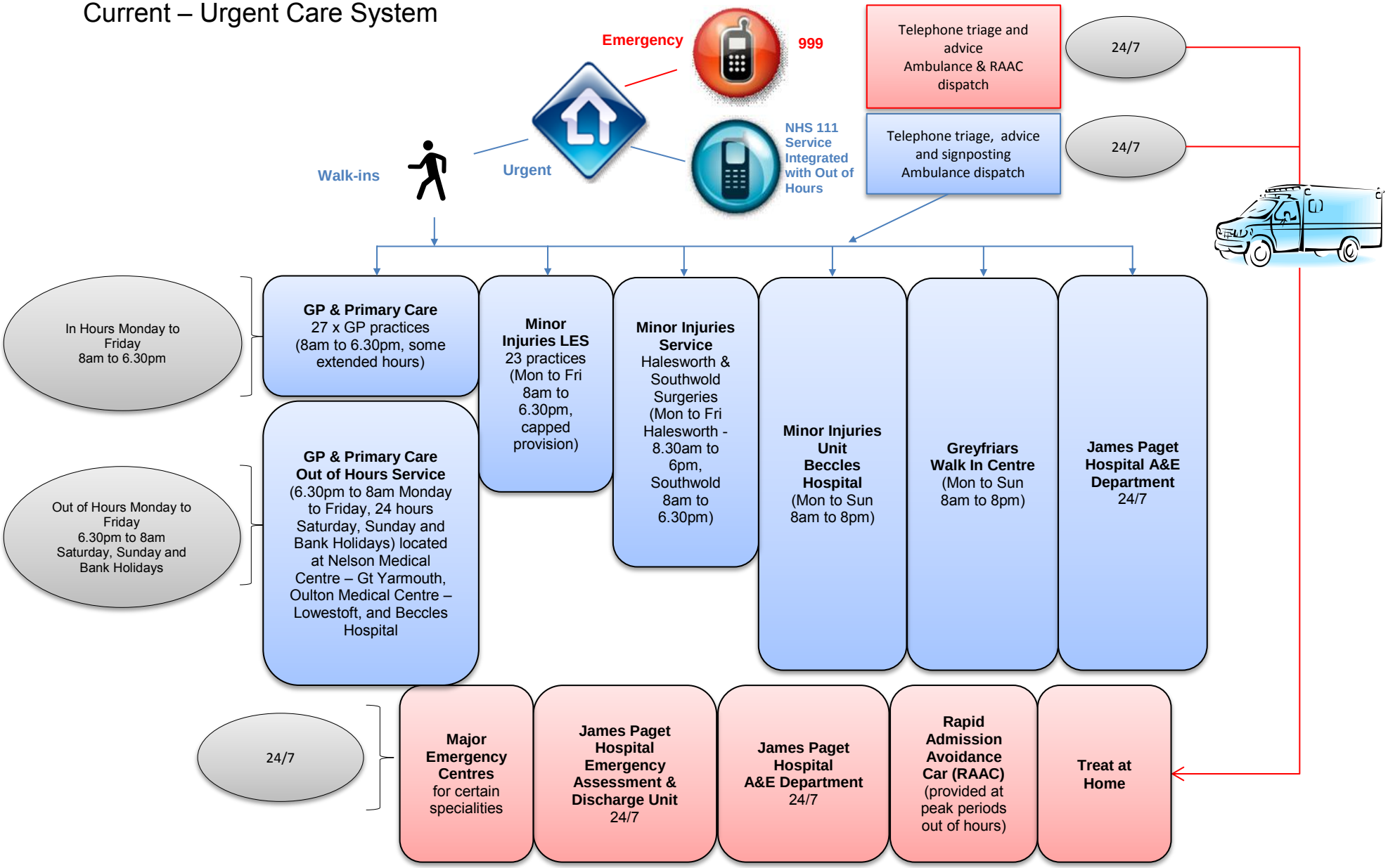
Following discussion at the UCB, it was acknowledged that it may be more appropriate to simplify access for patients with minor illness or injury.

The current service specification for out of hours stipulates that 'services will be provided to all sectors of the community within 30 minutes maximum travelling time from home to service base', and 'access to the service will be simple and consistent'. This model provides a simplified structure for organising services, and reducing the confusion for patients on where is appropriate to go for treatment.

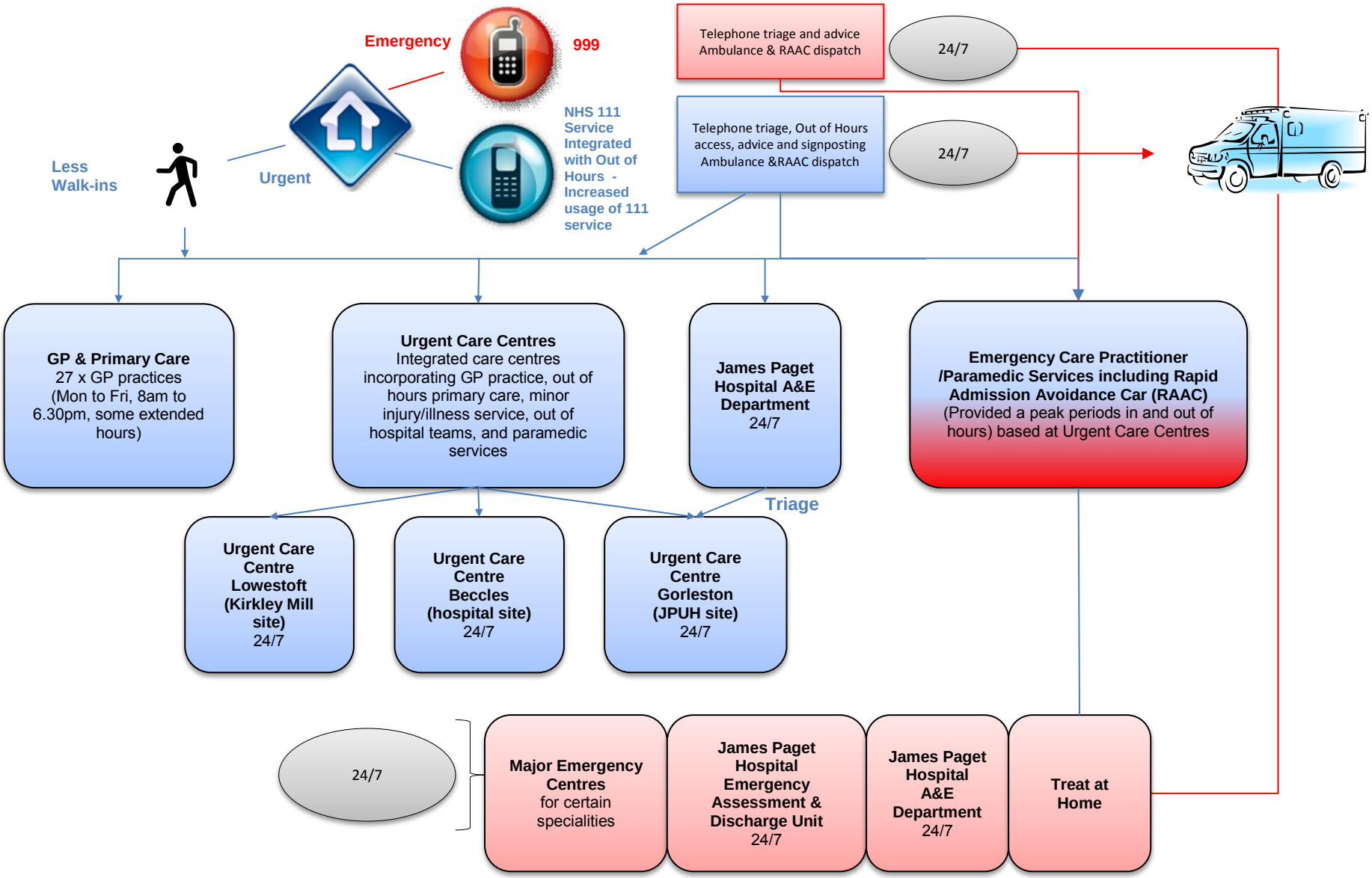
We have therefore looked at how this model can be adopted for urgent care services in the GYW area and will be taking significant proposals to the CCG's CEC and Governing Body in the near future. This includes a review of our minor injury services.

The potential development of a primary care centre at JPUH will also allow a further integration site with primary, community and social care teams co-locating in one centre. Multi-purpose clinic rooms will also support ambulatory care, and provide alternative locations for providing treatment such as IVs, minor surgery, dressings etc.

Current – Urgent Care System



Draft - Potential Vision
Future – Urgent Care System



Strategic Vision

The UCB is reviewing services across GYW to inform the strategy for delivering and developing urgent care services across GYW. This is guided by the four principles in the Urgent and Emergency Care Review – phase 1 report, and Evidence Base:

1. provide consistently high quality and safe care, across all seven days of the week;
2. be simple and guide good, informed choices by patients, their carers and clinicians;
3. provide access to the right care in the right place, by those with the right skills, the first time; and
4. be efficient and effective in the delivery of care and services for patients.

During 13/14 a number of major workstreams were developed by the UCB including:

- **Care Homes:**
    - falls
    - reduced admissions – UTI protocol
    - care homes local enhanced services (LES).
- **Ambulance and Acute Trust Interface:**
    - handover times
    - improved performance
    - introduction of Hospital Ambulance Liaison Officer.
- **A&E Frequent Attenders:**
    - Establishment of MDTs.
- **Primary Care Support:**
    - GP in A&E.
- **Long Term Conditions/Matrons:**
    - primary care, care bundles
    - direct admissions for matrons
    - matrons alert process.

The board have also agreed and implanted a number of winter initiatives which will be evaluated to inform any future commissioning decisions.

Following the development of a local strategy an updated programme of work will be agreed which will incorporate the key recommendations within the Keogh Report.

Finance, Activity and QIPP

The challenge facing the CCG and the wider health and care system reflects the national financial climate of flat or reducing resource versus growing demand. GYW CCG financial planning is undertaken in this context and recognises the risks intrinsic to this environment.

Financial Planning Assumptions

The GYWCCG challenge has been calculated by modelling both national and local planning assumptions. Everyone Counts: Planning for Patients 2014/15 to 2018/19 published in December 2013 contained the following key assumptions and requirements:

- limited growth in resource from 2014/15.
- -1.5% tariff deflator for 2014/15 for acute trusts and -1.8% for other services.
- 2.5% CQUIN payments.
- 0.5% Contingency Reserve.
- running cost allowance of £24.78 per head of population.

The tariff deflator for 2014/15 is based on achieving the maximum efficiency of 4% offset by anticipated provider inflationary cost pressures of between 2.2% and 2.5% set out in national planning guidance.

In addition to the above, GYWCCG has made the following local planning assumptions.

Area of Growth	% Growth
Demographic Growth	0.64%
Other Growth	1.00%
Prescribing Growth	5.00%
Continuing Healthcare Growth	5.00%

Local assumptions include growth in activity and price lead by population increase, demand and technology developments. Two other areas of high growth are prescribing and continuing healthcare.

Prescribing expenditure increased significantly in 2013/14 and the forecast growth for future years has been estimated at 5% to reflect a continued activity increase and to mitigate rises in the cost of drugs.

Continuing healthcare activity has also increased significantly year on year for the last three years and again has been estimated to grow by 5% in the years covered by this plan.

The Challenge

The challenge reflects the estimated growth in expenditure, set out above, if we do nothing but provide our current level of service.

In reality, the need to make provision for contingencies, meet previous commitments and set aside non recurrent reserves to pump prime system transformation means that there is a need to make large savings in each year of the plan. This reflects the local effect of the national £30 billion ‘Call to Action’.

Additional cost pressures that have been accounted for recurrently in each year of the plan include previous commitments such as the impact of investment in estate. Identifying these recurrent cost

pressures at the planning stage has helped inform decision making within the CCG for future years especially for future investments and QIPP plans.

GYWCCG is also seeing additional non-recurrent cost pressures in 2014/15 predominantly from Continuing Health Care restitution claims.

The table below models the CCG's available resources against our 'do nothing' expenditure.

Resources	2014/15 £000's	2015/16 £000's
Programme	**291,222**	**297,454**
Growth	6,232	5,057
Better Care Fund transfer from NHS England	0	4,646
Total Programme	**297,454**	**307,157**
Running Costs	5,610	5,038
CCG recurrent allocation	**303,064**	**312,195**
Return of prior year surplus	2,918	3,030
Total resources available	**305,982**	**315,225**

"Do nothing" expenditure	£000's	£000's
Carry forward previous year spend	295,613	302,951
Adjust previous year non-recurring spend / income	-966	-5,311
Revenue impacts of capital schemes	500	1,000
CHC Restitution	2,931	500
Inflation	-1,317	-1,203
Demographic change	2,619	2,680
Non Demographic	2,896	2,938
Subtotal "do nothing" expenditure	**302,276**	**303,555**

There are, however, additional requirements that the CCG will need to deliver in each year of the plan. These are shown in the table below and include a Primary Care Fund totalling £5 per head of population, a new out of hospital team and commitments towards the Better Care Fund (BCF).

There is also a need to set aside 2.5% in 2014/15 and 1% in 2015/16 of the CCG's recurrent allocation to be used as a non-recurrent reserve to support transition, transformation and BCF initiatives along with a requirement to achieve a 1% surplus at the end of each year. Non-recurrent reserves will only be committed non-recurrently and will be considered in part to mitigate in year financial risk.

New developments	£000's	£000's
£5 per head of population Primary Care Fund	1,172	7
Better Care Fund	0	15,516
Other Developments	3,342	0
Subtotal developments	**4,514**	**15,523**
Non-recurrent % of recurring funding	**7,436**	**3,025**
Subtotal do nothing plus developments	314,226	322,103
Total savings (Target for QIPP plan)	-11,275	-10,000
1% Surplus	**3,030**	**3,122**

The above table clearly demonstrates that the CCG's resources are not sufficient to cover all of these requirements. The CCG will need to release significant savings each year in order to balance its resource and expenditure. The gap in funding for 2014/15 is £11 million and 2015/16 is £10 million and this forms the GYWCCG QIPP challenge.

QIPP Planning and Monitoring

In order to achieve financial balance and the nationally required surplus every year, we have already been planning for the delivery of savings through QIPP initiatives. We are continuing to develop, build on and monitor our QIPP plans to ensure the required savings are made securing the foundations for a sustainable future.

The CCG has benefitted from some success in the past with delivering required savings and to ensure and that lessons learned and best practice are put in place the CCG has developed an enhanced monitoring process that resides with the executive team. Each initiative is assigned a lead director and has agreed milestones. Initiatives are tracked on a monthly basis through executive team meetings and our workstream planning forum. Where QIPP initiatives are embedded in contracts they are also monitored through the regular contract meetings.

Performance is reported to the Governing Body, Clinical Executive Committee and Audit Committee to ensure organisational oversight is achieved and progress is known and challenged.

It is essential that delivery of a financially sustainable health and care system is monitored across providers and commissioners as well as within individual organisations and service areas.

To facilitate development and innovation within the system the only source of investment is from our non-recurrent reserves and unless recurrent resource is freed up from divestment the only type of new investment available is non-recurrent. This means that the initiatives that will have the highest priority for investment are those which will lead to an overall saving. In addition it may also be possible to make further investments from services which we decommission.

We are proactively working with our partners in Norfolk County Council and Suffolk County Council around the use of the BCF in 2015/16. Our initiatives in 2014/15, as detailed in this section of the plan and on our financial template submission, will help to prepare us for this substantial funds transfer. With our move towards an ICS, there are significant opportunities to work jointly with our partners during 2014/15, 2015/16 and beyond, on schemes that will meet our collective ambition of improving the care we provide to our population outside traditional hospital settings, and these opportunities also align to our strategic intention to reduce acute and community bed capacity in the system.

The table overleaf sets out the areas where savings will come from. The means for cost reduction demonstrates how savings will be made through individual schemes aimed at shifting care from being provided in an acute setting to a community setting and reducing acute activity where appropriate. These initiatives will transform the current healthcare system providing appropriate care in an appropriate setting. The CCG will also continue to review our transactional spend, our high cost packages of care and prescribing behaviour.

Cost reduction means	Cost to implement from non recurrent reserves £000's	14/15 Activity Reduction	14/15 Saving £000's	15/16 Saving £000's
Optimising capacity	3,200	3100 acute bed days, 971 acute admissions,1356 community bed days, 1095 acute admissions	**3,640**	**1,000**
Reducing activity		1033 attenders	**1,783**	**50**
Paying Less			**900**	**400**
Using more appropriate care methods	800		**878**	**0**
Reducing system prescribing			**1,000**	**500**
Increasing efficiency			**415**	**600**
Transactional and procurement efficiencies			**1,400**	**800**
Combining budgets and pathways through ICS			**0**	**6,650**
Other			**1,259**	**0**
Total	**4,000**		**11,275**	**10,000**

Where non recurrent reserves are being employed to pump prime these initiatives it is shown above and any recurrent investment is included in our planning assumptions.

The activity trajectory based on the achievement of these initiatives both supports our direction of moving care closer to home whilst realising the financial efficiencies of a better patient pathway. We will see a reduction in day case activity along with a shorter length of stay and fewer A&E Attenders.

Using non-recurrent reserves the CCG will pump prime these QIPP initiatives to ensure that recurrent savings are released for the system. By funding the non-recurrent set up and transition costs future sustainability will be ensured.

To reduce cost as set out in the above table individual QIPP initiatives have been developed that will allow recurrent savings to be released.

Financial Risks and Risk Sharing

There are a number of cost pressures that need to be managed in future years together with QIPP challenges. The immediate financial risks include some that are generated in areas that are not within the control of GYWCCG, but that need to be managed to ensure financial stability.

The current balanced financial plan includes delivery of £10 million QIPP savings. If QIPP schemes fail to deliver there will be an increased pressure on the CCG's required surplus. Initiatives that can deliver headroom over and above the £10 million are being developed to mitigate this risk.

The financial plan has used 2013/14 forecast outturn plus estimated growth in activity as the basis for setting activity levels within 2014/15 contracts. Activity over and above that which is planned will increase the cost pressure for the CCG and if pressure exceeds the £1.5 million contingency reserve

then other mitigating actions will need to be taken. Demand management QIPP initiatives and risk sharing arrangements are being put in place to mitigate these risks.

GYW has seen a rise in continuing healthcare activity year on year steadily increasing expenditure. Financial planning uses a realistic uplift and QIPP savings plans have delivered as promised in 2013/14, however, the risk of further cost pressures remain. Restitution claims have caused an additional cost pressure as the result of a Department of Health imposed national deadline to submit claims, the outcome of this is still unknown and there is a high risk that it will have a significant financial impact above the level planned for in 2014/15 and following years.

The new NHS landscape reflects a change in commissioning responsibilities which has not fully settled. Changes within the system remain uncertain and this creates a financial risk for the CCG. If there are changes to those services defined as specialised a resulting change in responsible commissioner would transfer resource around the NHS and a funding transfer from the CCG that is greater than the resulting reduction in activity would be an unplanned for cost pressure. There is also a requirement for the CCG to increase its involvement in other areas of commissioning and there is an associated capacity risk that will need to be managed carefully.

The financial environment is challenging for commissioners and providers alike and there is a risk that providers are unable to manage the cost pressures that they are facing. GYWCCG is working closely with its providers to understand these costs pressures and put plans in place that generate efficiencies for the health system while maintaining and improving quality.

The necessity of sharing financial risks in the system is recognised by both GYW system commissioners and providers. The joint imperative to mitigate risk as a whole system has enabled risk share agreements to be built into contracts where appropriate and they will be a key element in the BCF for 2015/16.

National guidance also highlights risk sharing across CCGs as a recommended approach to mitigating financial risk. GYWCCG has been working with local CCGs in Norfolk to establish appropriate risk share agreements.

GYWCCG understands that the transformational change necessary to achieve the level of savings required needs a whole system approach. In summary, the CCG will need to take advantage of risk share agreements and make greater efficiencies to mitigate cost pressures outside of its control.

Workforce

As an employer

Our focus on the development of our people and our organisation was forged prior to authorisation as an NHS statutory body and our approach remains focussed on four key areas:

- capacity and capability to deliver
- quality and governance
- leadership and organisational effectiveness
- engagement with staff, public, primary care and other system providers, CCGs and our CSU

Our direction of travel was articulated in our Organisational Development Plan 2012/13 and beyond.

We believe that continuing and enhancing this focus will result in becoming a successful organisation that delivers for the population of GYW and one that is recognised as an employer of choice.

We are aspiring to be a learning organisation and are clear that the skills, experience and potential of all our staff is pivotal to our future success and sustainability and we continue to invest in their personal and professional development and we have clear and credible plans for talent management.

As a part of the local health system we recognise that we need to lead by example and we aim to consolidate and enhance our approach to staff health and wellbeing.

The voice of our staff is important to us and we will continue to actively seek their views on how we can continually improve – using briefings, surveys, appraisals and our staff forum to engender open and honest dialogue.

2013 Staff Survey Summary

Although the national NHS Staff Survey was not compulsory for CCGs, we developed a bespoke staff survey – via Survey Monkey - over a two week period ending 6 December 2013. An 85% response rate has given credibility to the findings and we are currently working with our Staff Involvement Group to develop actions that will address areas for development and further enhance our many strengths.

Among our strengths identified by staff included:

- internal communication
- teamwork
- accessible and skilled leaders and managers
- mandatory training
- job satisfaction.

Working with our Staff Involvement Group, we are considering our response to the areas for development which include:

- extending development opportunities across the workforce
- health and wellbeing
- consistent application of appraisals and induction
- staff awareness of progress and implications regarding integration.

Getting our internal workforce and organisational development right will not only maintain our success as an organisation but will underpin and prepare us for the challenges of our ambitious five year vision.

Workforce planning across our system

In order to deliver the CCG's ambitious vision for an ICS it is essential we are aware of the workforce implications and work closely with our providers and Health Education England (HEE) to ensure GYWCCG have the right staff with the right skills in the right place delivering excellent quality safe care. To this end we fully support HEE workforce planning intentions for 2014/15 and will play an active role in their delivery working alongside the CCG providers to ensure their workforce plans:

- are both consistent with service plans developed in accordance with the NHS England guidance and are affordable
- support transformation of services and workforce deployment to ensure appropriate access to high quality services
- describe safe staffing levels
- are developed collaboratively and signed off by senior managers and clinicians
- are transparent and agreed with all relevant stakeholders.

GYWCCG has invested in our internal workforce and organisational development expertise and these staff will work closely with the Director of Workforce for HEE to ensure that our 2 year and 5 year system service plans are reflected in the provider forecasts and the CCG will play an active role during the system review phase during the early summer. 2014. Workforce implications will be considered as part of all the CCG's inititaives.as highlighted in the CCG's operational plan.

As part of the local system

Our plans for an integrated care system will require us to instigate and support organisational and workforce development across the local system. The human resource and organisational development aspects of our plans for integration will form the basis for a discrete work stream in our emerging programme of work associated with integration. In order for patients to receive seamless quality services are aim is that staff from all organisations in our system work together across both professional and organisational boundaries for the good of the patient. Although this culture of cooperative working is evident across some areas there is still much work to do and we aim to focus our workforce plans to achieve this culture fully across GYW.

Our emerging priorities, recognising the imperative to maintain focus and morale in this huge time of change, are:

- communication, consultation and culture
- roles, working arrangements and co-location
- processes and policy.

We intend to work collaboratively with our partners to ensure that the staff aspects of integration are managed in such a way that support a sustainable, viable and effective integrated care system with:

- maximised and appropriate capacity and capability – and staff working to common values
- workforce plans that align to the vision
- excellent leadership with system resilience for the future
- joint posts and co-located teams
- collective budgets used effectively for staff development, generic roles and system organisational development.

A key theme throughout our strategy is system integration. In order to achieve this we do need to think differently about the workforce of a future health and social care system.

The workforce is the primary driver for improved patient care and experience as well having the greatest impact on future health and social care costs. Each year providers produce their annual

service plans which have a workforce component. These are actual plans which describe the number and mix of posts that providers intend to employ.

They may also be explicit about issues such as fill and vacancy rates, and associated planned spend on temporary staffing. They should also contain the service providers own plans to secure supply and development of their staff as an employer. We recognise the workforce component of these plans are frequently produced sequentially to service and activity plans depending on final agreement of contracts and related funding levels and .any key areas of under or over supply. The development of a workforce workstream as part of our integration programme with membership from our NHS and social care providers will help us identify how we can best make the most of our valuable workforce resource now and also going forward.

Information Technology and Data

We have a close and productive relationship with our CSU around the planning for how information management and technology (IM&T) will help us progress the integration of commissioner and provider organisations, and also how we ensure that national requirements such as linkages of GP records to hospital data and use of the NHS number are achieved (which is referenced in the Norfolk and Suffolk BCF plans). We are also progressing the use of an overarching system provider to enable the interoperability of systems, which will be critical to achieving integration.

Additionally, we are progressing the exploitation of existing services such as Summary Care Records and innovative systems such as the HealthCare Gateway solutions and the Eclipse Live "Patient Passport" to enable record sharing and interoperability.

We will shortly have a new CSU provider, North and East London. They have indicated a keen interest in information technology (IT) strategy and we will be taking discussions further with them as soon as they begin operating in this area from April 2014. There will be opportunities arising from the ICS to share their expertise and resource around IM&T and use it to support single information flows, risk stratification, assessing impact of interventions and reducing the multiple requests for the same information from patients to care givers. This will therefore facilitate a truly integrated service provision.

The Governing Body has approved data sharing protocols with our partners in Norfolk and Suffolk.

Better Care Fund

Norfolk and Suffolk Health and Wellbeing Boards have a statutory obligation to jointly agree and sign off BCF plans for its constituent councils and CCGs. GYWCCG have fully supported the BCF planning process for each county, with the plan developed as a fully integrated part of GYWCCG's wider strategic and operational plan. We have been engaged in productive discussions with both Norfolk and Suffolk County Councils together, to reflect our separate planning unit in GYW, which crosses the county boundary.

The Norfolk and Suffolk BCF plans, incorporating GYW, are included as Appendix 3 to this plan. During our discussions around the BCF, we have established a set of principles around how we will work together across the system to maximise the opportunities under the BCF, through maximising the amount of pooled budgets and working at scale to redesign services. The BCF will be used as a catalyst to achieve our ambition to create an integrated care system (virtual at first) encompassing the activities of all of the local organisations responsible for health, social care and District Council services. This will deliver high quality, person friendly services in a more coordinated way, which removes organisational and transactional barriers and duplicated costs so.

Crucial to this is an ambition to see the entirety of our system as a whole – not as fragmented services and organisations with different priorities and drivers. We believe that if we can create a shared vision, with shared principles and priorities we can achieve so much more than we are able to on our own. We are committed to remove organisational barriers and to having relentless focus on improving the health and care outcomes for people in GYW. We will identify and work to remove any incentives for cost shunting or unnecessary duplication of provision, and be able as a system to invest in the right things for our customers and patients. This will ensure that the maximum proportion of funding possible is used for the care of the population.

This shared vision gives us huge opportunities – to deliver excellent care within our communities, but also to support people who are tipping into need, to make sure they get the help they need early so that they can stay as well as possible with a good quality of life. The opportunity for shared budgeting as part of the BCF process, moving money to the right place in the system, enables these opportunities.

Our aim as health commissioners is to use BCF Funding to protect outcomes and individual eligibility to care which results in better health outcomes and supports placing individual needs at the centre.

Protecting social care in GYW means that people in need of care and support will receive the services they need in spite of budget reductions and increased demand. Our approach is founded on a whole system approach to health and care services. We recognise that without appropriate care and support, health and wellbeing will not thrive. We are committed to delivering the right service – whether health or care - at the right time and in the right place and to challenge the unnecessary boundaries between health and care services.

Protecting social care services means that people in GYW will have access to social care services to which they have an entitlement under the existing eligibility criteria but we will not be constrained by eligibility. We recognise that care and support can prevent escalating needs and we are committed to ensuring care services are available when this is the most effective way to need needs, as part of an integrated system of care.

Our approach will be that we will seek over time to allocate resource to provide the best outcomes for our residents. Whilst this will reflect the statutory requirements for access to services our shared mission is to improve our services such that effective intervention and targeted support not only improve outcomes but manages demand.

Delivery Mechanisms and Risks

The CCG has a strong track record of successful delivery and financial management, together with clinical transformation. Our strong clinical leadership has been instrumental in this, building on the mature relationships already established during the time of the PCT and the Practice Based Commissioning Groups.

We have a strong in-house team of staff, including our retained clinicians, supported by the clinical expertise and input available from our CEC, the Programme Boards, and the remainder of our Governing Body, including very experienced lay members.

We also have support from North East London CSU with regards to how we formalise a strategy around IT, including ensuring that we meet our responsibilities around IT for GP practices, as well as supporting our integration strategy. We are enthusiastic about the offerings the new CSU will be able to make, and will be looking for their support and advice especially in the area of IT strategy and delivery, including GP IT.

We plan to use our current successful delivery mechanisms for ensuring throughput and delivery. This includes regular financial and performance reporting to the Governing Body, the Finance and Performance Committee and the executive team. Our approach to ensuring quality has already been set out earlier in this plan. Additionally, there is a bi-weekly workstream group that reviews progress against QIPP schemes and contracting issues. The summary spreadsheet and delivery and resources map contained at the end of this plan, will be used throughout the year to monitor the delivery of the headline initiatives and QIPP schemes. Both will be regularly reviewed by the executive team, the Finance and Performance Committee and the Governing Body.

We have a well performing emergency care system, aided by our local Urgent Care Board.

The risks to our financial forecasts are generated in the areas that are not within the control of GYWCCG, but that need to be managed to ensure financial sustainability. These include:

- commissioning arrangements with external providers - We have made allowance for tariff uplift for PBR and non-PBR activity as per national guidance. However, an increase in prevalence or demographic pressures which have not been forecast, will lead to unexpected demand and activity
- the NHS landscape. While new structures embed cost pressures may occur as commissioning responsibilities are greater defined
- high cost drugs and technology increases
- continuing Healthcare costs rising. We have seen increased demands for continuing healthcare from policy changes around criteria and as a result of the local demographic. This area of spend will need to be closely monitored to ensure that successful implementation of revised processes are in place, particularly regarding procurement initiatives
- reduction in management capacity due to national targets for running costs resulting from efficiencies and the use of the CSU would impact on the organisations' ability to achieve the savings and transformation necessary to meet statutory targets
- non delivery of QIPP
- provider cost pressures. The financial environment is challenging for commissioners and providers alike and there is a risk that providers are unable to manage the cost pressures that they are facing. GYWCCG is working closely with its providers to understand these costs pressures and put plans in place that generate efficiencies for the health system while maintaining and improving quality.

Forecasting is underpinned by realistic budget setting which is zero based for commissioning contracts and set on the previous year's outturn including any productivity saving or demand management expectations in other areas. All known risks around resource allocation have been

incorporated, along with all the national tariff adjustments. Forecasts have been fully reconciled back to the current notified resource limit.

GYWCCG has been working with local commissioners and providers in Norfolk and Suffolk to establish appropriate risk share agreements and recognise that the transformational change necessary to achieve the level of savings required needs a whole system approach. In summary, the CCG will need to take advantage of risk share agreements and make greater efficiencies to mitigate cost pressures outside of its control.

Additionally we are carefully managing our identification and mitigation of risk, with regular reports to the Governing Body in respect of financial and non-financial risk.

Risk (Current RAG Rating)	Mitigations	Five Year Strategic Two Year Operational Year One Operational
Sustainable Financing		
Continuing Care Demand and Cost Risk	All posts filled and team progressing with review of cases. Team restructured to meet needs of the service.	**2**
Medium to Long Term Capital Needs Resource Risk	Ongoing projects currently in progress risk now with medium to long term new funding. Guidance awaited from NHS England and prioritisation process underway.	**5**
High Cost Drugs - risk of overspend and loss of control and focus on transition as 70% of budget moves to NHSCB management for 13/14 onwards.	New management in JPUH pharmacy unit that will be reviewing procedures and systems to support more effective pharmacy services going forwards.	**2**
QIPP Planning and Delivery Risk 2013/14	QIPP plan to CEC and Governing Body; Monitoring via the workstream planning group and individual meetings with responsible directors; Vision/Cultural change and clinicians fully engaged in CCG development; Unidentified QIPP reduced and new and existing schemes reviewed regularly for additional savings.	**1**
Reduce Inequalities & Deliver		
CSU Risk - timeliness in development and viable finance function and delivery risk during takeover by new CSU provider.	SLA has been signed and pricing agreed. Some pressures on capability and capacity within CSU. New provider secured and transition plan underway to initiate revised provider platform delivery from 1st April 2014.	**1**
NHS England Risk – East Anglian Area Team (LAT) responsibilities for GP performance and contract monitoring	Closer working with NHS England agreed, with mandate for CCG to become more involved in Primary Care Commissioning and Primary Care Configuration.	**2**
Provider and Commissioning Risks - quality, financial, patient choice, safety and Mental Health provider restructure.	Consultation continues until 24 April 2014, concerns continue on costs and savings and implementation of service change. CEC requested Chairman and CEO of provider attend future meeting for assurance purposes in relation to concerns. CCG CEO leading informal discussions with the provider.	**All**

Risk (Current RAG Rating)	Mitigations	Five Year Strategic Two Year Operational Year One Operational
Business Continuity and Emergency Planning Risk - Lack of Clarity from NHS England on demarcation of Category 1 and Category 2 responsibilities between NHS England LAT and CCGs and resourcing post April 2013.	Memorandum of Understanding with East Anglian Area Team and SLA between Norfolk County Council and the five Norfolk and Waveney CCGs for provision of support have been signed. Business Continuity Plan has been recognised as robust. EPRR assurance of providers completed December 2013.	**2**
Risk of Compliance Breaches and Best Practice Failures	Ongoing monitoring in place with support from CSU on Information Governance and Freedom of Information. Information Governance (IG) toolkit submitted end October 2013, internal audit review with report to Audit Committee, currently at interim Accredited Save Haven status awaiting notification of remaining accreditation requirements.	**All**
Failure to operate mental health services within existing resources including IAPT.	Remains a risk - links to provider risk specifically NSFT recent announcement of their Radical Pathway Redesign Programme. Process for IAPT review and targets for 13/14 agreed.	**2**
IT Controls Risk	Copy of CSU detailed IT risk register received.	**2**
Learning disabilities (LD) Risks Financial and Inequitable Service Provision	Risk remains. Programme board in place monitoring requirements. Suffolk learning disability review progressing. Progress update expected to be reported to the Governing Body in May 2013.	**2**
Climate Change Adaptation Risk	Requirements for Sustainable Development Management Plan under review.	**5**
Key Provider (CCG Commissioning) Risk - NSFT	Service and clinical risks resulting from NSFT programme for service strategy. Consultation continues until 24 April. NSFT Interim CEO attended CEC.	**All**
Quality		
Adverse Commissioning Risk due to Lack of Control Over Improvement in Quality of National Screening Programmes	CCG monitoring via Public Health partners.	**2**

Risk (Current RAG Rating)	Mitigations	Five Year Strategic Two Year Operational Year One Operational
Policy Gap regarding Patient Transfer from Acute Trust - policy provision for rapid discharge of patients with DNACPR order 'at home to die' required. Linked to risk 30 on syringe driver protocols.	This risk is linked to the joint community and acute work re the rapid discharge home to die pathway which is nearing completion.	**1**
Infection Control Cdiff case risk: Number of cases being reported early in 2013/14 giving rise to concern of risk of breach in targets.	Incidents continue to be higher than monthly threshold. Comprehensive c diff improvement plan in place.	**2**
Risk of patient harm and systematic failure in respect of rising Cdiff infection rates	Frequent meetings between Director of Infection Prevention and Control, ECCH, JPUH and Public Health IPC leads Re-commencement of JICC - GYW system. Reporting to CEC.	**2**
Antibiotic Prescribing risk	Comprehensive C-diff improvement programme developed which is multi agency.	**2**
Make a difference for local people		
Commissioning Transition Vision Risk	Lack of coordination and accountability remains a risk through final half of transition year. Out of Hospital Strategy and Model board approved and being communicated to stakeholders effectively. Horizontal integration progressing at Shrublands Site.	**5**
Performance Risk	Monitoring meetings scheduled, Finance and Performance committee established and JPUH RTT report taken to earlier Governing Body meeting. Gradual improvement in IAPT performance demonstrated but continues to be closely monitored.	**All**
Project risks1. Delay in roll out of EMIS web2. Failure to upload patient records on Summary Care Records system3. Implementation of SBS provided ISFE Finance Ledger project	Risks tracked as part of Project risks, transition to new ISFE system complete and ongoing issues now being managed. IG toolkit submitted interim 'ASH' status sought.	**2**

Risk (Current RAG Rating)	Mitigations	Five Year Strategic Two Year Operational Year One Operational
Risks in Stroke Service Delivery	Metrics continue to improve at provider overall; Norfolk HOSC reviewing Stroke services and performance across the Norfolk and Great Yarmouth region. Joint consultant posts currently out to advert.	**2**
Integration Scope and Development and Resilience	Engagement event took place in December 2014. Five year strategy in development incorporating Integration at the centre of the CCG approach.	**2-5**
Improved Experience		
Risk of Lack of Improvement regarding Care Quality Commission (CQC) Special Review of Care Homes	System-wide 'DNR' process established, action plan in place, awaiting CQUIN reports. Sharepoint (multi agency group) meeting discuss actions on care homes and reports to PSCQ committee.	**2**
Effectiveness		
Procurement Risk - lack of resource, AQP, and procurement process not adding value where no ability to stimulate demand.	Head of Procurement appointed to CSU, discussions ongoing on resource provision. New CSU provider approved with transition plan in development to takeover from 1 April 2014.	**2**
Risk CCG does not assimilate changes required to ensure link with Public Health service relocated within Local Government.	Risk potential cost pressure for funding C-diff typing now resolved, Memorandum of Understanding has been signed and Director of Contracting reviewing performance.	**2**
Commissioning Strategy and Property Company Planning mismatch	Increasing levels of assurance regarding commissioner sign off of estates initiatives, good joint work with NHS Property Services currently in progress with capital pipeline paper taken to NHS England, Governing Body standby to undertake prioritisation process.	**5**
Local Authority Spending Pressures Impacting on Local Healthservice Provision	The CEC are monitoring the impact of the challenging financial position, which currently has the potential to impact adversely on local health service provision.	**2**
Direct Commissioning Risk - Risk of shortage of GP cover due to number of GPs approaching retirement.	Primary Care Strategy engagement underway with Primary Care Development Manager post filled and Assistant Manager role covered by interim resource. Further recruitment event for local trainees planned for early new year.	**2**

Risk (Current RAG Rating)	Mitigations	Five Year Strategic Two Year Operational Year One Operational
Complaints and PALs CSU Processing - backlog and administration issues leading to quality, litigious and reputational risk.	Significant improvement of timeliness of complaint management. Response to seven historical complaints outstanding. Director of Quality and Safety working with CSU to improve quality of responses. Fortnightly complaints tracker sent from CSU.	
Ability to process dataflows resulting in finance risk	Monitoring forms in place; S251 extensions based on Data Agreements with HSCIC; Level 2 IG toolkit submission; DSCRO procured working towards providing invoice validation; interim Accredited Safe Haven Status sought subject to finalising Data Share Agreements.	**1**
Transition Risk New Pathology Contract Implementation	Close monitoring of progress nationally underway, transition locally managed via Contract Management function to be facilitated by continued full engagement with current and new provider through the transition process. Liaising closely with practices to ensure smooth transition.	**1**

Appendix 1

Seven day services bid.

Seven day services bid.pptx

Appendix 2

Better Care Fund plans.

Norfolk BCF template 1 text FINAL v2.pdf

Norfolk BCF template 2 FINAL.xlsx

Suffolk 2014-04-04 Better Care Fund Plan

Suffolk 2014-04-04 Better Care Fund Plan

Appendix 3

Population growth.

2014-02-10 population growth.xls

Additional Supporting Evidence

JPUH – Monitoring Mortality

Monitoring Mortality 25102013.pdf

JPUH –Mortality Update

Mortality Update - November 2013 2911

West Norfolk Clinical Commissioning Group

5 year strategic, and 2 year operational plan

April 2014

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Our first year of authorisation as a Clinical Commissioning Group (CCG) has been one of significant challenge, however one that we have undoubtedly risen to.

WNCCG is founded on the principle of ensuring timely access to high quality care according to the health needs of local people. Quality has always been the key priority and the CCG has developed a reputation for uncompromising standards when assessing the quality of services, leading the way in developing local frameworks for working with providers of care. In the first year since authorisation, the CCG has accomplished a great deal, establishing the systems and processes necessary to commission local health services with an excellent team of committed, high calibre staff. The CCG is a values-based organisation with a culture of openness and transparency in which staff are encouraged to contribute at all levels and supported to develop new skills. The last year has been challenging for the CCG, with a capitation-based funding allocation that creates constraints on the affordable number of staff, resulting in roles with a very wide remit and a high workload in a new, evolving organisation. Staff have risen to this challenge, producing some excellent examples of local, clinically driven improvements in health services at the same time as managing the day-to-day operational performance.

The NHS faces an on-going challenge, having to deliver increasingly expensive health services to more people within existing funding. This creates a funding 'gap' which is increasing year-on-year. At a local level this pressure is particularly acute, as we have an increasingly ageing population and a District General Hospital in severe financial difficulty and we need to find ways to ensure services continue to be affordable and delivered locally. We have ambitious plans to achieve this, working closely with health and social partners, NHS England and Monitor (the independent regulator for hospital trusts) to design a cost effective service that provides better coordinated care for patients. Much of our plan hinges on reducing waste, duplication and delays currently experienced by people who are referred for care from various health social and voluntary organisations. We will work to improve communication with the public and involve them as co-creators of their care, and in shaping the planning and delivery of health and care services in West Norfolk.

In our work during 2013/14 we have done much to set the foundations for the next 2-5 years of health and care commissioning and service delivery in West Norfolk. Our overarching strategy and 2 year operational plan sets out our intentions for the future, and our means to deliver these.

Dr Ian Mack, Chair

Dr Sue Crossman, Chief Officer

Introduction

Document navigation

About us…summarises our geography, our Governing Body, our partnerships, our integrated pioneer status, our strategic SWOT analysis

Our achievements…describes our achievements to date against our 13/14 plan, against the 5 Quality Domains, against the CCG authorisation domains, and in response to our stakeholders

Our future…describes the challenges we face in the future, and our planned response to this, including the establishment of the West Norfolk 'Alliance', our partnership work with NHS England and Monitor to plan for the future, the methodology we used to develop our plan, our high level plan on a page and our quality ambitions for 5 years time

Our interventions…sets out our planned commissioning interventions for the coming years, covering key milestones and projected impact on quality outcomes, system characteristics and finances

Clinical quality…sets out our approach to patient safety and clinical quality

Our governance…sets out our approach to ensuring robust governance to execute our plans, including our approach to programme management, contract management, NHS constitution delivery and research and innovation

Section 1: About us

West Norfolk Clinical Commissioning Group comprises 23 GP practices, covering a population of circa 165,000 residents with a budget of circa £220 million. Apart from the small part of Breckland District Council around Swaffham that is covered by WNCCG, it is co-terminous with King's Lynn & West Norfolk Borough Council. WNCCG has a rapidly ageing population, pockets of urban and rural coastal deprivation, and a higher than average incidence of diseases, such as diabetes and respiratory conditions.

The priorities identified by WNCCG at its formation in 2013 remain relevant now, and in the future. Namely, this includes a focus on:

- **Quality** – improving the quality of services and value for money within budgetary constraints
- **Performance** – minimising variations in performance, reducing the gap in inequalities
- **Integration** – building on health and social care integration, working closely with local authorities, the voluntary sector and the local population

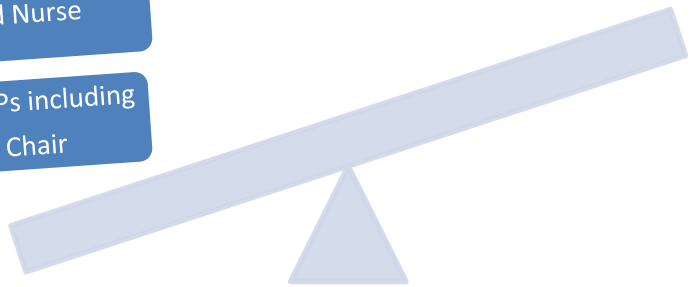
Our core focus remains delivery of optimum health and care services to our local population. Our ambition is for local patients and the wider public to be co-producers of their health and care. We have a strong emphasis on the role of local GP practices, as constituent members of our 'Council of Members', who in turn hold to account our Governing Body in discharging its duties.

Voting clinicians (10)

- Chief Officer (Nurse)
- Secondary Care Doctor
- Lead Nurse
- 7 local GPs including GP Chair

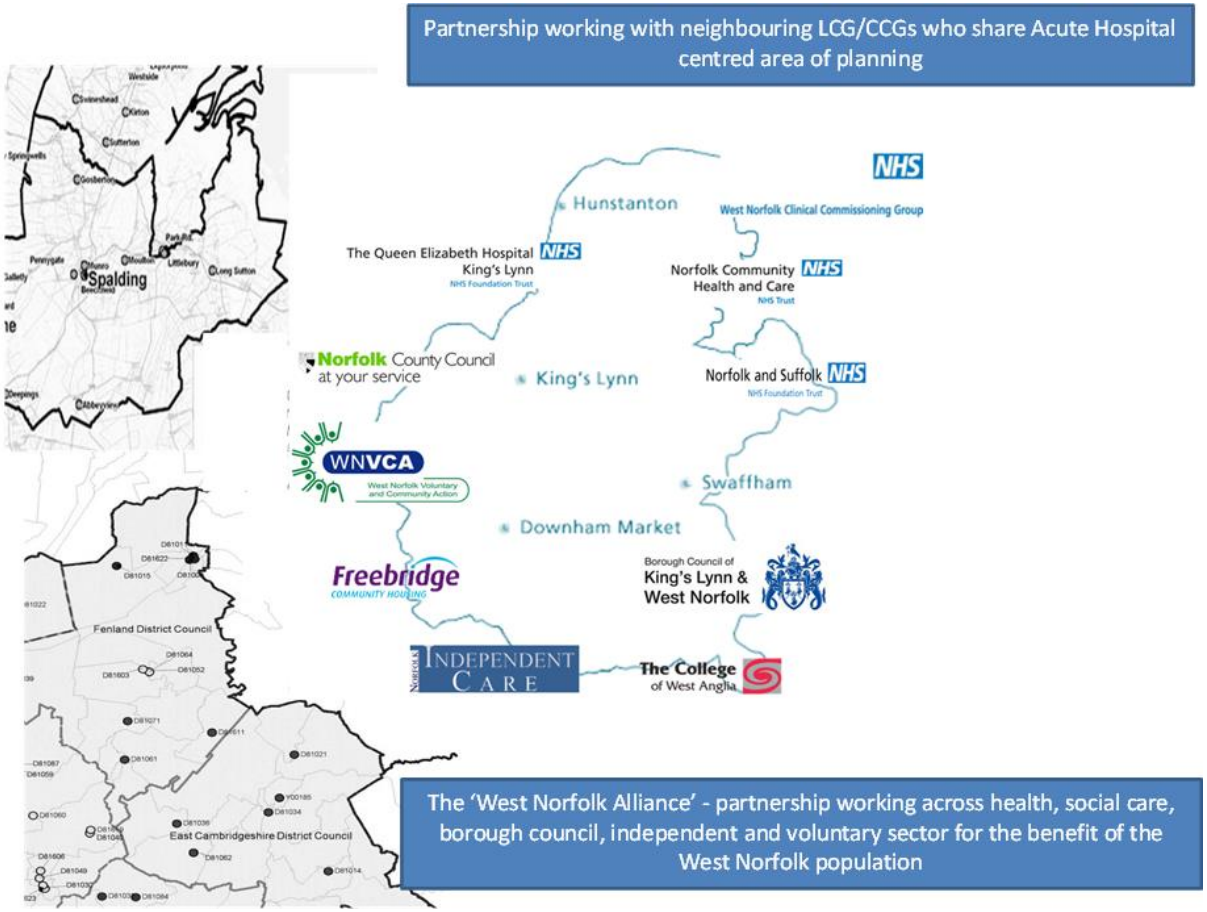
Voting non-clinicians (3)

- Chief Finance Officer
- 2 'lay' members



Our Governing Body comprises 13 voting members: Dr Ian Mack (GP Chair), Hilary De Lyon (Deputy Chair and Lay Member – Audit), Dr Sue Crossman (Chief Officer), John Ingham (Chief Finance Officer), Professor Paul Jenkins (Secondary Care Doctor), Dr Imran Ahmed (GP), Dr Palluvi Devupali (GP), Dr Paul Williams (GP), Dr Julian Brown (GP), Dr Mark Funnell (GP), Dr Tony Burgess (GP), Penny Sutton (Lay Member), Sue Hayter (Lead Nurse)

Our Governing Body composition is predominantly made up of clinicians, reflective of our core value to enshrine clinicians at the heart of commissioning for the West Norfolk population.

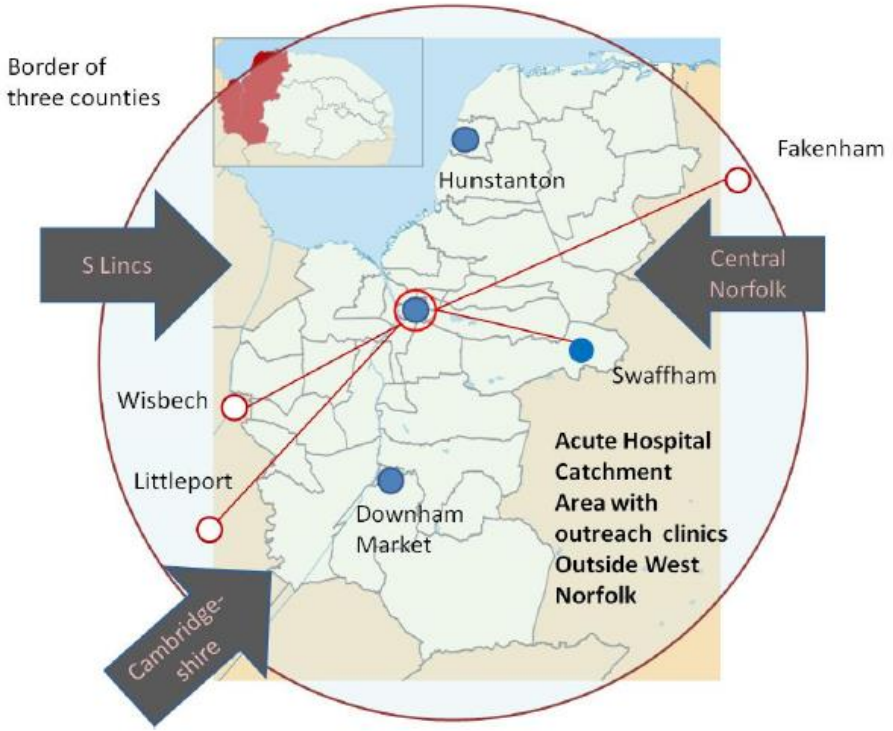


In an increasingly challenging financial climate, with growing health and care needs, changing demography and rightly growing public expectation we believe we can only deliver optimum care locally through partnership with others. We have a strong track record of collaboration with a range of partners to deliver optimum health and care services for the population of West Norfolk, hence our strapline 'Leading the way through partnership working'.

We also have a track record of working in partnership with neighbouring Local Commissioning Groups (LCGs) or CCGs; for example the cross Norfolk Collaborative Commissioning Agreement and the arrangements with Cambridgeshire and Lincolnshire CCGs for commissioning from the QEHKL, or for wider regional CCGs for the commissioning of Ambulance services. Our relationship with Norfolk County Council includes the Public Health team, Adult Social Care and Children's services.

We have also developed strong, embedded working partnerships through an 'Alliance' with a range of health and care providers from the voluntary, statutory and independent sector across the West of Norfolk. Our desire to foster these strong links is predicated on the belief that there are many factors which determine the health and wellbeing of our local population, and via partnership working we can best harness opportunities to deliver improved outcomes.

West Norfolk is a distinct healthcare economy and system with a single Clinical Commissioning Group coterminous with Kings Lynn Borough Council. At its centre is The Queen Elizabeth Hospital, King's Lynn, which serves the West Norfolk CCG area and some populations from neighbouring Cambridgeshire, Lincolnshire and Central Norfolk (which equates to approximately 30% of the QEHKL's income). This is depicted to the right:



Health and care system partners already have a legacy of working together to deliver integration and partnership working. This includes:

- An integrated commissioning team, comprising West Norfolk CCG and Norfolk County Council West commissioning locality team
- Joint health and social care leadership of operational teams via integrated management posts
- Dedicated Norfolk County Council (NCC) Public Health staff co-located with WNCCG
- Community health and social care teams operating from three integrated locality hubs
- 'Prevention first' partnership between health, social care and voluntary sector, district and county councils to target prevention initiatives to maintain the health and wellbeing of the older population
- System wide CQUIN initiatives that have targeted the avoidance of emergency admissions to hospital

In view of the above legacy, West Norfolk partners submitted a bid and was awarded 'Integrated Pioneer Status'; one of 14 health systems nationally who have been recognised as forerunners in leading integration in health and social care.

STRENGTHS	WEAKNESSES
• WNCCG track record of delivery of commissioning initiatives and leading momentum for change • Strong and embedded partnership working with County, Borough Council, neighbouring CCGs and other stakeholders • Forerunner in leading integration of services with partners • Strong underlying financial position of WNCCG in year 1 • Embedded clinical engagement in decision making • Highly committed workforce	• Current performance on key standards unacceptable (RTT, R1 response) • Financial deficit faced in year, and future years at QEHKL • Quality concerns regarding provision of care at QEHKL in line with CQC inspection and improvement plan • Size of WNCCG, and capacity to effect change given running cost constraints
OPPORTUNITIES	**THREATS**
• Leadership of the 'Alliance' programme provides an opportunity to shape local service delivery in an innovative and integrated form • Partner collaboration – neighbouring CCGs commitment to work collaboratively to pool resources and align commissioning intentions where mutually beneficial • Better Care Fund offering opportunity to pool resources with County Council to improve care for the frail and elderly • Emergence of GP federation and collaborative models to deliver new ways of working at scale • £5 per head funding offering opportunity to engage primary care in enhancing service provision for the over 75s	• QEHKL future viability, and potential of Monitor escalation to more formal intervention which may in turn constrain WNCCG ability to shape service configuration • Impact of further budget pressures in local authority 'compounds' financial pressures in health sector • Continued requirements on providers year on year to deliver further efficiencies via 'CIP' programmes is becoming increasingly difficult to achieve without impacting on quality of care, and requires a radically different approach to achievement

To support the development of our Strategic, and Operational plan, we have undertaken a SWOT analysis.

This depicts those areas we believe constitute our current strengths and weaknesses, highlighting areas to build upon, and take remedial improvement action.

Our strategy is designed to exploit those strategic opportunities that exist, and to manage or mitigate strategic threats.

Our management of our strategy, and our related 'weaknesses' and 'threats' is encompassed in our Governing Body Assurance Framework, monitored monthly via our Governing Body, and Audit Committee sub-committee.

Section 2: Our achievements to date

13/14 Plan on a page

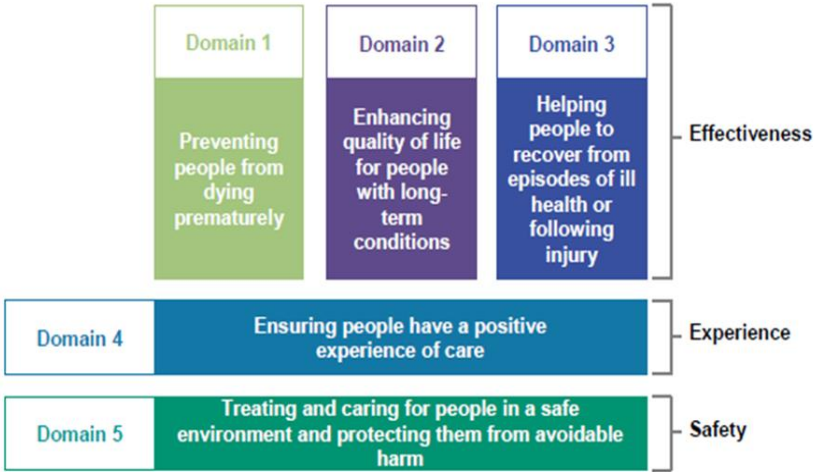
Health and Wellbeing	Strategic Priorities	Commissioning Themes	Objective	2013/14 Achievements	RAG status
Lifestyle factors • Alcohol • Smoking • Physical • Activity • Obesity **Life expectancy** **Diabetes** **Coronary heart disease** **High frail/ older population** **Dementia** **Emergency admissions for** • COPD • CHD • Ambulatory care sensitive conditions	**Quality** Improve the quality of services and value for money within the existing CCG budget **Performance** Minimise variations in performance and reduce the gap in inequalities **Integration** Build further on integration between health and social care, working closely with local authorities, the voluntary sector and the local population	**End of Life** NHS Outcomes Framework - 2,4,5	• Improve end of life care choices for patients • Improve co-ordination of community and specialist services • Improve quality of training throughout the health system on end of life care.	• Facilitating over 65% people to die in their PPOC • Award of MacMillan Innovation funding to progress strategy, education and community provision, including Hospice at Home	
		Urgent Care NHS Outcomes Framework - 2, 3, 4	• Ensure a whole system approach is adopted to deliver and actively manage patient pathway developments across health and social care service providers through the 1% CQUIN Initiatives - *next day consultant clinics, expansion of the rapid assessment team, joint assessment team, and routine review of frequent attender's* • Increase availability of community beds within West Norfolk • Enhance the delivery of the Acute GP service.	• Whole system approach to urgent care delivery has achieved EMA and A&E Attend rate below 12/13 outturn and 14% reduction in excess bed days saving £0.2million • Additional Winter monies investment in community capacity • Evolution of Acute GP service to Ambulatory Emergency Care model	
		Reducing Unwarranted Variation in Care NHS Outcomes Framework - 1, 2, 3, 4	Optimise pathways to align with best practice whilst reducing activity to national and cluster levels. • Digestive system disorders • Cardiology • Ophthalmology • Urology and • Ambulatory care sensitive conditions (ACSC).	• Pathway reviews completed for all identified specialties, and improvements implemented to enhance quality and activity levels, contributing to 2% reduction in elective planned admissions • Establishment of AEC model to enhance provision for patients with ACSC, and to reduce unnecessary long term admission to hospital	
		Long Term Conditions NHS Outcomes Framework - 1, 2, 3, 4, 5	• Increase community capacity and capability to manage the increase in demand for Continuing Health Care (CHC) • Continue development of Community Matron service • Improved patient self management of long term conditions. • Enable the delivery of best practice pathway for Stroke – Efforts focused on community rehab and early supported discharge	• Enhanced CHC capacity to support delivery • Community Matron continuation complemented via running of 'Virtual Ward' additional capacity • Comparatively good stroke performance	
		Mental Health NHS Outcomes Framework - 2, 4, 5	• Review and develop the Dementia care pathway • Enhance the deliver of the Memory service • Improve access to IAPT and Wellbeing service • Enhance community mental health support for adults and those with long term conditions.	• Establishment of enhanced Dementia pathways and Dementia Intensive Support service • Establishment of Mental Health Liaison service at A&E, with Mental Health Acute and Voluntary Sector providers • Improved access to IAPT and Wellbeing service	
		Prescribing NHS Outcomes Framework - 1, 2	• Optimise wastage initiatives • Facilitate QIPP prescribing initiatives in general practice in high cost areas such as stoma, diabetes, respiratory and pain • Deliver an effective General Practice Prescribing Incentive Scheme • Support community matron and specialist nurse medication reviews.	• QIPP prescribing initiatives intervention, delivering a saving of circa £900k for 2013/14 • Early implementation of 'Eclipse Live' IT prescribing solution	
		Prevention NHS Outcomes Framework - 1, 2	• Enable practice members to deliver Lifestyle Referral Pathway, for patients needing to make behavioral changes in healthy eating, physical activity • Improve the capabilities and capacity at general practice to optimise cardiac care.	• Lifestyle referral pathways established, and improved outcomes for patients in making healthy lifestyle behavioural changes	

WNCCG achievement against NHS Outcomes Framework: 5 Quality Domains

As an expectation of quality standards required, NHS England published the NHS Outcomes Framework. This Framework articulated 5 'Domains'; quality outcomes directly attributable to service effectiveness, patient experience and safety.

These 'Domains' were a key part of WNCCG's plan for 2013/14, and were articulated on the 2013/14 'Plan on a Page'.

The following section articulates WNCCG current performance against the 5 quality domains, linking performance to commissioning interventions that have been put in place.

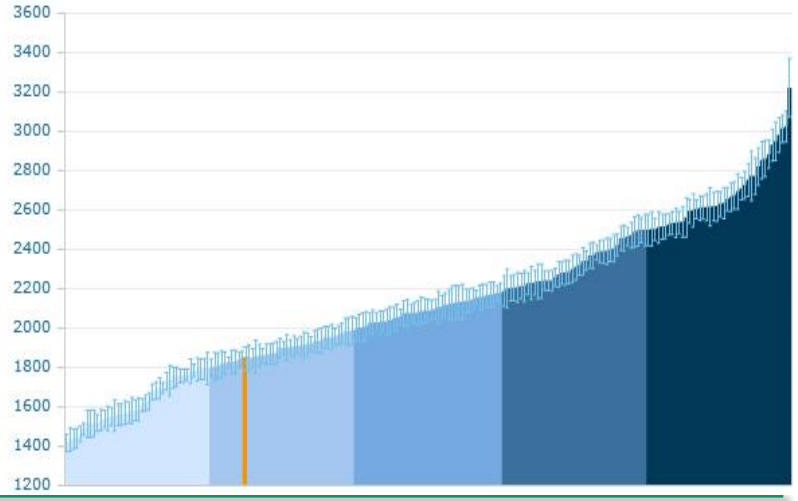


Quality Domain 1: Ensuring additional years of life for people with treatable mental and physical health conditions

The chart adjacent shows WNCCG's performance for potential years of life lost to causes considered amenable to timely and effective healthcare. WNCCG's position is indicated in orange.

Nationally, WNCCG performs better than the majority of CCGs in England; within East Anglia WNCCG sits in the middle of the range.

Given the demographics outlined above this is generally satisfactory and may be partially attributed to the good quality of primary care services in West Norfolk, along with community initiatives such as Intra Venous Antibiotics and Osteoporosis scanning providing early access to diagnosis and treatment.

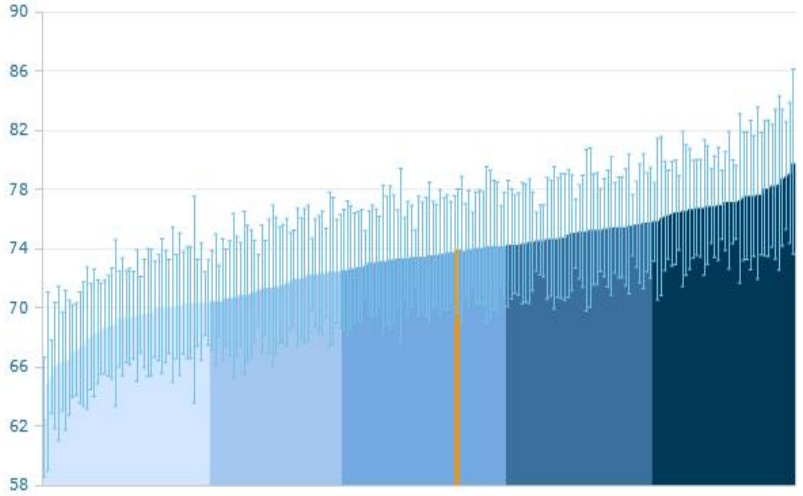


Quality Domain 2: Improving health-related quality of life for people with Long Term Conditions, including Mental Health

Health related quality of life for people with long term conditions is measured through the EQ-5D survey; a higher value is desirable on this indicator. WNCCG's position both nationally and within the area team's CCGs is shown in the adjacent chart, indicated by the orange bar.

The CCG falls in the middle quintile nationally, and locally appears to be one of the poorer performing CCGs in the region. However, the wide confidence intervals means this is uncertain.

West Norfolk has a higher than average prevalence of long term conditions, and with the ageing demographic profile, an increasing number of people will have 3 or more conditions. Living with co-morbidities has a significant impact on quality of life.

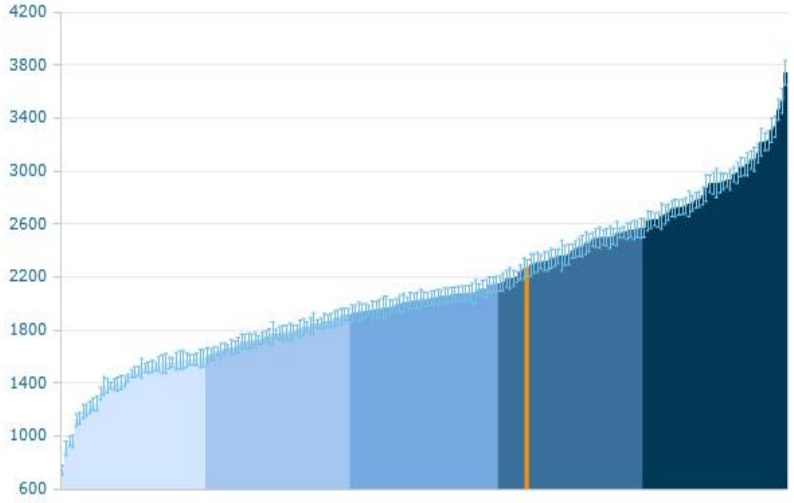


Quality Domain 3: Reducing the amount of time people spend in hospital by having better, more integrated care in the community

The chart adjacent shows the rate of avoidable emergency admissions, which includes a composite of all emergency admissions considered avoidable. This shows that at a national level WNCCG (orange bar) is performing significantly worse than the majority of CCGs in England. Compared to the other CCGs in the East Anglia Area Team, it also has the highest rate of avoidable emergency admissions.

The position reflects the high levels of health needs, as regards people with long term conditions and indicates the need for continued work on the model of care for ACS and children's urgent care.

Much of the focus in the West Norfolk 'Alliance' centres on achieving better integrated care in the community, using patient, carer and practitioner experience. The 'Alliance' has goals that will impact on this indicator.



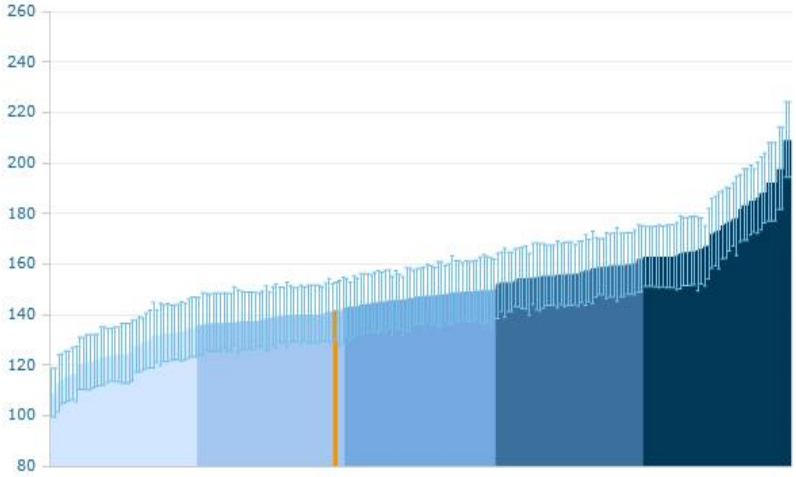
Our achievements

Quality domains (4, 5)

Quality Domain 4: Increasing the number of people with physical and mental health conditions who have a positive experience of hospital care

West Norfolk CCG is in the second to worst quintile for patients reporting that they had a poor experience of healthcare in the inpatient survey, as highlighted by the orange bar in the chart below. This outcome is less favourable when compared within the region.

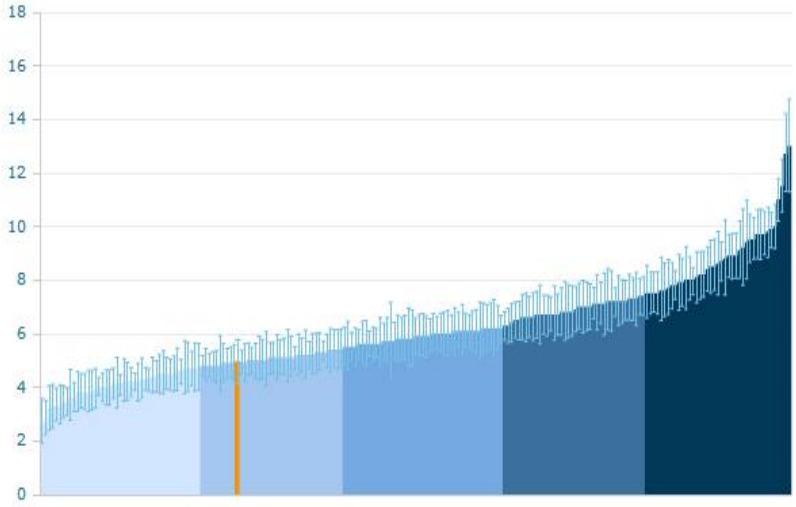
This may reflect the issues surrounding the local DGH. Achieving a sustainable model for local acute care is central to the CCG's planning, as is robust quality monitoring of patient experience via provider contracts.



Quality Domain 5: Increasing the number of people with a positive experience of care outside of hospital, in General Practice and in the community

Questions from the GP Patient Survey are used to assess patients' experience of care outside of hospital, WNCCG's performance is indicated by the orange bar in the chart adjacent. WNCCG compares favourably both when viewed nationally, and to the other CCGs in the East Anglian local area team, as illustrated.

This reflects the substantial investment in recent years in person-centred community services, such as the community matrons, falls team and Hospice at Home, all based around general practice.



Our achievements

Authorisation domain achievements

A strong clinical and multi-professional focus which brings real added value	•Clinically led Governing Body, with a wide range of clinical representation and leadership responsibilities •Strong representation of constituent practices via Council of members •Robust quality monitoring enshrined in every contract
Meaningful engagement with patients, carers and their communities	•Stakeholder engagement strategy developed •Stakeholder engagement events held, influencing future commissioning decisions •Focus on patient and carer involvement for each provider
Clear and credible plans which continue to deliver the QIPP challenge within financial resources, in line with national and local requirements	•Projected successful attainment of QIPP plan financial saving of circa £7.6m for 2013/14 •Effective delivery of key QIPP schemes linked to quality improvement, for example medicines management •Effective plans led to improvement in A&E delivery
Proper constitutional governance arrangements, with the capacity and capability to deliver all CCG duties and responsibilites, including financial control	•Robust arrangements in place to ensure statutory compliance with requirements (e.g. evidenced by Internal Audit) •Effective in year utilisation of full spectrum of commissioning cycle activities
Collaborative arrangements for commissioning with other CCGs, local authorities, NHS England and commissioning support bodies	•Collaboration with Cambs and Lincs CCGs relating to QEHKL commissioning and urgent care delivery •Joint working with Norfolk County Council and Kings Lynn and WN Borough Council to jointly commission services for local people
Great leaders who individually, and collectively can make a real difference	•Evidence of a broad spectrum of clinical and managerial professional roles across the Governing Body and Senior Management Team. •Effective system wide leadership of 'Alliance' programme and financial stewardship

As part of the CCG authorisation process WNCCG's performance was assessed against the 6 domains.

During 2013/14 the CCG continued to develop its commissioning approach, and has further evidence of in year development against each domain.

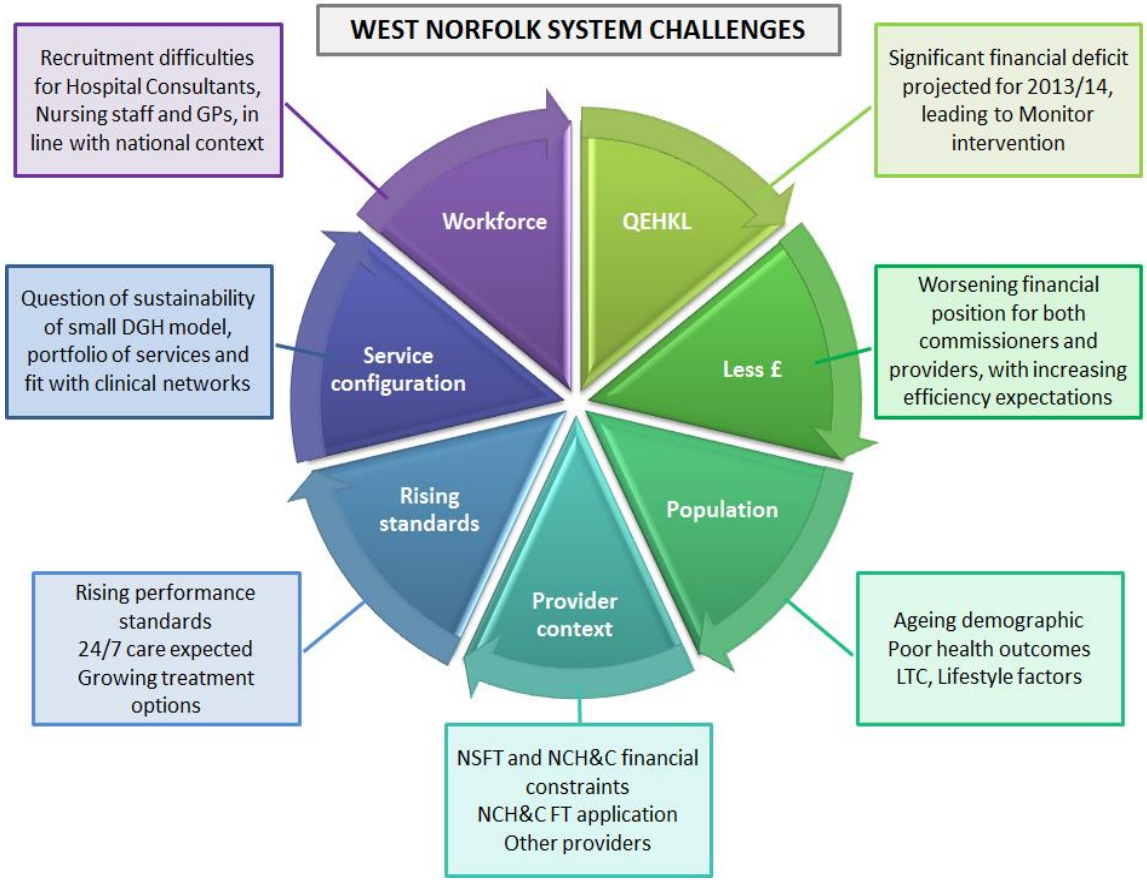
Our achievements

'You said, we did'

Of utmost importance to us is our ability to listen to patients and the public, and translate that feedback into the way in which we commission and monitor health and care services.

Early in 2013/14 we held a number of stakeholder events to seek stakeholder feedback to inform future commissioning. Key points of feedback are listed here, with detail of the WNCCG response to this feedback.

Section 3: Our future



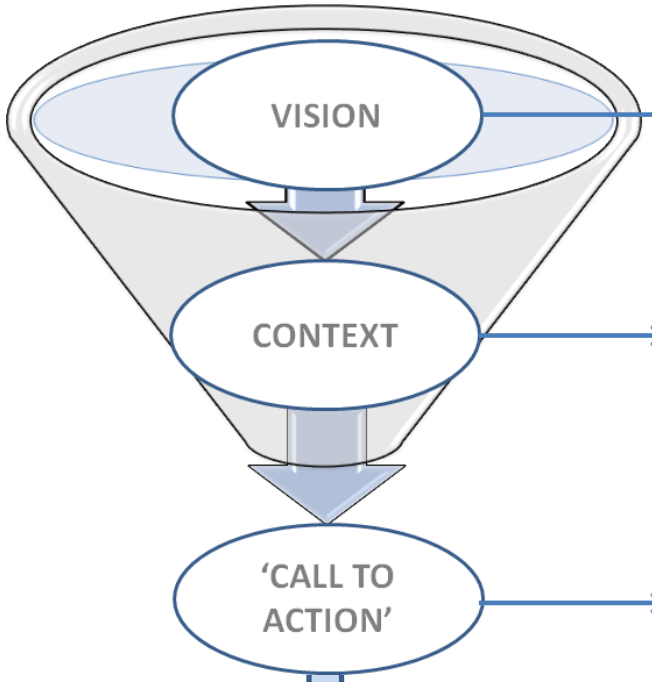
The West of Norfolk system faces many challenges now, and in the future that are faced nationally, and articulated in NHS England's 'Call to Action' (2013).

However, there are a number of factors which have served to expedite these issues, and have created a 'Case for Change'. These factors are illustrated to the left.

Particular financial difficulties faced by the local Acute hospital, QEHKL, a small DGH provider in a rural geography has initiated Monitor intervention.

Long term, this situation will be further exacerbated by an ageing demography, with higher prevalence of chronic disease and pockets of deprivation.

The converging West Norfolk system challenge



Vision ('Pull' factors)
- Strong system wide leadership and desire to drive integration and innovation in West Norfolk
- Compelling vision for future integration and partnership working
- Commissioner innovation

System context ('Push' factors)
- QEHKL finances
- Financial challenge across system
- Demography and health outcomes
- Provider context
- Rising standards and expectations
- Service configuration challenge
- Workforce challenge

Call to action
- Monitor/LAT intervention requires immediate action
- 'Do nothing' may lead to system failure

In July 2013 the above 'Call to Action' was presented to local West Norfolk system partners; health and care commissioners and providers. All parties committed to engage in an 'Alliance' to serve the needs of West Norfolk. The purpose of the West Norfolk Alliance is to provide governance and strategic oversight of all collaborative projects, protect and promote the interests of local patients and service users at all times, explore opportunities to maximise the efficient use of public resources collectively, provide the opportunity to design innovative solutions to shared problems, thereby enhancing patient and user experience. A Memorandum of Understanding, designed to underpin this arrangement has been agreed.

Following review of the 'Call to Action' all partners agreed to support us in the initiation of the 'Alliance' 'System Sustainability' programme to safeguard sustained and optimum service delivery to best meet the needs of our West Norfolk population. This programme was initiated by us, to lead proactive intervention to shape the future of health and care delivery in West Norfolk, rather than wait for system pressures to converge further leading to more formal 'crisis' intervention at a later point in time.

Monitor

Sector Regulator of NHS

Organisational Leadership

"ensure NHS payment system rewards quality and efficiency",

"make sure choice and competition operate in the best interests of patients",

"make sure essential NHS services continue if a provider gets into difficulty"

"make sure public sector providers are well led so that they can provide high quality care to local communities"

NHS England

High Quality Care for All

Strive for Improvement

"bring about change in every part of the NHS to continuously improve quality",

"create the culture and conditions for health and care services and staff to deliver the highest standards of care",

"empower patient, clinical and professional leadership at every level of the NHS"

"lead strategy, research and innovation for outcomes and growth"

WNCCG

Whole System Approach

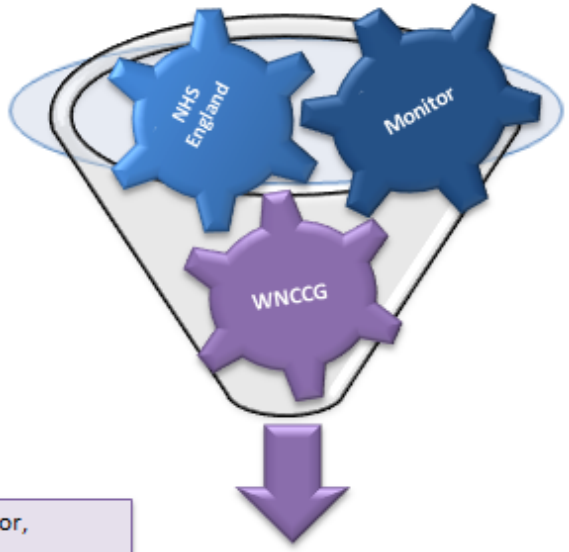
Partnership – W Norfolk Alliance

"Commissioning integrated services for the patient population in order to improve the quality of care with best possible outcomes for patients within resource allocation",

"Improving the health and wellbeing of the people of West Norfolk",

"Preventing disease and premature death"
"Decreasing hospital admissions for long term conditions",

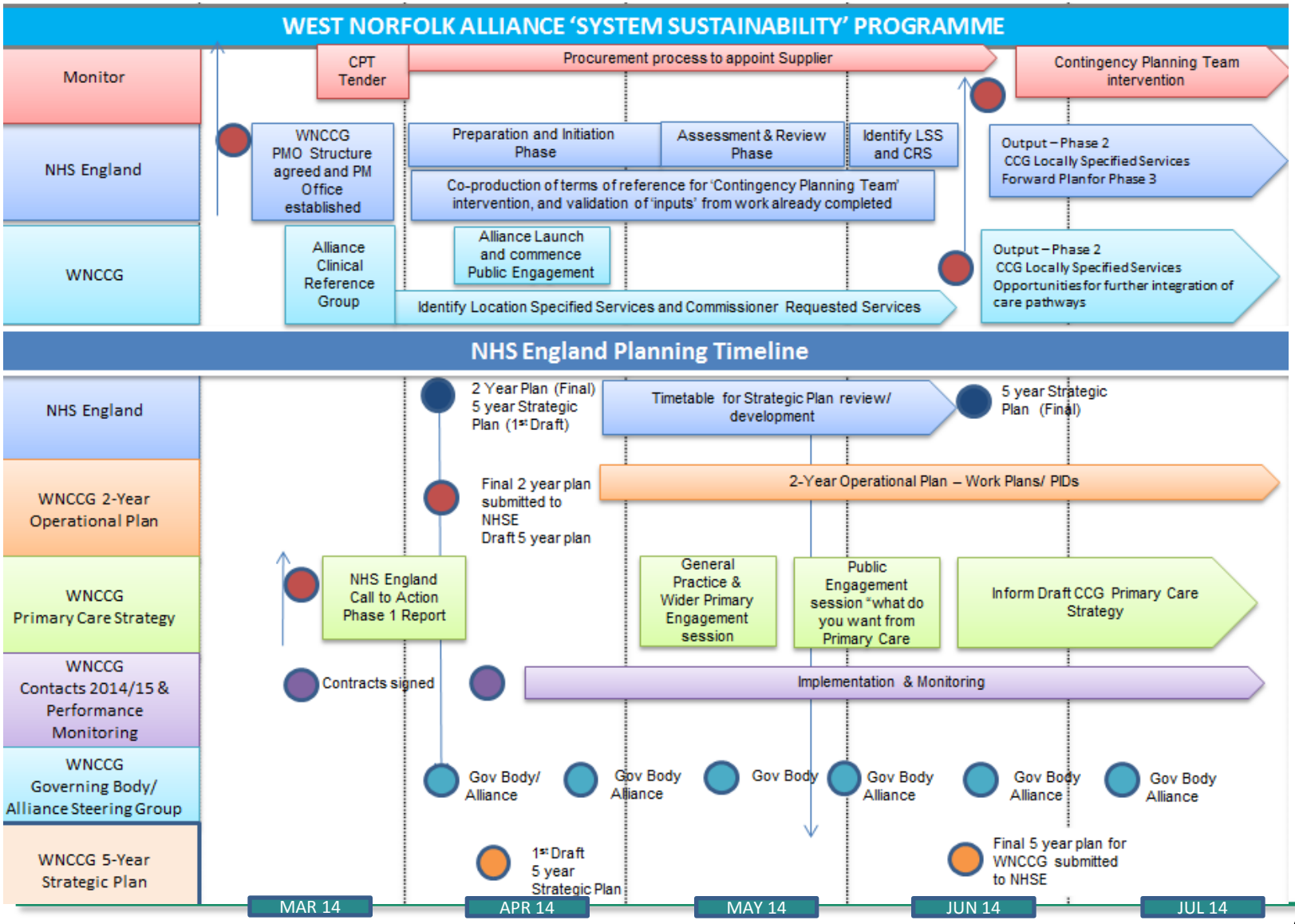
West Norfolk CCG are working with partners from NHS England and Monitor to adopt an innovative approach to intervention where a provider Trust is in failure. This is based on the premise of collaborative, whole system redesign focussed on configuring a solution for the whole health economy.



- WNCCG Responsible for the Commissioner-Led Sustainability Programme Phase 2, reporting to NHS England/ Monitor,
- West Norfolk Alliance provides the strategic oversight and direction to ensure all stakeholders are fully engaged and supporting project deliverables for Phase 2,

Aligned Strategic Direction Locally Led

Our future ‘Alliance’ programme and 5 yr plan



The chart to the left illustrates the alignment between the West Norfolk ‘Alliance’ system sustainability programme, focussed on ensuring long term sustainability for West Norfolk acute care, and ‘fit’ with the 2 and 5 year planning timetable.

A key early product of the ‘Alliance’ work will be the articulation of ‘Locally Specified Services’ for acute care provision. These will be determined by clinically lead discussions, considering factors such as demography, clinical networks, workforce, regional acute provision and national guidance. This will feed into Monitor’s Contingency Planning Team intervention at QEHKL, planned for Summer 2014 and will inform WNCCG 5 year planning for future system configuration.

Clinical Reference Group – Defining local services

WNCCG CRS	Clinical Reference Group Tasks	Timeline	Product
Preparation Phase	• CRG Fortnightly meetings, members confirmed • Task and finish Pathway Groups confirmed • Identify external input • Agree ground rules • Produce reading and information pack	Early April 14	• Agreed TOR and Frame of reference • Pathway leads identified • Reference Documents shared
Initiation Phase	• Learning from other System Reconfigurations • Consider Public Health data plus travel times, Clinical Networks • Agree principles, framework for critical analysis of services, e.g. "vertical Integration" vs. "Horizontal" service delivery , critical tests etc	Complete by End April 14	• Shared baseline of Population challenges • Information Pack • Opportunities for extended clinical networks • Capacity Risk assessment
Assessment Phase	• Shaping pathways "from patient presentation to stability/resolution" • Testing against framework questions • Workforce implications • Opportunities for integration with Partners • Common themes and what needs to change • Opportunities for technology & innovation	Complete by end May 14	• Weekly Stocktake progress report flagging risks and gaps • Opportunities shared with work-streams for service integration, workforce, technology and innovation • Recommendations to CRG
Review Phase	• Identify potential benefits, cost efficiency, quality implications and contracting options • Expert Opinion to challenge local thinking • Compare Findings with other systems – validation • Public Involvement event	End June 14	• Option Appraisal • Benefits Realisation • Risks and mitigation • Communication & Engagement Plan
Refresh Update Phase	• Refine model • Review Evidence and Recommendations • Produce report on local services to CCG	Early July 14	• Recommendation to CCG to inform report for NHS England & Monitor (CPT) on local services

The chart to the left illustrates the key deliverables from the 'Clinical Reference Group' that has been established to underpin the process WNCCG will lead to define local services, (and Commissioner Requested Services – CRS) as a precursor to the planned Monitor CPT intervention.

At WNCCG we asked our team what we stand for, here's what they said…

Our future

Redesigning care in West Norfolk

"Working together to improve and protect health and wellbeing in West Norfolk"

VALUES

Integration and partnership working

Commissioning fit for purpose, sustainable health and care services

Services tailored to the individual, whoever provides them

High quality, cost effective care

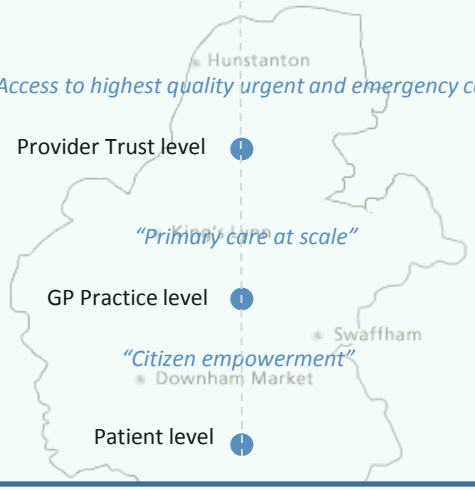
SYSTEM CONFIGURATION

"Specialised services concentrated in centres of excellence"

Regional level

"A step change in the productivity of elective care"

System level



"Access to highest quality urgent and emergency care"

Provider Trust level

"Primary care at scale"

GP Practice level

"Citizen empowerment"

Patient level

"Integrated model of care"

Integrated patient pathways

Patient pathways, service model configuration and regional networks to be shaped by West Norfolk 'Alliance' programme

OUTCOMES

Securing additional years of life for people with treatable mental and physical conditions

Increase health quality of life for people with Long Term Conditions including Mental Health

Reducing time spent avoidably in hospital via integrated service provision

Increase the proportion of older people living independently

Increase the number of people who have a positive experience of acute hospital care

Increase the number of mental and physical health conditions who have positive experience of GP and community care

Eliminating avoidable deaths in hospital

Enabling transformation through innovation in technology, infrastructure, workforce, information sharing, contracting and payment mechanisms

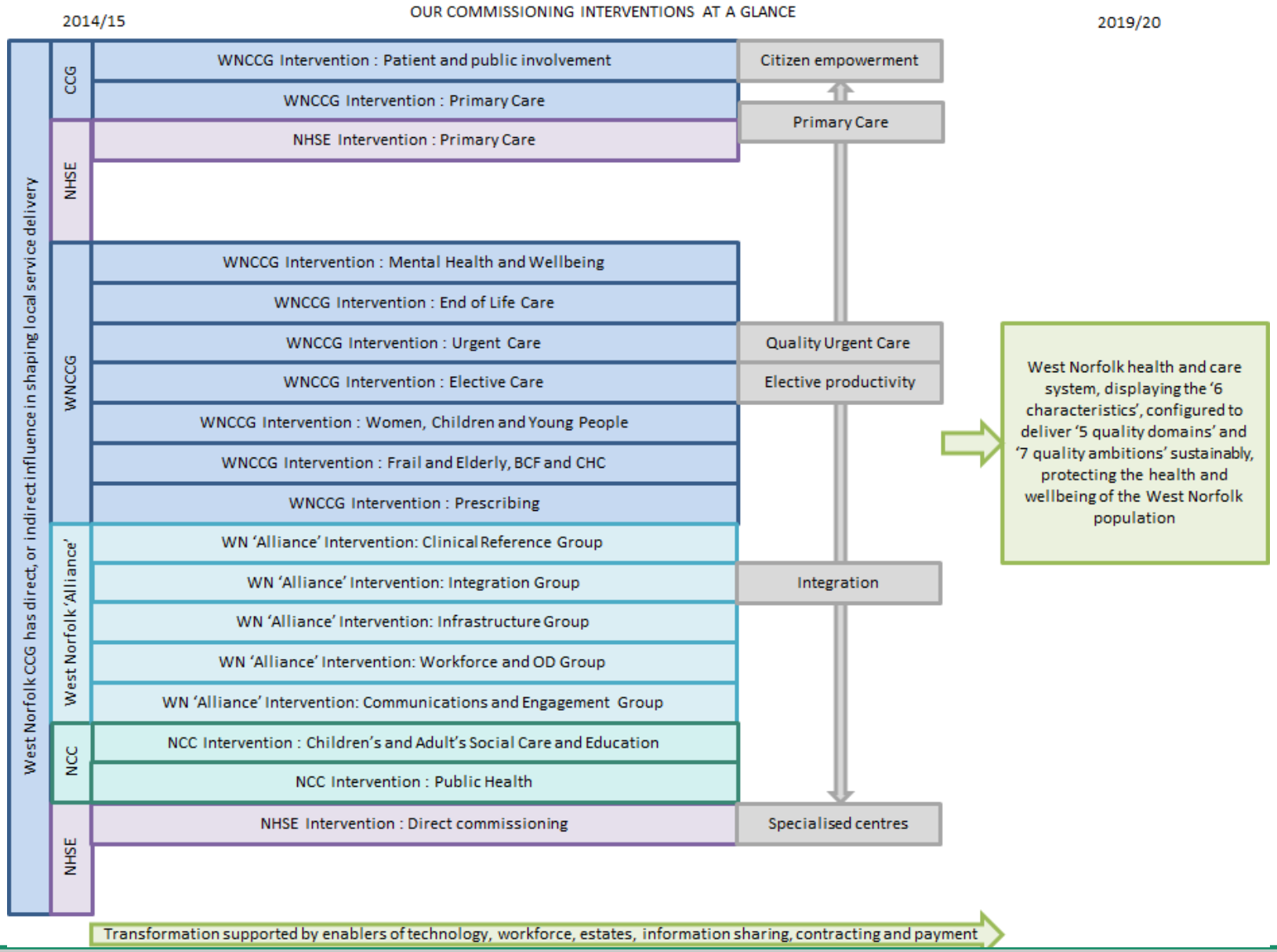
Our future

Developing our plan

'Scope and engage'	•CCG planning lead appointed with responsibility for leadership of a programme of work to deliver 5yr plan •Multidisciplinary working group convened •West Norfolk 'Alliance' partners engaged
Data analysis (our 'West Quest' exercise)	•A variety of data sources and tools were utilised, including Commissioning For Value data pack, CCG outcomes tool, previous JSNA and public health analytics. These were triangulated statistically to draw evidenced themes
Identify opportunities and challenges from the analysis	•Comparison of WNCCG performance alongside 'like' CCGs for rurality and demography, and also for 'like' sole acute provider systems •Utilisation of 'Levels of Ambition' Atlas to identify opportunities
Horizon scanning the future	•Data modelling for projections in future demography and demand for services to determine 'do nothing' scenario •Inclusion of stakeholder events feedback to identify 'what good looks like' •Preparatory work
Generating solutions	•Identification of HIIs and EAIs within 'Anytown' guidance, which mirror current, and have informed future commissioning interventions •Further solution generation within 'Alliance' programme
Exploring the detail	•WNCCG 5 year outcome projections set in line with planned commissioning interventions •Commissioning intervention project plans developed to underpin delivery
Modelling and projecting	•Utilisation of 'Anytown' resource pack and national evidence base to inform modelling impact (activity, finance and quality) of each commissioning intervention
Sense checking and pacing	•Project documentation for each intervention includes a 'stop/go' point, accounting for feasibility and likelihood of delivery and other associated risks •PMO approach to pacing implementation and ensuring delivery
Peer review and stretch	•Early NHSE feedback incorporated in V2; further feedback to be incorporated from NHSE and West Norfolk 'Alliance' partners

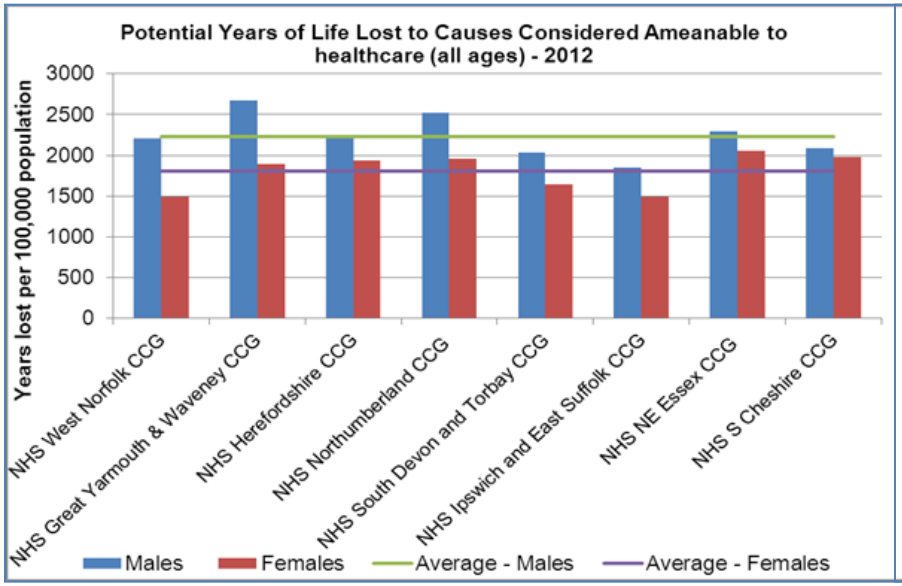
The methodology for development of WNCCG 2, and 5 year plans has been informed by NHSE's 'Setting Quality Ambitions' guidance (2013).

This methodology is depicted here, with further commentary on WNCCG work undertaken.

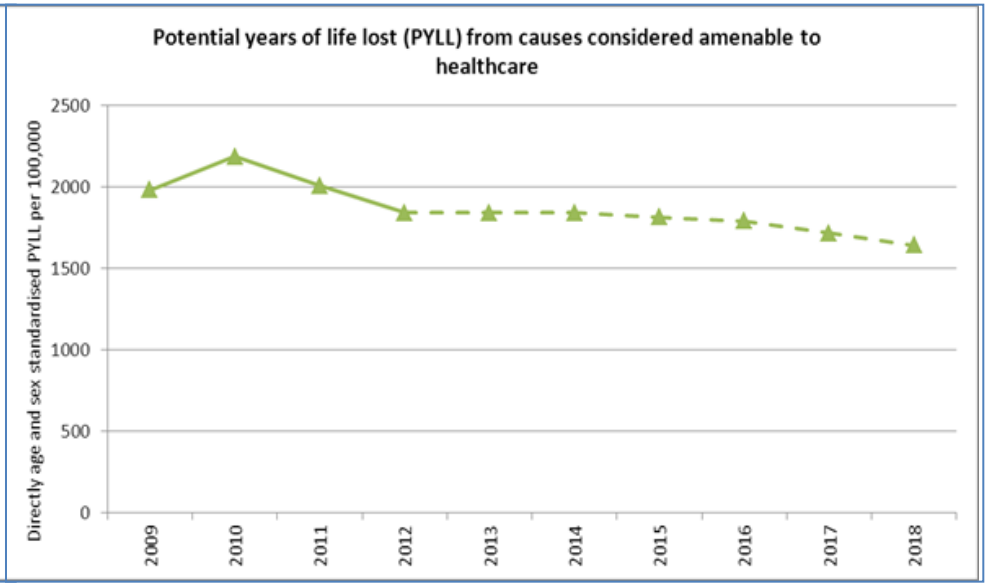

OUR COMMISSIONING INTERVENTIONS AT A GLANCE
2014/15
2019/20
West Norfolk CCG has direct, or indirect influence in shaping local service delivery
CCG
NHSE
WNCCG
West Norfolk 'Alliance'
NCC
NHSE
WNCCG Intervention : Patient and public involvement
WNCCG Intervention : Primary Care
NHSE Intervention : Primary Care
WNCCG Intervention : Mental Health and Wellbeing
WNCCG Intervention : End of Life Care
WNCCG Intervention : Urgent Care
WNCCG Intervention : Elective Care
WNCCG Intervention : Women, Children and Young People
WNCCG Intervention : Frail and Elderly, BCF and CHC
WNCCG Intervention : Prescribing
WN 'Alliance' Intervention: Clinical Reference Group
WN 'Alliance' Intervention: Integration Group
WN 'Alliance' Intervention: Infrastructure Group
WN 'Alliance' Intervention: Workforce and OD Group
WN 'Alliance' Intervention: Communications and Engagement Group
NCC Intervention : Children's and Adult's Social Care and Education
NCC Intervention : Public Health
NHSE Intervention : Direct commissioning
Citizen empowerment
Primary Care
Quality Urgent Care
Elective productivity
Integration
Specialised centres
West Norfolk health and care system, displaying the '6 characteristics', configured to deliver '5 quality domains' and '7 quality ambitions' sustainably, protecting the health and wellbeing of the West Norfolk population
Transformation supported by enablers of technology, workforce, estates, information sharing, contracting and payment

Ambition 1: Securing additional years of life for the people of England with treatable mental and physical health conditions

Measure: Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people, (NHS OF 1a i&ii)



Potential Years of Life Loss to causes considered amenable to healthcare for WNCCG and CCGs with a similar demographic and provider profile. Source: HSCIC.



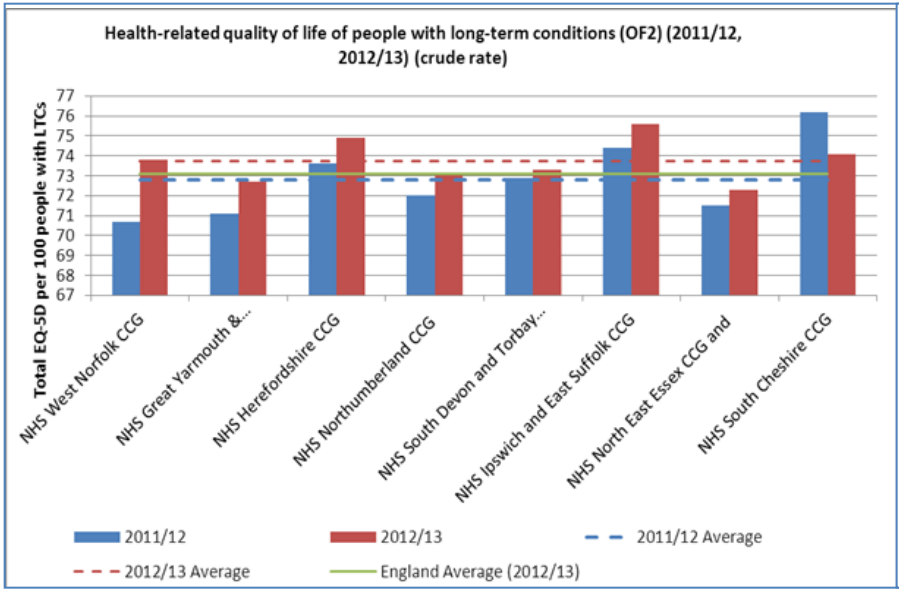
Target trend for potential years of life lost for WNCCG (all persons), 2009-2018. Source: HSCIC, projection (dotted line) provided by Norfolk County Council, Public Health

The above figure shows the comparison of the cluster CCGs against the average PYLL per 100,000 population for males and females, against the benchmarking set average. The baseline for WNCCG is positive with a lower than average value for both males and females. The level for females is particularly favourable. However, the exercise shows that the gap between males and females is larger than in most of the other CCGs. Consideration will therefore be given to targeting male health in future commissioning interventions to narrow this gender gap.

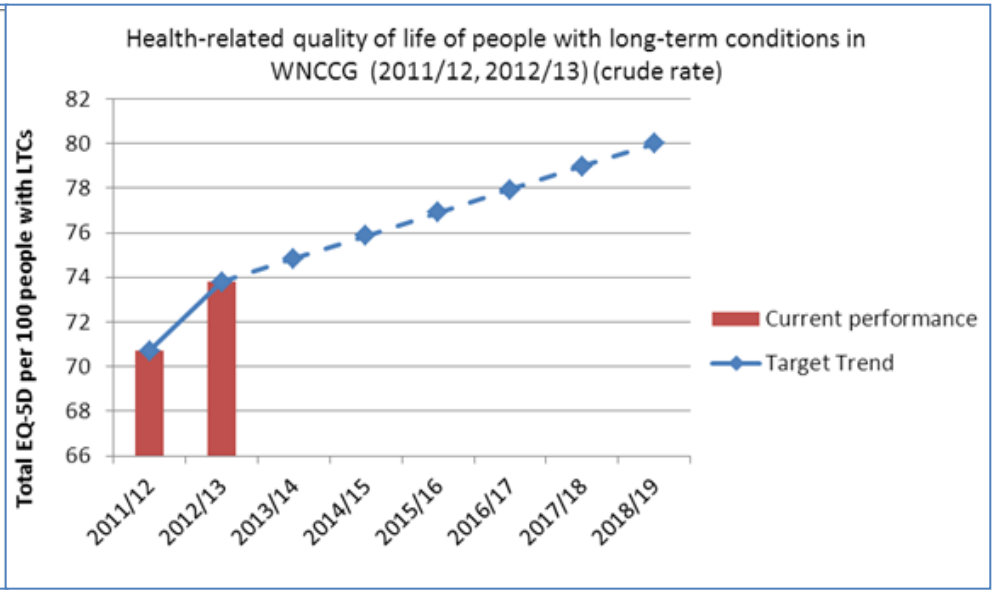
The above figure maps the available data for the last four years and the trajectory set (dashed line). Work will continue to reduce the PYLL to causes considered amenable to healthcare, maintaining the projected 2013 level through to 2014, and aiming for a gradual decline over subsequent years. Preventing people from dying prematurely is a priority for WNCCG, however, given the current and projected population profile with a predominance of older people, the level of ambition is fairly moderate. Also it is recognised that much of the planned prevention work addressing lifestyle issues has a delayed effect on mortality statistics.

Ambition 2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions

Measure: Enhancing quality of life for people with long-term conditions – Health-related quality of life for people with long-term conditions (NHS OF 2)



Health related quality of life of people with long-term conditions (crude rate, 2011/12 and 2012/13). The comparator CCGs are compared to the England and group averages. Source: GP Patient Survey



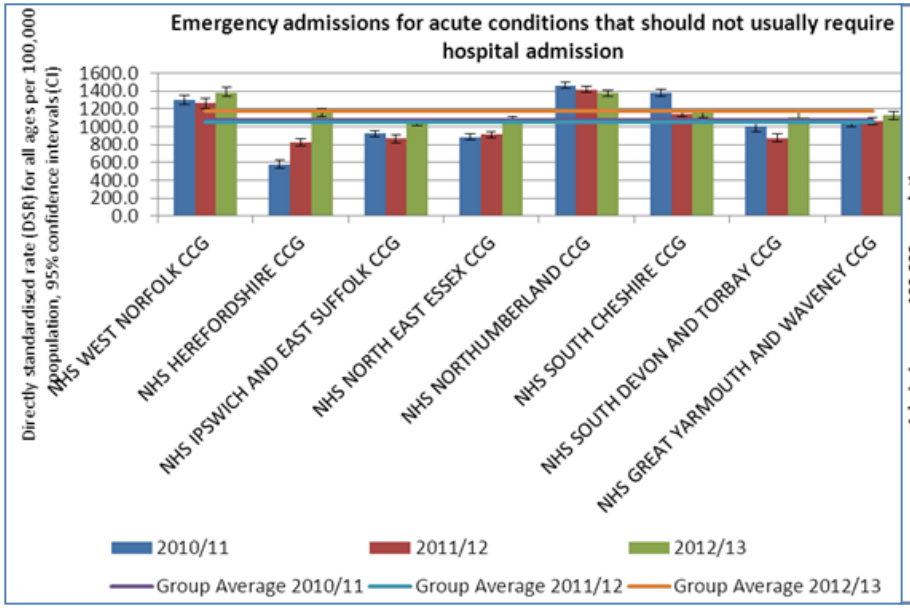
Health-related quality of life of people in WNCCG with long-term conditions, as measured by EQ-5D. Projected target is to the level of the best quintile nationally in 2012/13.

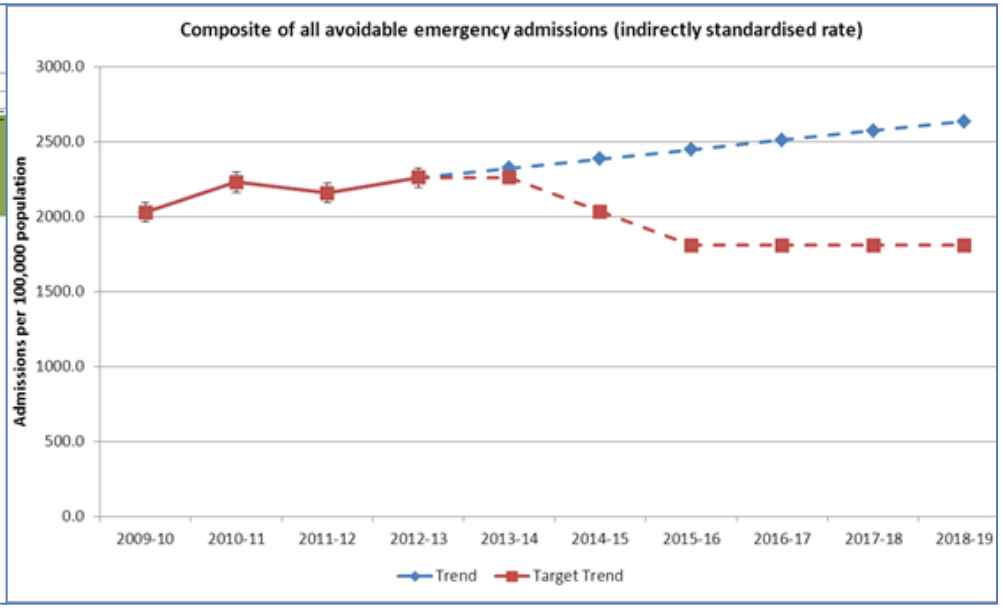
The above figure shows the total EQ-5D per 100 people with long term conditions for the benchmarking set, as well as the group and England averages for 2011/12 and 2012/13. WNCCG had a similar crude rate to the England average in 2012/13, which was a considerable improvement on the previous year's data. A number of initiatives may have impacted upon this, however it is difficult to analyse precisely the basis of this change. Also with only two years data it is too early to conclude that these figures indicate a clear trend. Currently WNCCG sits in the middle quintile nationally, however, given the local population profile plus feedback from local involvement work, the improved management of long term conditions is a key issue for WNCCG. This ambition is therefore set at a fairly high level, i.e. to reach the current level of the national top quintile CCGs. This will be supported by work on the pathways for ambulatory care sensitive conditions and on dementia.

Our future > Our quality ambitions

Ambition 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

Measure: A composite measure of avoidable emergency admissions



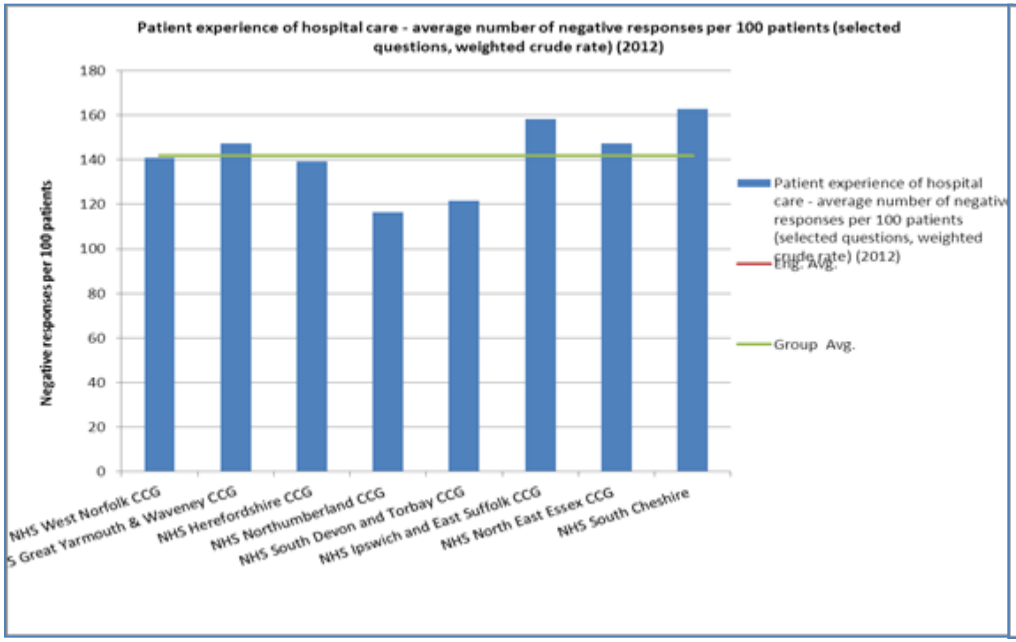


Emergency admissions for acute conditions that should not usually require hospital admissions for the comparator CCGs showing the group averages for the 3 years. Source: HSCIC.

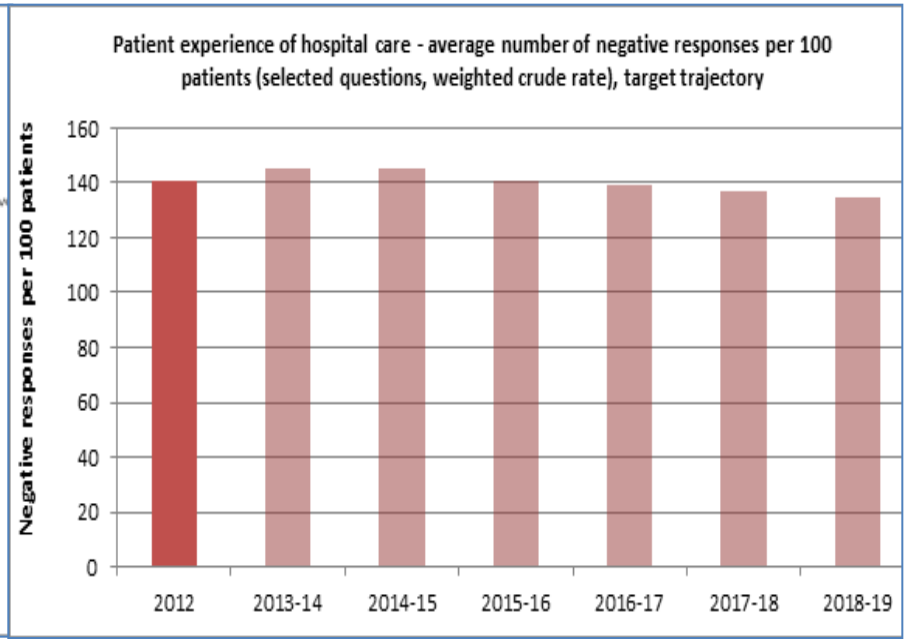
Composite of all avoidable emergency admissions (indirectly standardised rate). The blue dashed line follows the trend based on the previous 4 years of data. The red dashed line indicates the WNCCG target to 2018/19.

The trajectory for this composite avoidable admissions ambition has therefore been set at 10% for years one and two, with the aim of maintaining this progress in the three subsequent years. The rational for the trajectory levelling out is the anticipated impact of the forecast demographic growth in older age groups. Without continued action this could lead to a further rise in the rate of urgent care admissions.

Ambition 5: Increasing the number of people having a positive experience of hospital care



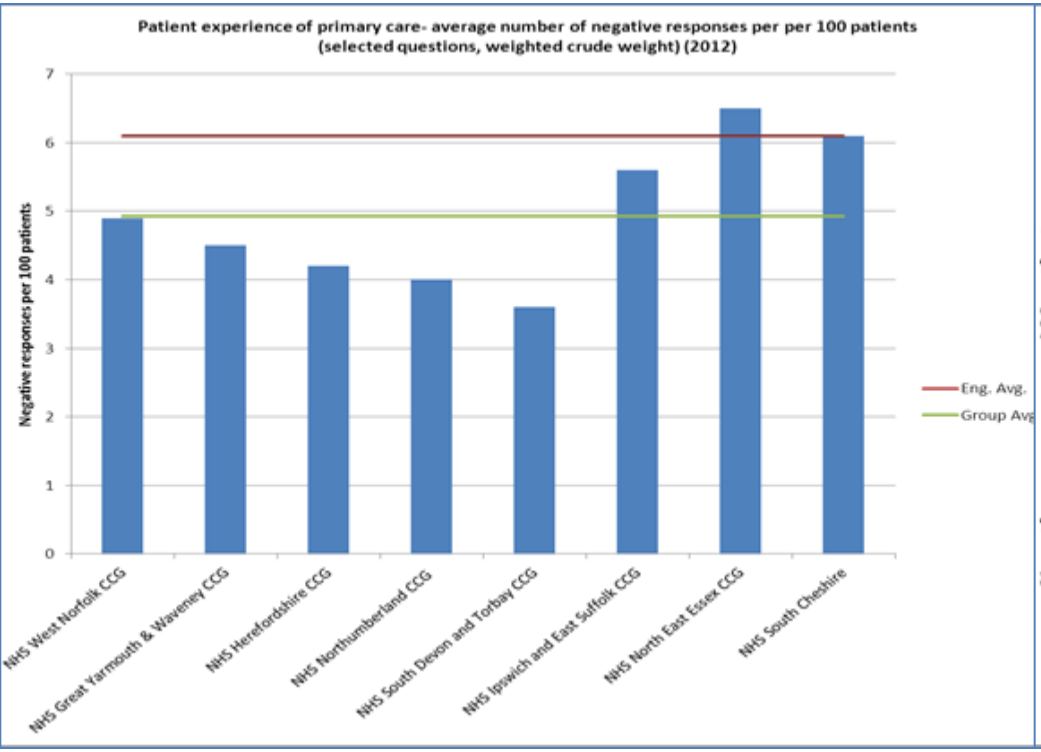
Patient experience of hospital care for cluster CCGs (2012). Source: Inpatient Survey. Patient experience of hospital care for cluster CCGs (2012). Source: Inpatient Survey.



Patient experience of hospital care, planned trajectory (lighter red). Source: Inpatient Survey

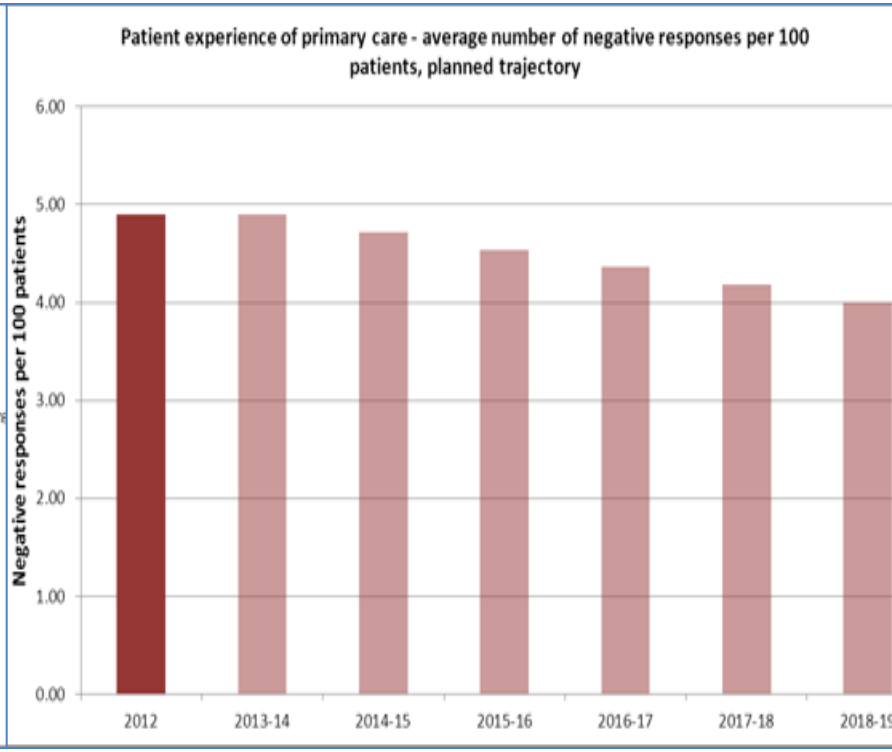
The figure above left shows how WNCCG compares on patient experience of hospital care, as measured by the inpatient survey. WNCCG has fewer negative responses per 100 patients than the group average. This is positive, however in the context of the Strategic Plan, there is a risk that steps necessary to ensure the sustainability of local services in the long term may result in a shift towards the average inpatient satisfaction scores in the short term. This is therefore reflected in the trajectory for this ambition, shown in the figure above right

Ambition 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community



Patient experience of primary care for cluster CCGs (2012). Source: GPPS

The figure above left shows how WNCCG compares to the comparator CCGs. WNCCG has fewer negative responses per 100 patients than the group and England average, and is already in the second lowest (best) quintile nationally for this indicator.



Patient experience of primary care - planned trajectory (lighter red). Source GPPS.

Given the already strong position for GP services and the impact of the procurement for Out of Hours, WNCCG anticipates that a positive working relationships within the Unit of Planning should support a steady reduction in negative responses and the trajectory is therefore set to reach the current level of the best performing CCG quintile over the five year period (as shown in the figure below).

Note: Ambitions 4 and 7 indicators and analysis remain in development nationally, and at county level

Section 4: Our planned commissioning interventions

Commissioning intervention: Mental Health and Wellbeing

WNCCG demography	WNCCG current performance
WNCCG has a higher number than England average for hospital stays for those self-harming (271 per 100,000 for 2011/12 against an England average of 207) WNCCG has a higher number than England average for hospital stays for those with alcohol related harm (2269 per 100,000 for 2011/12 against an England average of 1895) WNCCG has the second highest population of people over 65 of any CCG in England and the present fourth lowest rate of dementia diagnosis out of 211 CCGs	Improving Access to Psychological Therapies (IAPT) access in 2013/14 for those with relevant mental health needs of 6.5% against target of 13%. The trajectory for 2014/15 is 15%. Current dementia diagnosis rate circa 35-40%
Relevant guidance and strategies	**WNCCG current service initiatives**
'No Health Without Mental Health' DoH ''A Call to Action: Achieving Parity of Esteem; transformative ideas for commissioners' NHS England, 2013	Mental Health Liaison Service commissioned for 2013/14 winter period for patients presenting at A&E who have reached crisis Dementia Intensive Support Team (DIST) established during 2013/14 to provide integrated community care, and to offset the impact of Service provision/current initiatives - Main provider CIP and service redesign issues - Quarterly clinical dialogue meeting - Annual conference and workshops with stakeholders - Mental Health Liaison trial over Winter period, statutory and third sector collaboration - Early testing of TSS and bed requirements for elderly and adults – subject to CQN and ongoing dialogue - Dementia a local priority for 2013/14

Commissioning intervention: Mental Health and Wellbeing → Our deliverables → Parity of esteem

To deliver parity of esteem in planning, securing and monitoring health and care services

Parity of esteem

Measured via audit to evaluate evidence of parity of esteem 'characteristics', service user and carer feedback, improved performance rates (e.g. IAPT access, recovery rate, Dementia diagnosis rate), and ultimately improved health and wellbeing outcomes

Planning services

Planning the commissioning of mental health services in an integrated, and informed way, considering the provider marketplace and aligning health and wellbeing objectives

- WNCCG 2 and 5 year plans developed via integrated review of physical and mental health needs (Apr 2014)
- Planned Norfolk mental health dementia needs assessment will consider physical health needs (Aug 2014)
- Market analysis of current Mental Health service providers offering to contribute to 2 and 5 year plans (Apr 2014)
- West Norfolk Health and Wellbeing strategy, aligns mental and physical health intentions, with quality outcomes, and Partners from borough council and wider public and voluntary sector objectives

Securing services

Commissioning services that are evidence based, informed via stakeholders including users and carers, and allocating resources an in integrated and effective way

- Designing services that are evidence based as effective interventions, e.g. implementation of the Mental Health Liaison service and enhanced Dementia Care service (both 'High Impact Interventions)
- Historic and forthcoming stakeholder events (Apr 2014) to inform future mental health and wellbeing commissioning
- Exploration of innovative partnership contracting models, for example 'Alliance' contracting, as part of WN Alliance programme (Mar 2016)
- Utilisation of pooled budgets, including the Better Care Fund 2014/15 to improve mental health commissioning, in particular Dementia Care (Mar 2016)

Monitoring services

Monitoring services robustly to ensure improved patient outcomes

- Service evaluation of MH Liaison provision over Winter 2013/14 (Apr 2014) to inform future service delivery
- 2014/15 contracts do, and 2015/16 will contain KPIs aligned across providers to support parity of esteem, for example Smoking Cessation service specifications in place requiring targeting of Smoking population with mental health needs, IAPT specification requiring monitoring of MUS

Adapted from NHS England: Commissioning for parity of esteem, 2013

Commissioning intervention: Mental Health and Wellbeing → Our deliverables → IAPT

To support improved mental health and wellbeing via improved IAPT access and recovery rates, and a re-procured IAPT service

IAPT

Measured via IAPT access and recovery rates, successful re-procurement and service evaluation, service user and carer feedback

Increasing access to IAPT services

A joint programme of work between NSFT and commissioners, at CCG locality level, initially until end Q1 2014 to drive improvement to 15% during 2014/15.
Monthly review of access via local CQRM meetings

- Increasing referral numbers from GPs, with targeted intervention scheduled to develop individual GP practice remedial action plans (Mar 2014)
- Develop direct referral pathways embedded within 111 and Police, with direct booking into service workshops available as an option (Mar 2014)
- Review demography, and develop WNCCG migrant population improvement plan, with review of efficacy in April 2014
- Assertive follow up system implemented for those who have made initial contact, but not engaged further with the IAPT service (Apr 2014)
- Development of Norfolk wide 'taster' sessions, and of working in partnership with other agencies to extend access to the service (Apr 2014)
- Develop taster sessions for specific target populations, and review delivery methods with 3rd sector agencies (Apr 2014)
- Review the impact of the above, and develop further remedial actions as necessary (May 2014)

Increasing recovery conversion

Ensuring continued delivery of IAPT recovery conversion rate

- Review April 2014 delivery against IAPT 50% conversion to recovery standard (May 2014)
- Review any additional national guidance on application of recovery target (End Jun 2014)

IAPT re-procurement

Ensuring continued delivery of IAPT recovery conversion rate

- CCG development of IAPT service specification (End Jun 2014)
- ITT issued (Jul 2014)
- Contract signed with new provider (Oct 2014)
- New service mobilised (Apr 2015)
- Monthly performance monitoring of new service provision (Apr 2015 onwards)

Commissioning intervention: Mental Health and Wellbeing → **Our deliverables** → **Adult acute care**

Ensuring appropriate, timely care for adults with mental health needs

Adult acute care

Measured via jointly support TSS implementation plan, KPIs for Mental Health Liaison service (A&E mental health breaches), audit of appropriateness of referrals

Trust service strategy review

Ensuring implementation of clinically appropriate service models to ensure long term financial and clinical sustainability

- Continue review with NSFT of TSS programme; modelling future demand needs against projected bed and community capacity requirements. This will culminate in a joint implementation plan with the Trust, to ensure appropriate clinical engagement and public consultation in future service provision (End June 2014)
- Implementation of necessary consultation for service change (Jul 2014 -)

Mental Health Liaison service

Establishment of Mental Health Liaison service at QEHKL A&E

- Service model and funding agreed with NSFT for Mental Health Liaison model (Apr 2014)
- Consolidation of existing team to full staffing complement (End Jun 2014)
- Commencement of training programme for QEHKL staff (Jul 2014)
- Evaluation and review of 1st quarter of full running (End Sep 2014), prior to 'Winter' period

Access and Assessment access

Improvement to timely referrer access to NSFT services according to clinical need and priority

- Continue joint work with NSFT to ensure implementation of remedial actions to improve access to 'AAT', and achievement of contractual response times (Apr 2014 onwards)
- Review efficacy of remedial plan on a monthly basis, seeking referrer feedback and adjusting remedial actions as required (Apr 2014 onwards)

GP referrer education

GP education on mental health referral and treatment pathways

- Continue bi-monthly clinical dialogue meetings between NSFT and GP clinicians to maintain info sharing, education and joint dialogue (Apr 2014)
- Targeted GP education sessions, approximately bi-monthly, the first of which is on dementia (Apr 2014)

PBR cluster implementation

Further implementation with NSFT of PBR clusters to enhance clinical and currency understanding

- Joint working with NSFT throughout 2014/15 to progress the implementation of PBR clusters (Apr 2014 onwards)

Commissioning intervention: Mental Health and Wellbeing → Our deliverables → Dementia

Ensuring timely access, referral and treatment for those with dementia

Dementia

Measured via Dementia diagnosis rates, referral to specialist service volumes, service user and carer feedback

Dementia as local priority, BCF

Dementia as a key priority for WNCCG given local prevalence, current performance and future population projections

- Norfolk Public Health 'Dementia Needs Assessment' published Aug 2014, the findings from which will be used to support future dementia commissioning
- Implementation of 'Primary Care support worker' function; implementation plan will be developed in line with delivery of the 'Gnosall approach' and corresponding actions below as part of the Better Care Fund

Training and awareness raising

Training and education programme to support increased dementia training, education and GP awareness

- SPECAL clinical visit to Burford Hospital to explore the model in practice (May 2014)
- Review of SPECAL implementation plan for W Norfolk (Jun 2014)
- GP 'dementia from diagnosis to death' event (Apr 2014)
- Gnosall approach – NSFT GP survey on Gnosall implementation (by end Jun 2014)
- Gnosall approach – development of Gnosall implementation plan (by end Aug 2014)

Trust service strategy review

Review of TSS programme service redesign for elderly patients with mental health needs, including the Dementia Intensive Support Team

- Review Trust evaluation of DIST model implementation and bed reductions (Apr 2014)
- Continue review with NSFT of TSS programme; modelling future demand needs against projected bed and community capacity requirements. This will culminate in a joint implementation plan with the Trust, to ensure appropriate clinical engagement and public consultation in future service provision (End June 2014)
- Implementation of necessary consultation for service change (Jul 2014 -)

KEY DELIVERABLES	5 Outcome Domains					7 Outcome Ambitions							6 system characteristics					
	1	2	3	4	5	1	2	3	4	5	6	7	1	2	3	4	5	6
Parity of esteem: Planning services	■	■	■	■	■	■	■				■	■	■		■			
Parity of esteem: Securing services	■	■	■	■	■	■	■				■	■	■		■			
Parity of esteem: Monitoring services	■	■	■	■	■	■	■				■	■	■		■			
IAPT: Improving Access		■		■		■	■											
IAPT: Increasing Recovery conversion rate		■	■	■		■	■				■							
IAPT: Re-procurement		■	■	■		■	■				■							
Adult MH: TSS review																		
Adult MH: Mental Health Liaison			■			■	■	■			■				■	■		
Adult MH: Improving Access and Assessment				■							■							
Adult MH: GP referrer education																		
Adult MH: PBR cluster implementation																		
Dementia: A local priority		■													■			
Dementia: Training and awareness raising		■				■	■	■			■							
Dementia: TSS review																		

Commissioning intervention: End of Life care

WNCCG demography	WNCCG current performance
Estimated future need for palliative care is about the same over the next five years and increasing over the longer term due to an ageing population. By 2025 it is estimated there will be an additional 130 deaths with palliative care need each year QoF Cancer prevalence for WNCCG 2.2%, against national average of 1.6% On average 490 people are diagnosed with cancer each year, with higher rates among women than men	Cancer deaths at home (elderly demography) – trend indicates gradual increase to circa 42% in 2012 (NCC) Marie Curie EoL Atlas, 2010/11 for West Norfolk - 42% of bereaved relatives rated the overall quality of care as excellent or outstanding - 40% of bereaved relatives rated coordinated care as very good - 42% of bereaved relatives agreed that pain relief in the last 2 days of life was excellent - 47% of bereaved relatives felt well supported during the last 3 months of life Audit – the numbers dying at their PPOC Numbers dying in hospital in last 'x' days Cancer admissions – WNCCG average is 50 per 1000 people
Relevant guidance and strategies	**WNCCG current service initiatives**
NICE – Guidance for Commissioners on End of Life Care for Adults, Dec 2011	Current service provision – acute centric model Local priority for 2013/14 Hospice at Home model End of life beds Macmillan programme

Commissioning intervention: Cancer and End of Life care → Our deliverables → Cancer - TCCC

Implementing 'Transforming Cancer Care in the Community', supporting those living with Cancer, and their families to receive the support they need

Cancer - TCCC

Measured via reduced avoidable emergency admissions for cancer related conditions, reduced length of stay and follow up, service user and carer feedback

Service delivery

Delivery of TCCC pilot; 3 nurses and 2 support workers linked to 8 GP practices clustered around Kings Lynn, Swaffham and coastal areas

- Primary Care Cancer Nurse (PCCN)/Cancer Support Worker (CSW) model in place and fully operational (Apr 2014)
- Patient group promotion of whole pathway approach to ensure Health and Social Care integration (ongoing)
- 30 practice nurses trained on Primary Care Practice Nurse course (by end Aug 2015)

Monitoring and evaluation

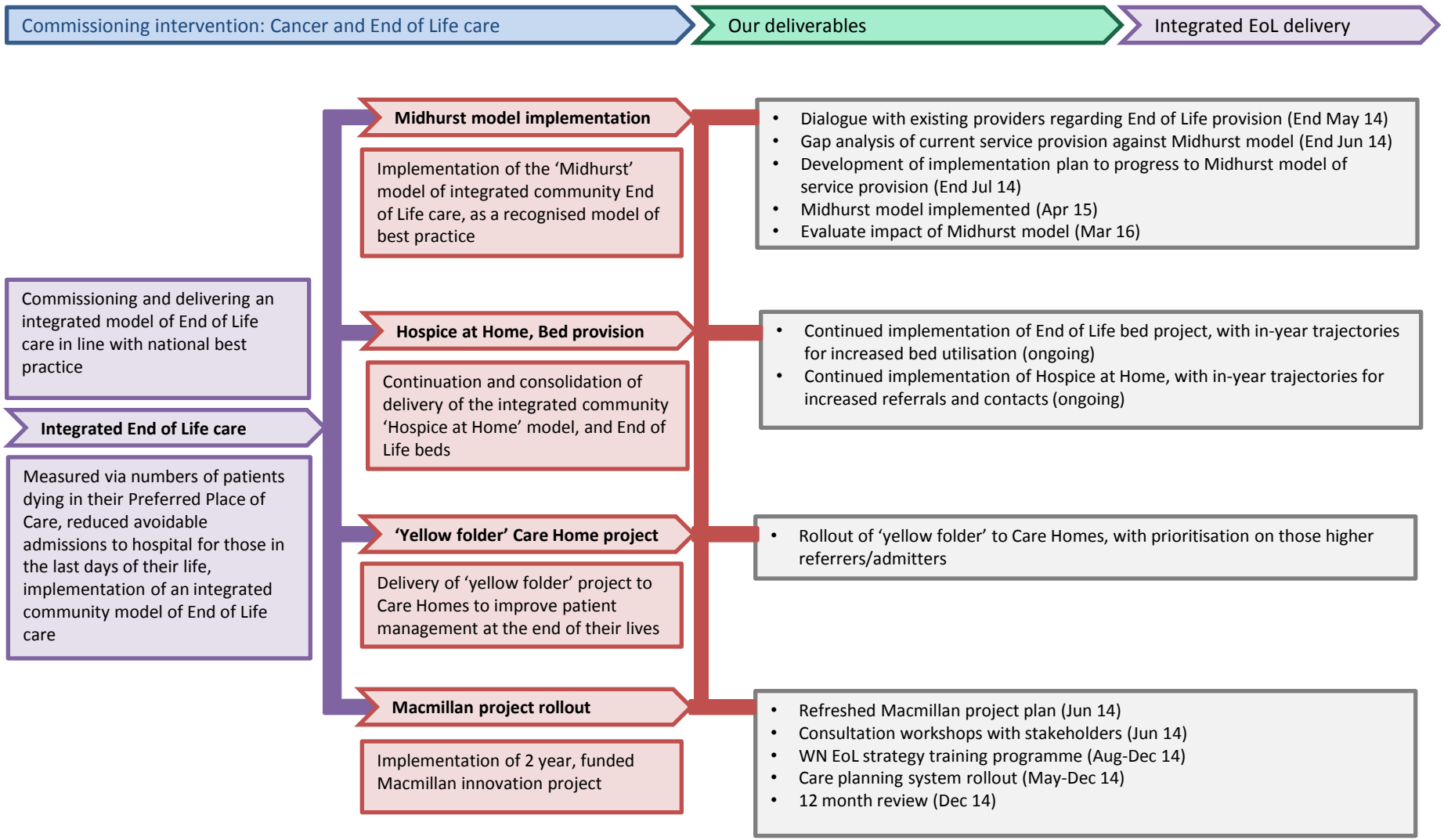
Monitoring of performance measures and quality outcomes. Full evaluation of the pilot to review efficacy.

- Monthly KPI monitoring (ongoing)
- Full evaluation by University of East Anglia (UEA) to review impact of the pilot

Informing future commissioning

Drawing on performance and outcome measures, and evaluation to inform future commissioning. Proposals developed to support spread of best practice.

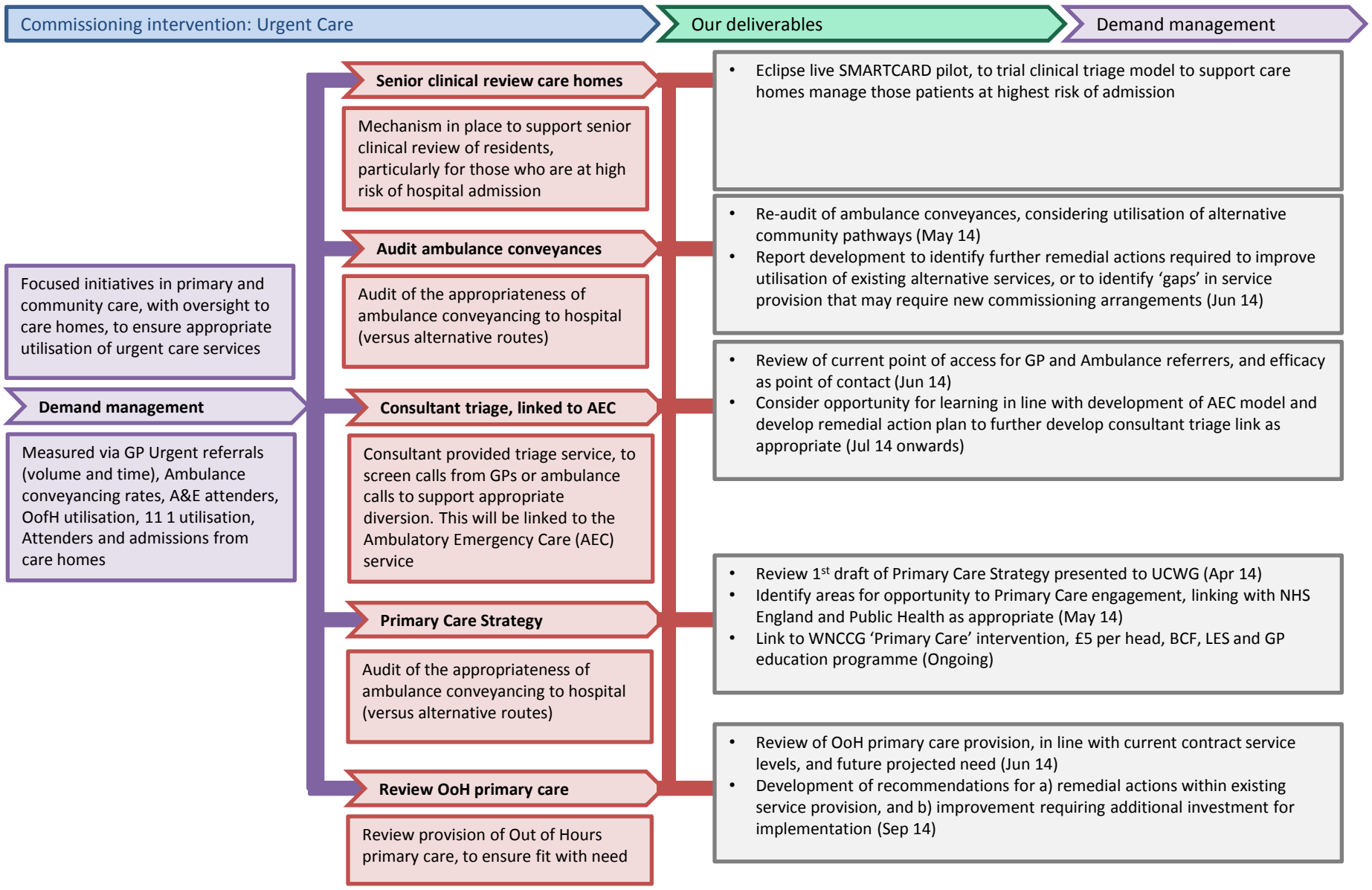
- Business case for CCGs to commission whole pathway approach (by Aug 2015)
- Agreed plan for adoption and spread of model across East of England (by Aug 2015)

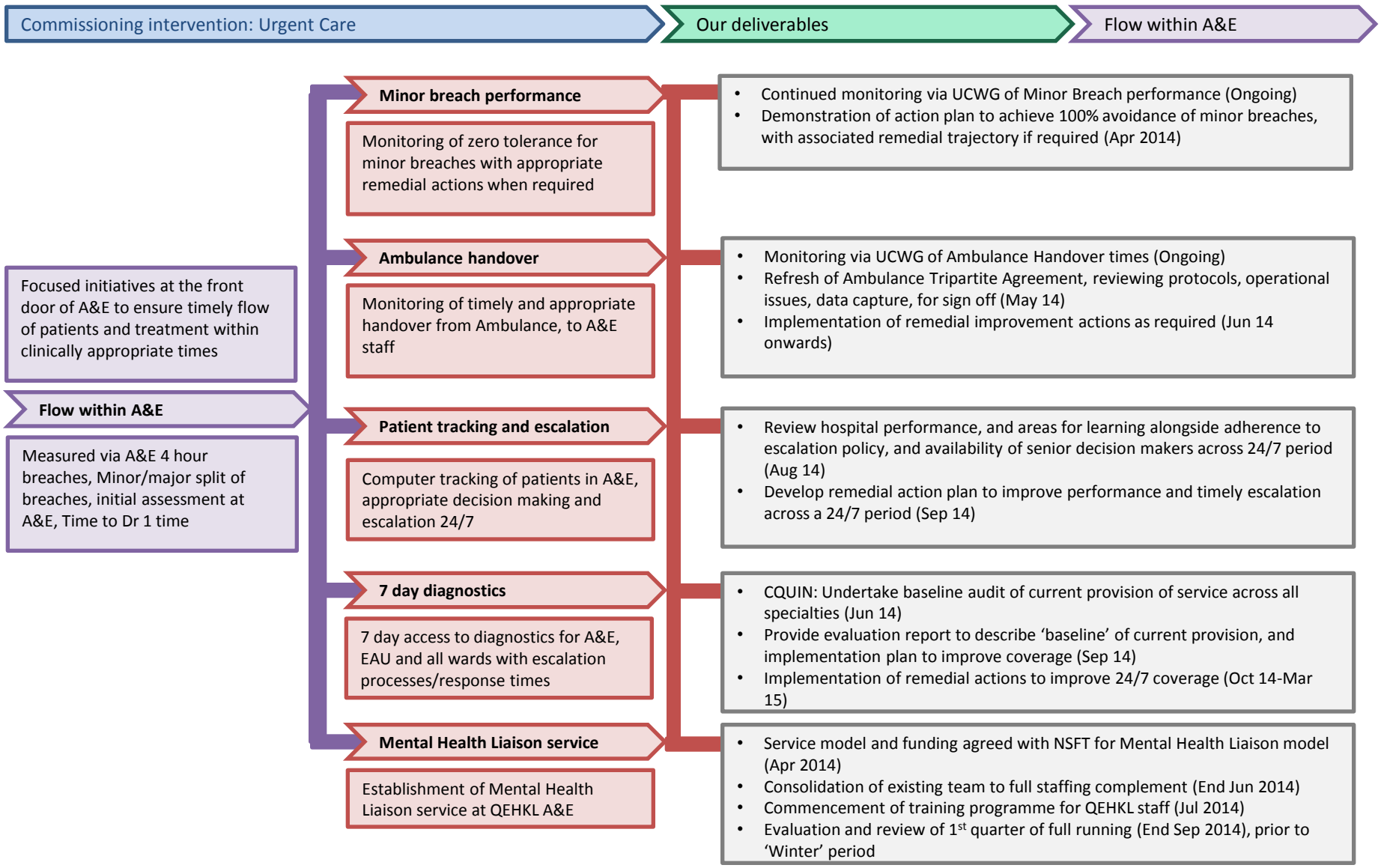

Commissioning intervention: Cancer and End of Life care
Our deliverables
Integrated EoL delivery
Commissioning and delivering an integrated model of End of Life care in line with national best practice
Integrated End of Life care
Measured via numbers of patients dying in their Preferred Place of Care, reduced avoidable admissions to hospital for those in the last days of their life, implementation of an integrated community model of End of Life care
Midhurst model implementation
Implementation of the 'Midhurst' model of integrated community End of Life care, as a recognised model of best practice
• Dialogue with existing providers regarding End of Life provision (End May 14)
• Gap analysis of current service provision against Midhurst model (End Jun 14)
• Development of implementation plan to progress to Midhurst model of service provision (End Jul 14)
• Midhurst model implemented (Apr 15)
• Evaluate impact of Midhurst model (Mar 16)
Hospice at Home, Bed provision
Continuation and consolidation of delivery of the integrated community 'Hospice at Home' model, and End of Life beds
• Continued implementation of End of Life bed project, with in-year trajectories for increased bed utilisation (ongoing)
• Continued implementation of Hospice at Home, with in-year trajectories for increased referrals and contacts (ongoing)
'Yellow folder' Care Home project
Delivery of 'yellow folder' project to Care Homes to improve patient management at the end of their lives
• Rollout of 'yellow folder' to Care Homes, with prioritisation on those higher referrers/admitters
Macmillan project rollout
Implementation of 2 year, funded Macmillan innovation project
• Refreshed Macmillan project plan (Jun 14)
• Consultation workshops with stakeholders (Jun 14)
• WN EoL strategy training programme (Aug-Dec 14)
• Care planning system rollout (May-Dec 14)
• 12 month review (Dec 14)

KEY DELIVERABLES	5 Outcome Domains					7 Outcome Ambitions							6 system characteristics					
	1	2	3	4	5	1	2	3	4	5	6	7	1	2	3	4	5	6
TCCC – Service Delivery																		
TCC – Monitoring and Evaluation																		
TCC – informing future commissioning																		
EoL – Midhurst model implementation																		
EoL – Hospice at Home, Bed provision																		
EoL – 'Yellow folder' care homes																		
EoL – Macmillan project rollout																		

Commissioning intervention: Urgent Care

WNCCG demography	WNCCG current performance
Growing proportion of frail and elderly patients Pockets of deprivation, and rural geography which make Urgent Care provision more difficult Higher prevalence of chronic disease problems Higher prevalence of alcohol related, and self harm non-elective admissions	Historic under-performance against 95% A&E 4 hour target, however achieved 95% for Q4 2013/14 Peak in discharges from acute to community at approximately 4pm in the day Difficulties in managing internal QEHKL patient flow, due to a variety of factors (bed and staffing availability, internal process, community 'bed' availability, cross county border difficulties) Emergency Admission rate which has 'flat lined' in the past year, however in the context of a relatively high level of EMAs when compared to national average
Relevant guidance and strategies	**WNCCG current service initiatives**
Keogh review of Urgent and Emergency Care NHS England Emergency Care 'Checklist'	2013/14 Winter Monies investments which include 'Virtual Ward', A&E accommodation redesign, additional Out of Hours GP capacity, additional clinical Consultant capacity at QEH, rapid response community nursing and therapy provision Weekly UCWG providing health and care system oversight


Commissioning intervention: Urgent Care
Our deliverables
Demand management
Focused initiatives in primary and community care, with oversight to care homes, to ensure appropriate utilisation of urgent care services
Demand management
Measured via GP Urgent referrals (volume and time), Ambulance conveyancing rates, A&E attenders, OofH utilisation, 11 1 utilisation, Attenders and admissions from care homes
Senior clinical review care homes
Mechanism in place to support senior clinical review of residents, particularly for those who are at high risk of hospital admission
Audit ambulance conveyances
Audit of the appropriateness of ambulance conveyancing to hospital (versus alternative routes)
Consultant triage, linked to AEC
Consultant provided triage service, to screen calls from GPs or ambulance calls to support appropriate diversion. This will be linked to the Ambulatory Emergency Care (AEC) service
Primary Care Strategy
Audit of the appropriateness of ambulance conveyancing to hospital (versus alternative routes)
Review OoH primary care
Review provision of Out of Hours primary care, to ensure fit with need
• Eclipse live SMARTCARD pilot, to trial clinical triage model to support care homes manage those patients at highest risk of admission
• Re-audit of ambulance conveyances, considering utilisation of alternative community pathways (May 14)
• Report development to identify further remedial actions required to improve utilisation of existing alternative services, or to identify 'gaps' in service provision that may require new commissioning arrangements (Jun 14)
• Review of current point of access for GP and Ambulance referrers, and efficacy as point of contact (Jun 14)
• Consider opportunity for learning in line with development of AEC model and develop remedial action plan to further develop consultant triage link as appropriate (Jul 14 onwards)
• Review 1st draft of Primary Care Strategy presented to UCWG (Apr 14)
• Identify areas for opportunity to Primary Care engagement, linking with NHS England and Public Health as appropriate (May 14)
• Link to WNCCG 'Primary Care' intervention, £5 per head, BCF, LES and GP education programme (Ongoing)
• Review of OoH primary care provision, in line with current contract service levels, and future projected need (Jun 14)
• Development of recommendations for a) remedial actions within existing service provision, and b) improvement requiring additional investment for implementation (Sep 14)


Commissioning intervention: Urgent Care
Our deliverables
Flow within A&E
Focused initiatives at the front door of A&E to ensure timely flow of patients and treatment within clinically appropriate times
Flow within A&E
Measured via A&E 4 hour breaches, Minor/major split of breaches, initial assessment at A&E, Time to Dr 1 time
Minor breach performance
Monitoring of zero tolerance for minor breaches with appropriate remedial actions when required
• Continued monitoring via UCWG of Minor Breach performance (Ongoing)
• Demonstration of action plan to achieve 100% avoidance of minor breaches, with associated remedial trajectory if required (Apr 2014)
Ambulance handover
Monitoring of timely and appropriate handover from Ambulance, to A&E staff
• Monitoring via UCWG of Ambulance Handover times (Ongoing)
• Refresh of Ambulance Tripartite Agreement, reviewing protocols, operational issues, data capture, for sign off (May 14)
• Implementation of remedial improvement actions as required (Jun 14 onwards)
Patient tracking and escalation
Computer tracking of patients in A&E, appropriate decision making and escalation 24/7
• Review hospital performance, and areas for learning alongside adherence to escalation policy, and availability of senior decision makers across 24/7 period (Aug 14)
• Develop remedial action plan to improve performance and timely escalation across a 24/7 period (Sep 14)
7 day diagnostics
7 day access to diagnostics for A&E, EAU and all wards with escalation processes/response times
• CQUIN: Undertake baseline audit of current provision of service across all specialties (Jun 14)
• Provide evaluation report to describe 'baseline' of current provision, and implementation plan to improve coverage (Sep 14)
• Implementation of remedial actions to improve 24/7 coverage (Oct 14-Mar 15)
Mental Health Liaison service
Establishment of Mental Health Liaison service at QEHKL A&E
• Service model and funding agreed with NSFT for Mental Health Liaison model (Apr 2014)
• Consolidation of existing team to full staffing complement (End Jun 2014)
• Commencement of training programme for QEHKL staff (Jul 2014)
• Evaluation and review of 1st quarter of full running (End Sep 2014), prior to 'Winter' period

Commissioning intervention: Urgent Care → Our deliverables → Hospital bed flow

Focused initiatives to support timely flow of patients through the QEHKL non-elective pathway

Hospital bed flow

Measured via planned versus actual admissions and discharges, outliers, delayed discharges, timing and volume of discharges

Estimated date of discharge use

Each emergency patient given expected date of discharge (EDD) to support patient tracking and avoidance of delays

- Audit setting of, and compliance to EDD within QEHKL (Jun 14)
- Review with system wide partners opportunities to improve EDD setting and adherence (Jun 14)
- Develop remedial action plan to improve consistency of EDD setting, and accuracy and compliance against EDD set (Jul 14), learning from best practice

Earlier discharge during the day

Morning discharges should make 70% of day's discharges before 1300 so that beds can be made available

- Review of efficacy of 13/14 task group plans to bring forward discharge time (Apr 14)
- Refresh of remedial action plans to facilitate earlier discharge, including multi-agency partners to support expedited discharge (May 14)
- Monitoring of timeliness of discharge via UCWG (Ongoing)

Mental Health Liaison

Establishment of Mental Health Liaison service at QEHKL A&E

- Service model and funding agreed with NSFT for Mental Health Liaison model (Apr 2014)
- Consolidation of existing team to full staffing complement (End Jun 2014)
- Commencement of training programme for QEHKL staff (Jul 2014)
- Evaluation and review of 1st quarter of full running (End Sep 2014), prior to 'Winter' period

Increased use Discharge Lounge

Discharge lounges should be available and appropriately sized to support timely patient discharge

- Review of Discharge Lounge at QEH, by volume and time of day, as part of wider 'Discharge pathway review, identifying opportunities for increased appropriate utilisation (Jun 14)
- Implementation of remedial actions to improve utilisation of Discharge Lounge to facilitate timely discharge to the community (Jul 14 onwards)'

Senior Medical Reviews

Timely senior medical review to support earlier discharges and sufficient bed availability

- Audit to review of timeliness of Senior Medical Review across all specialties (Jun 14)
- Identification of opportunities for further improvement, and associated remedial action plan (Jul 14)

Commissioning intervention: Urgent Care → Our deliverables → Delayed transfers

Focused initiatives to support timely and appropriate discharge of patients to the right place of care

Delayed transfers

Measured via delayed transfers of care incidence, availability of community services to support discharge across 7 day period

Setting maximum DTOC ceiling

OBD based maximum DTOC level below 3.5%, compliance monitored by UCWG

- Review of average DTOC levels, and consideration of appropriate DTOC ceiling based on guidance and precedent (May 14)
- Proposal paper to UCWG to set maximum DTOC ceiling for agreement and sign off (Jun 14)
- Monitoring in place for compliance with DTOC ceiling (Jul 14 onwards)

Refresh patient choice policy

Robust locally agreed patient choice policy in place, adhered to and utilised

- Undertake review of current Patient Choice policy considering content, protocol, adherence and impact of current policy, and potential for revisions (Jun 14)
- Development of refreshed Patient Choice policy, for consideration and UCWG sign off (Sep 14)

Discharge pathway review

Review of hospital discharge pathway, with community partners, across Norfolk and border counties to identify opportunities for improvement

- Working group established, with Terms of Reference to scope and review the current discharge pathway arrangements (Apr 14)
- Evaluation of current discharge performance, and development of remedial action plan to improve discharge process (Jun 14)
- Implementation of remedial action plan, and monitoring of impact (Jul 14 onwards)

Primary/Community 7 day

Supporting transfer from acute hospital to the community, including equipment provision over a 7 day period

- Undertake gap analysis to review across primary and community care settings provision across a 7 day period (Jun 14)
- Develop proposal to improve 24/7 coverage in areas of greatest need, with associated implementation plan (Jul 14)

Commissioning intervention: Urgent Care	Our deliverables	UCWG oversight
Focused initiatives to ensure appropriate West Norfolk system leadership and governance to support Urgent Care delivery		
UCWG oversight Measured via existence of refreshed UC action plan, refreshed system escalation policy, system dashboard and ideas for Winter investment		
UCWG To have an effective, functioning Urgent Care Working Group (UWCG), with robust action plan		• Ongoing running of UCWG, at a frequency in line with system performance and need (Ongoing) • UCWG workshop to review and refresh UC action plan in line with national guidance and learning from 13/14 (By end Jun 14) • Revised action plan circulated and signed off by UCWG (By end Jul 14)
ECIST intervention To take the learning from the planned ECIST intervention, and incorporate into the UWCG plan		• Report detailing ECIST recommendations to be received at the UCWG (By end Apr 14) • Immediate implementation of actions where appropriate (Apr 14 onwards) • Incorporation of ECIST recommendations into wider UCWG action plan (By end Jul 14)
System escalation policy To refresh the system escalation policy to ensure it is fit for purpose, and well tested		• Workshop to review and refresh WN system escalation plan and policy (Jul Aug 14) • Testing of proposed escalation plan, via 'Winter Summit' (Sep 14) • Sign off of refreshed escalation plan (Oct 14)
System dashboard To develop a system operational dashboard to support ops management and escalation		• Development of 'mock up' dashboard for partner review (May 14) • Development of protocols to support dashboard usage (May 14) • Testing of dashboard for trial period (Jun 14) • Review learning from testing, and establish permanent dashboard for usage (Jul 14)
Winter Monies preparation To proactively develop a list of potential initiatives for investment over the Winter period 14/15		• Receive evaluation of Winter Monies schemes for 14/15 at UCWG (May 14) • Review learning from 14/15, and 'in year' Urgent Care performance and relevant guidance to develop a list of proposals for investment for Winter 14/15 (Aug 14) • UCWG consideration of proposals for investment, and prioritisation (Sep 14) • Authorisation and implementation in line with £ available (Sep 14 onwards)

Commissioning intervention: Urgent Care > Our deliverables > 7 day working

Focused initiatives to support the provision of timely assessment, diagnostics and care over a 7 day period in line with patient need

7 day working

Measured via gap analysis of current provision versus actual demand, and implementation of remedial actions to support UC working over a 7 day period; evidenced via activity in line with clinical need over a 24/7 basis

Time to first Consultant review

To ensure timely access to senior clinical consultant to facilitate first patient review

Diagnostic availability

To ensure timely, appropriate access across 24/7 period to diagnostics

Key service availability

To ensure appropriate, timely access across 24/7 period to appropriate consultant intervention

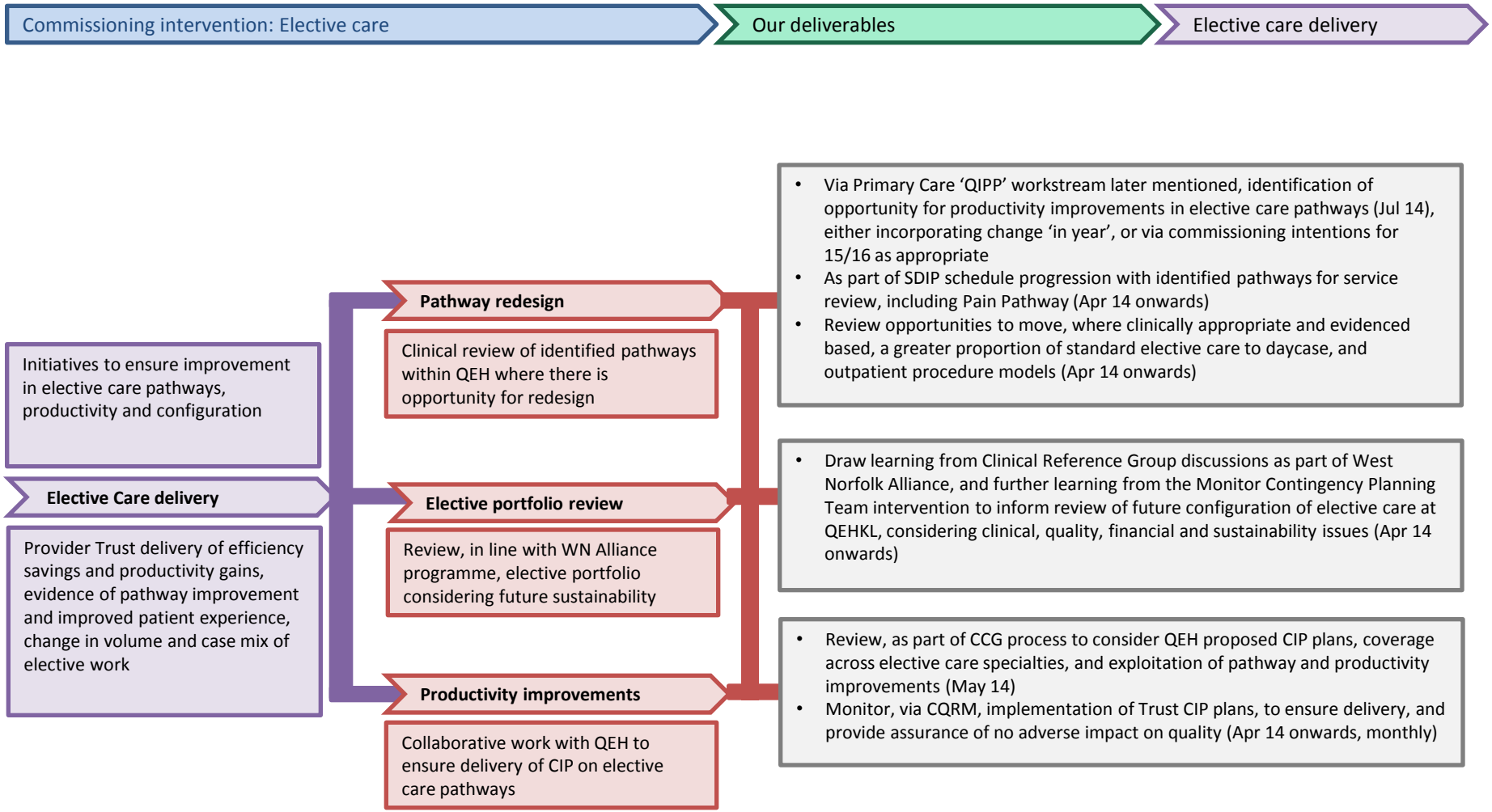
Multidisciplinary review

To facilitate MDT review and integrated discharge management plan across 24/7 period

- CQUIN: Undertake baseline audit of current provision of service across all specialties (Jun 14)
- Provide evaluation report to describe 'baseline' of current provision, and implementation plan to improve coverage (Sep 14)
- Implementation of remedial actions to improve 24/7 coverage (Oct 14-Mar 15)

KEY DELIVERABLES	5 Outcome Domains					7 Outcome Ambitions							6 system characteristics					
	1	2	3	4	5	1	2	3	4	5	6	7	1	2	3	4	5	6
Demand management																		
Flow within A&E																		
Hospital bed flow																		
Delayed transfers																		
UCWG oversight																		
7 day working																		

Commissioning intervention: Elective Care


Commissioning intervention: Elective care
Our deliverables
Elective care delivery
Initiatives to ensure improvement in elective care pathways, productivity and configuration
Elective Care delivery
Provider Trust delivery of efficiency savings and productivity gains, evidence of pathway improvement and improved patient experience, change in volume and case mix of elective work
Pathway redesign
Clinical review of identified pathways within QEH where there is opportunity for redesign
Elective portfolio review
Review, in line with WN Alliance programme, elective portfolio considering future sustainability
Productivity improvements
Collaborative work with QEH to ensure delivery of CIP on elective care pathways
• Via Primary Care 'QIPP' workstream later mentioned, identification of opportunity for productivity improvements in elective care pathways (Jul 14), either incorporating change 'in year', or via commissioning intentions for 15/16 as appropriate
• As part of SDIP schedule progression with identified pathways for service review, including Pain Pathway (Apr 14 onwards)
• Review opportunities to move, where clinically appropriate and evidenced based, a greater proportion of standard elective care to daycase, and outpatient procedure models (Apr 14 onwards)
• Draw learning from Clinical Reference Group discussions as part of West Norfolk Alliance, and further learning from the Monitor Contingency Planning Team intervention to inform review of future configuration of elective care at QEHKL, considering clinical, quality, financial and sustainability issues (Apr 14 onwards)
• Review, as part of CCG process to consider QEH proposed CIP plans, coverage across elective care specialties, and exploitation of pathway and productivity improvements (May 14)
• Monitor, via CQRM, implementation of Trust CIP plans, to ensure delivery, and provide assurance of no adverse impact on quality (Apr 14 onwards, monthly)

KEY DELIVERABLES	5 Outcome Domains					7 Outcome Ambitions							6 system characteristics					
	1	2	3	4	5	1	2	3	4	5	6	7	1	2	3	4	5	6
Elective care delivery																		

Commissioning intervention: Women, Children and Younger People

WNCCG demography	WNCCG current performance
Just under 1,000 C&YP have statements of Special Educational Need. This includes 183 with ASD, 59 severe LD and 17 profound and multiple LD (Norfolk County Council, 2012) Above national average for childhood obesity. Below national average for educational attainment.	Urgent care admissions high relative to national average for asthma, diabetes, epilepsy Urgent care admissions high relative to national average for Lower Respiratory Tract infections Quality issues present regarding Looked After Children assessments Ongoing quality issues with Maternity service provision, and choice in terms of location and method of service delivery at birth
Relevant guidance and strategies	**WNCCG current service initiatives**
Achieving equality and excellence for Children, DH 2010 Children and Families Act 2014 Working together Maternity Matters The Healthy Child Programme 0-19	West Norfolk Paediatric clinical network in place Paediatric Urgent Care pathway review (including Diabetes BPT) and remodelling Integration of services for C&YP with Special Educational Needs and Disabilities (SEND) including: joint commissioning, integrated assessment and single health, education and care plan, integrated transition planning Review of Looked After Children Service (LAC) Performance management of Maternity Services, especially delivery of a Midwifery Led Birthing Unit (MLBU) service

Commissioning intervention: Women, Children and Younger People > Our deliverables > Maternity provision

Focused initiatives to ensure the delivery of high quality, cost effective Maternity services now, and in the future

Maternity provision

Measured via Maternity dashboard metrics…

Supporting core service delivery

To ensure delivery against core service standards, and high quality maternity service provision

- Review of core service provision against specification requirements (Apr 14)
- Develop remedial action plan with providers to improve performance standards (May 14)
- Review provision against core maternity standards and maternity performance dashboard(Ongoing)

Enhancing service delivery

Developing future service plans in line with best practice, to ensure long term sustainability

- Gap analysis of current service model and provision against national guidance, such as 'Maternity Matters' (Apr 14)
- Joint work with QEH as part of SDIP to develop an implementation plan for service development of Maternity provision, to include provision of further choice about location and method of support for birthing (May 14)
- Implementation of improvement plan (Jun 14 onwards)
- Review provision against core maternity standards and maternity performance dashboard (Ongoing)

Commissioning intervention: Women, Children and Younger People > Our deliverables > Paediatric pathway

Focused initiatives to drive improved performance, quality and integration in the delivery of Paediatric Care, in particular Urgent Care

Paediatric pathway

Measured via Paediatric attenders, Paediatric admissions, Paeds admissions LoS, utilisation of community paediatric alternatives

Review current pathway

Review current Paediatric pathway across WN, mapping provision across providers, patient journey, opportunities for improvement

- Review of current Paediatric pathway, to include system workshop with partners to map current pathway and opportunities for change (Jun 14)
- Consideration of causal factors for high levels of admissions for Paediatric patients in Asthma, Diabetes, Epilepsy, Lower Respiratory Tract infections (Jun 14)
- Review of non-elective pathway, considering patient journey through QEH Paediatric Assessment Unit, and supporting coding of activity and admissions (Jun 14)
- Review of best practice models in Paediatric Care (Jun 14)

Improvement strategy

To ensure delivery against core service standards, and high quality maternity service provision

- Development of system service improvement plan for implementation (Jul 14 onwards)
- Paediatric Network workshop to involve partners in the development of system improvement strategy (Jul 14)
- Development of Paediatric Network workplan and education strategy to support improvement strategy implementation (Aug 14)
- Monitoring of performance against improvement strategy, and wider Paediatric pathway to evaluate impact of strategy (Sep 14 onwards)
- Incorporation of proposed service developments into commissioning intentions and contracts for 2015/16 (Oct 14)

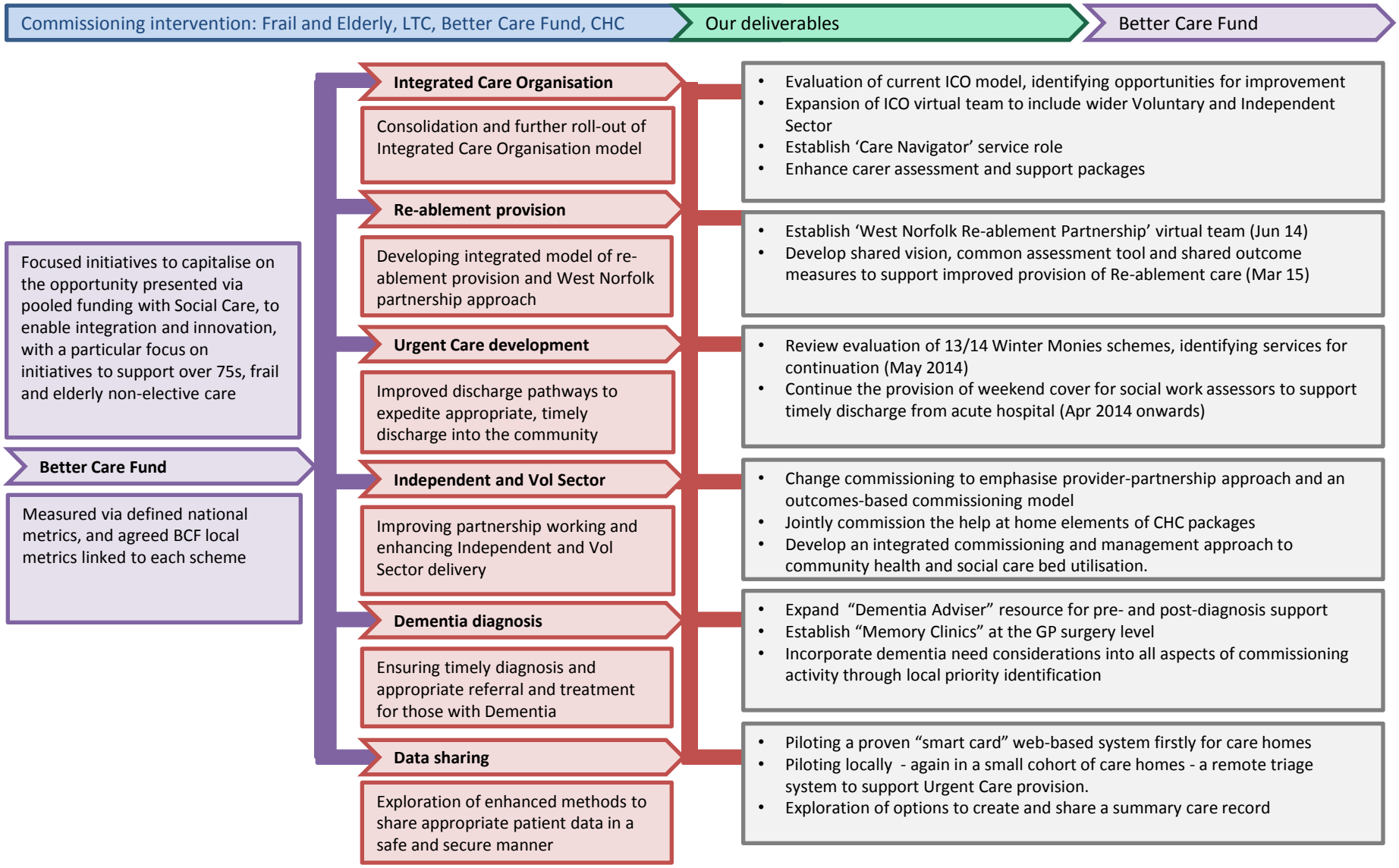
KEY DELIVERABLES	5 Outcome Domains					7 Outcome Ambitions							6 system characteristics					
	1	2	3	4	5	1	2	3	4	5	6	7	1	2	3	4	5	6
Maternity pathway improvement																		
Paediatric pathway improvement																		

Commissioning intervention: Frail and elderly, Long term conditions, Better Care Fund, Continuing Healthcare

Commissioning intervention 5: Frail and Elderly, LTC, Better Care Fund, CHC

Our context

WNCCG demography	WNCCG current performance
• Population profile – increasingly ageing population, with higher proportion of older people than elsewhere in England • High prevalence of Long Term Conditions, particularly diabetes and respiratory disease • Social isolation and loneliness due to rural communities – implications for mental health	• High admissions for respiratory disease and diabetes • High admissions for vaccine preventable illness • Evidence of reductions in emergency admissions from Community Matron intervention • Dementia under-diagnosed
Relevant guidance and strategies	**WNCCG current service initiatives**
National Service Framework, Older People; DH (2001) Making our health and care systems fit for an ageing population, King's Fund (2014) Caring for our future: reforming care and support; DH (2012) Older people living in rural areas,; DfE (2012) Making Integrated Care Happen, King's Fund (2013)	• Community matrons – 7 day service • Community IV therapy • Community clinics for COPD, pulmonary rehab, heart failure, Doppler and leg ulcer care • Integrated teams around general practice • Integrated Care Coordinators to connect services to each other • MDT Rapid Assessment Team to support people home from A&E attendance • Falls team • Hospice at Home team to support choice to die at home • Pilot in care homes with 'Smart-card' and triage support for admission avoidance


Commissioning intervention: Frail and Elderly, LTC, Better Care Fund, CHC
Our deliverables
Better Care Fund
Focused initiatives to capitalise on the opportunity presented via pooled funding with Social Care, to enable integration and innovation, with a particular focus on initiatives to support over 75s, frail and elderly non-elective care
Better Care Fund
Measured via defined national metrics, and agreed BCF local metrics linked to each scheme
Integrated Care Organisation
Consolidation and further roll-out of Integrated Care Organisation model
• Evaluation of current ICO model, identifying opportunities for improvement
• Expansion of ICO virtual team to include wider Voluntary and Independent Sector
• Establish 'Care Navigator' service role
• Enhance carer assessment and support packages
Re-ablement provision
Developing integrated model of re-ablement provision and West Norfolk partnership approach
• Establish 'West Norfolk Re-ablement Partnership' virtual team (Jun 14)
• Develop shared vision, common assessment tool and shared outcome measures to support improved provision of Re-ablement care (Mar 15)
Urgent Care development
Improved discharge pathways to expedite appropriate, timely discharge into the community
• Review evaluation of 13/14 Winter Monies schemes, identifying services for continuation (May 2014)
• Continue the provision of weekend cover for social work assessors to support timely discharge from acute hospital (Apr 2014 onwards)
Independent and Vol Sector
Improving partnership working and enhancing Independent and Vol Sector delivery
• Change commissioning to emphasise provider-partnership approach and an outcomes-based commissioning model
• Jointly commission the help at home elements of CHC packages
• Develop an integrated commissioning and management approach to community health and social care bed utilisation.
Dementia diagnosis
Ensuring timely diagnosis and appropriate referral and treatment for those with Dementia
• Expand "Dementia Adviser" resource for pre- and post-diagnosis support
• Establish "Memory Clinics" at the GP surgery level
• Incorporate dementia need considerations into all aspects of commissioning activity through local priority identification
Data sharing
Exploration of enhanced methods to share appropriate patient data in a safe and secure manner
• Piloting a proven "smart card" web-based system firstly for care homes
• Piloting locally - again in a small cohort of care homes - a remote triage system to support Urgent Care provision.
• Exploration of options to create and share a summary care record

Commissioning intervention: Frail and Elderly, LTC, Better Care Fund, CHC → Our deliverables → Continuing Healthcare

Focused initiatives to drive improvements in the allocation of resources for CHC, expenditure on home care, and expenditure on residential and nursing homes. Work to improve operational performance of CHC service delivery

Continuing Healthcare

Measured via monitoring of expenditure (actual versus planned) and performance against CHC contractual standards

Improved allocative efficiency

Improvement in allocation of resources through improved referrals and utilisation of care options

- Reduce inappropriate referrals through training and education

Reduced home care costs

Reduction in expenditure on home care costs through service improvement and contracting

- Continuation of 2013/14 QIPP CHC initiatives
- Cap dom care costs at a premium against care home cost
- Critical review of high cost packages, utilising benchmarking data and exploring opportunities for innovation in delivery

Reduced res/nursing home costs

Reduction in residential and nursing home costs through service improvement and contracting

- Convert 1:1 care to 2:1 care in facilities housing multiple patients
- Reduce costs through standardisation of care home pricing
- Block purchase beds/negotiation of longer term contracts for long term Mental Health patients

Complex case review panel

Improvement in timeliness and process for complex case reviews

- Review effectiveness of current CHC panel set up.
- Critique reasons for sending cases to CHC panel

CHC Outstanding Reviews

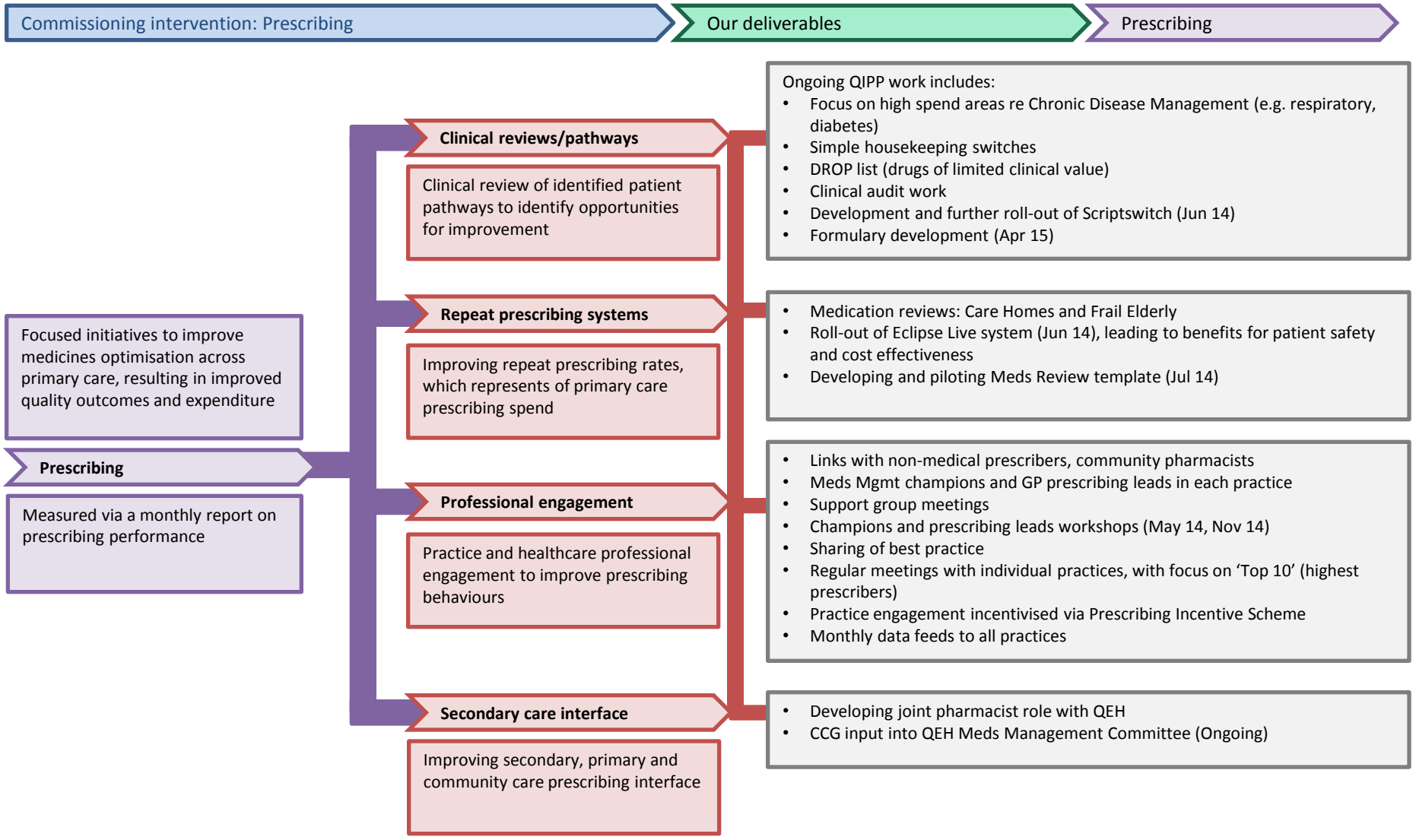
Improvement in timeliness and process for outstanding CHC reviews

- Critical review of West Norfolk process, and comparison with other similar CCG populations

KEY DELIVERABLES	5 Outcome Domains					7 Outcome Ambitions							6 system characteristics					
	1	2	3	4	5	1	2	3	4	5	6	7	1	2	3	4	5	6
BCF: Integrated Care Organisation																		
BCF: Re-ablement provision																		
BCF: Urgent Care development																		
BCF: Independent and Vol Sector																		
BCF: Dementia diagnosis																		
BCF: Data sharing																		
CHC: Allocative efficiency																		
CHC: Reduced Care Home costs																		
CHC: Reduced Residential/Nursing home costs																		
CHC: Complex case review panel																		
CHC: Outstanding review backlog																		

Commissioning intervention: Prescribing

WNCCG demography	WNCCG current performance
Elderly, deprived population with foreign nationals Prevalence of Long Term Conditions e.g. Respiratory, Diabetes, Cardiovascular Disease Dispensing issues due to rural geography	Outlier on GP prescribing costs locally, and nationally Significant variation in prescribing activity between GP Practices
Relevant guidance and strategies	**WNCCG current service initiatives**
NICE guidance All WNCCG QIPP projects are based on national, evidence-based recommendations National strategies on Medicines Optimisation (especially with regards to appropriate treatment of the frail and elderly)	2014/15,15/16 initiatives build on work already undertaken in 13-14; Medicine Optimisation QIPP was part of the WNCCG Prescribing Incentive Scheme 13-14. These initiatives are currently delivering financial savings i.e. more cost effective prescribing. Medication review work has delivered significant numbers of quality interventions, which has the potential to avoid hospital admission. Eclipse Live improves safety, reduces prescribing errors


Commissioning intervention: Prescribing
Our deliverables
Prescribing
Focused initiatives to improve medicines optimisation across primary care, resulting in improved quality outcomes and expenditure
Prescribing
Measured via a monthly report on prescribing performance
Clinical reviews/pathways
Clinical review of identified patient pathways to identify opportunities for improvement
Repeat prescribing systems
Improving repeat prescribing rates, which represents of primary care prescribing spend
Professional engagement
Practice and healthcare professional engagement to improve prescribing behaviours
Secondary care interface
Improving secondary, primary and community care prescribing interface
Ongoing QIPP work includes:
• Focus on high spend areas re Chronic Disease Management (e.g. respiratory, diabetes)
• Simple housekeeping switches
• DROP list (drugs of limited clinical value)
• Clinical audit work
• Development and further roll-out of Scriptswitch (Jun 14)
• Formulary development (Apr 15)
• Medication reviews: Care Homes and Frail Elderly
• Roll-out of Eclipse Live system (Jun 14), leading to benefits for patient safety and cost effectiveness
• Developing and piloting Meds Review template (Jul 14)
• Links with non-medical prescribers, community pharmacists
• Meds Mgmt champions and GP prescribing leads in each practice
• Support group meetings
• Champions and prescribing leads workshops (May 14, Nov 14)
• Sharing of best practice
• Regular meetings with individual practices, with focus on 'Top 10' (highest prescribers)
• Practice engagement incentivised via Prescribing Incentive Scheme
• Monthly data feeds to all practices
• Developing joint pharmacist role with QEH
• CCG input into QEH Meds Management Committee (Ongoing)

KEY DELIVERABLES	5 Outcome Domains					7 Outcome Ambitions							6 system characteristics					
	1	2	3	4	5	1	2	3	4	5	6	7	1	2	3	4	5	6
Prescribing improvements																		

Commissioning intervention: Primary Care

WNCCG demography	WNCCG current performance
WNCCG is covered by 23 practices in a primarily rural community: 6 PMS and 17 GMS practices 4 town practices, 3 coastal, 6 semi-rural market town practices and 10 rural practices. Individual practice populations range from 3,111 to 21,786. One of the town practices has recently merged with another town practice, resulting in a total patient population of 27,718.	The GP patient survey, Dec 2013: - Overall experience of GP survey: 47% very good, 42% fairly good, 1% very poor - Recommending GP surgery to someone who has just moved to the area: 53% definitely would, 29% probably would, only 2% would definitely not - Satisfaction with opening times: 39% very satisfied, 43% fairly satisfied, 2% very dissatisfied, 3% not sure when surgery is open - Overall experience of making an appointment: 36% very good, 44% fairly good, 3% very poor Overall, WNCCG practices are high QOF achievers, however, the CCG will work with individual practices to understand why they are outliers on individual targets, particularly in regard to areas that overlap with the QIPP agenda and any planned service redesign.
Relevant guidance and strategies	**WNCCG current service initiatives**
Everyone Counts: Planning for Patients 2014/15-2018/19 and *Improving General Practice- A Call to Action Phase 1 Report* *The Quality and Outcomes Framework 2014/15* *General Medical Services Contract 2014/15 – Guidance and Audit Requirements*	2013/14 WNCCG Local Enhanced Services • Minor surgery • Anti-Coagulation monitoring • Near Patient Testing • Post operative removal of sutures and wound management in general practice • Phlebotomy • DVT assessment and treatment in primary care Engagement activities with practices during 2013/14: working with practices on a locality basis and engaging with them through Practice Managers Advisory Group (PMAG) and locality groups. Working with practice managers to develop practice-level financial plans to support delivery of QIPP and national planning requirements.

Commissioning intervention: Primary Care → Our deliverables → Primary care (NHSE/WNCCG)

An initiative to ensure seamless primary care commissioning and partnership working between NHSE and WNCCG

Primary care (NHSE/WNCCG)

Measured via Primary Care performance and quality outcomes

Interdependencies articulated

Review of respective roles and responsibilities of WNCCG and NHSE in relation to primary care engagement and initiatives

- Meeting with NHSE to establish roles and responsibilities (Apr 14)
- Develop shared work plan for 2014/15, ensuring alignment between respective strategic objectives (May 14)

Communication and commissioning

Ongoing dialogue and joint working with NHS England to ensure collaborative commissioning of primary care

- Review and develop communications and engagement plan for West Norfolk primary care (Apr 14)
- Determine frequency of review meetings between NHSE and WNCCG (Apr 14)
- Establish regular contract performance meetings with NHSE LAT locality lead (Apr 14 onwards)
- Commence dialogue for 2015/16 commissioning intentions, ensuring appropriate strategic alignment (Jul 2014)
- Issue commissioning intentions for 2015/16 (Oct 14)
- Place contracts (NHSE and WNCCG) (Feb 15)

Commissioning intervention: Primary Care → Our deliverables → Referral management

Evaluation, review and re-commissioning as appropriate of a referral management function, to support appropriateness of referrals

Referral management (RMC)

Implementation to time of evaluation project, and re-commissioning of appropriate alternative

Review current service provision

3rd party commissioned to undertake a review of the current RMC service provision

- Develop specification for review, for sharing with NHSA CSU (Apr 14)
- Commence review of current RMC service provision (Apr 14)
- Present review findings to CLEX (May 14), for agreement of next steps

Options appraisal

Consider outcome of 'review', and develop future options for provision of referral information/management

- Develop options appraisal for future RMC service, considering best practice, evidence base, clinical views, efficacy of current service, and financial envelope (May 14)
- Present options appraisal to CLEX to determine future RMC model (May 14)

Securing a service

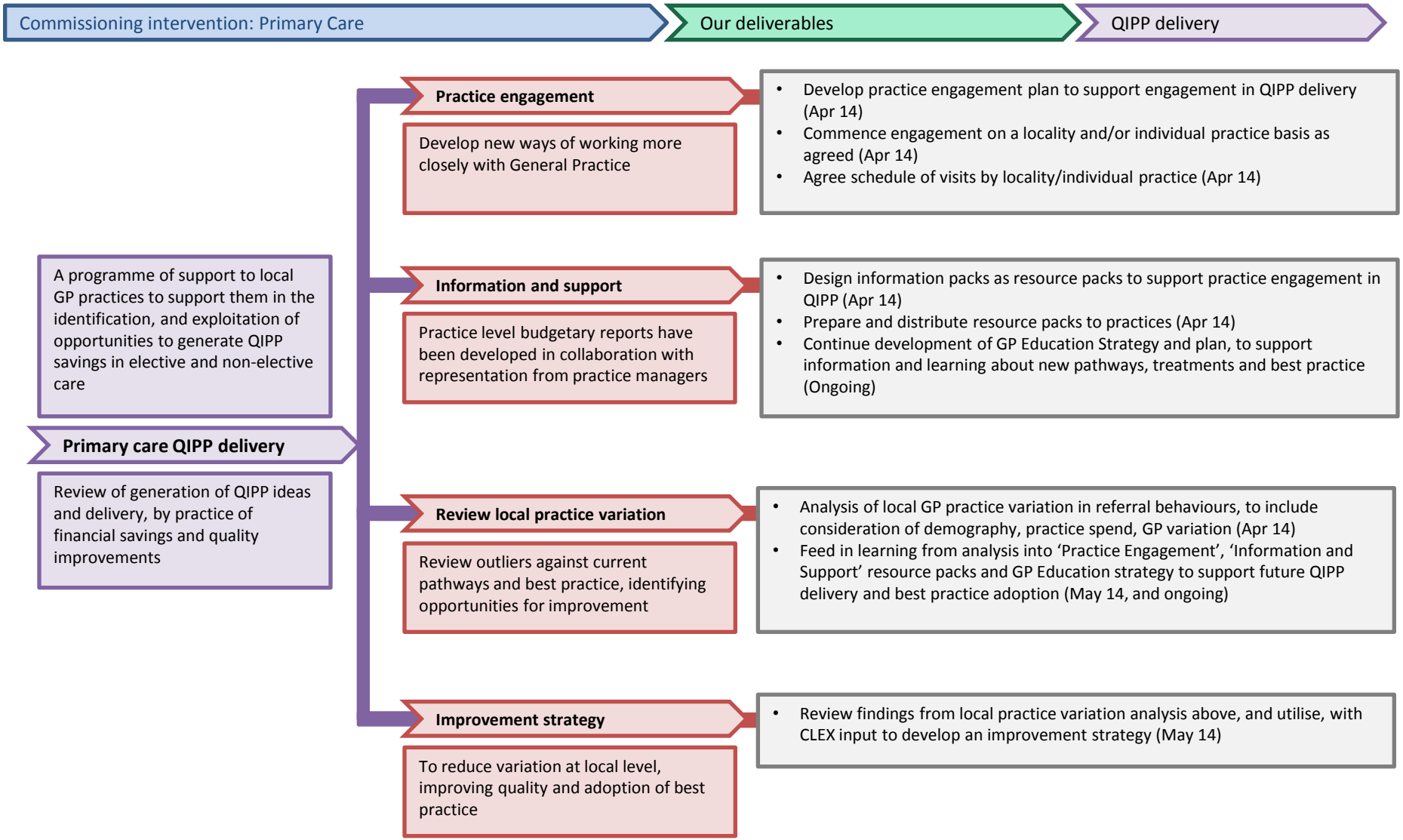
Commission a referral information/management service that is fit for purpose

- Develop service specification for RMC provision (May 14)
- Develop monitoring arrangements and performance kpis (May 14)
- Secure service provision from RMC provider (Jun 14)
- Commence service provision against new service (Jul 14)

Monitoring service performance

Establish a robust contract monitoring process

- Establish monitoring mechanisms to review quality and performance of service provision (Jun 14)
- Undertake monthly performance monitoring, and quarterly performance reviews (Jul14 onwards)


Commissioning intervention: Primary Care
Our deliverables
QIPP delivery
A programme of support to local GP practices to support them in the identification, and exploitation of opportunities to generate QIPP savings in elective and non-elective care
Primary care QIPP delivery
Review of generation of QIPP ideas and delivery, by practice of financial savings and quality improvements
Practice engagement
Develop new ways of working more closely with General Practice
• Develop practice engagement plan to support engagement in QIPP delivery (Apr 14)
• Commence engagement on a locality and/or individual practice basis as agreed (Apr 14)
• Agree schedule of visits by locality/individual practice (Apr 14)
Information and support
Practice level budgetary reports have been developed in collaboration with representation from practice managers
• Design information packs as resource packs to support practice engagement in QIPP (Apr 14)
• Prepare and distribute resource packs to practices (Apr 14)
• Continue development of GP Education Strategy and plan, to support information and learning about new pathways, treatments and best practice (Ongoing)
Review local practice variation
Review outliers against current pathways and best practice, identifying opportunities for improvement
• Analysis of local GP practice variation in referral behaviours, to include consideration of demography, practice spend, GP variation (Apr 14)
• Feed in learning from analysis into 'Practice Engagement', 'Information and Support' resource packs and GP Education strategy to support future QIPP delivery and best practice adoption (May 14, and ongoing)
Improvement strategy
To reduce variation at local level, improving quality and adoption of best practice
• Review findings from local practice variation analysis above, and utilise, with CLEX input to develop an improvement strategy (May 14)

Commissioning intervention: Primary Care → Our deliverables → Local Enhanced Services (LES)

Review and re-commissioning of LESs for WNCCG

Local Enhanced Services (LES)

Re-commissioning of LESs to project timescales, LES uptake and associated quality outcome improvement

Review existing LESs

Review of existing LES in relation to need and appropriate provider provision

- Review existing LESs, considering content and fit with CCG requirements, performance to date (Jun 14)
- Develop report recommending future scope and process for administering of LESs (Jul 14)

Transition to NHS Standard Contract

Transition from current contract documentation to NHS Standard Contract documentation

- Develop transition programme to support practices moving to NHS Standard Contract documentation (Apr 14)
- Transitional programme commences (May 14), comprising education sessions, 121s, practice visits

Performance monitoring

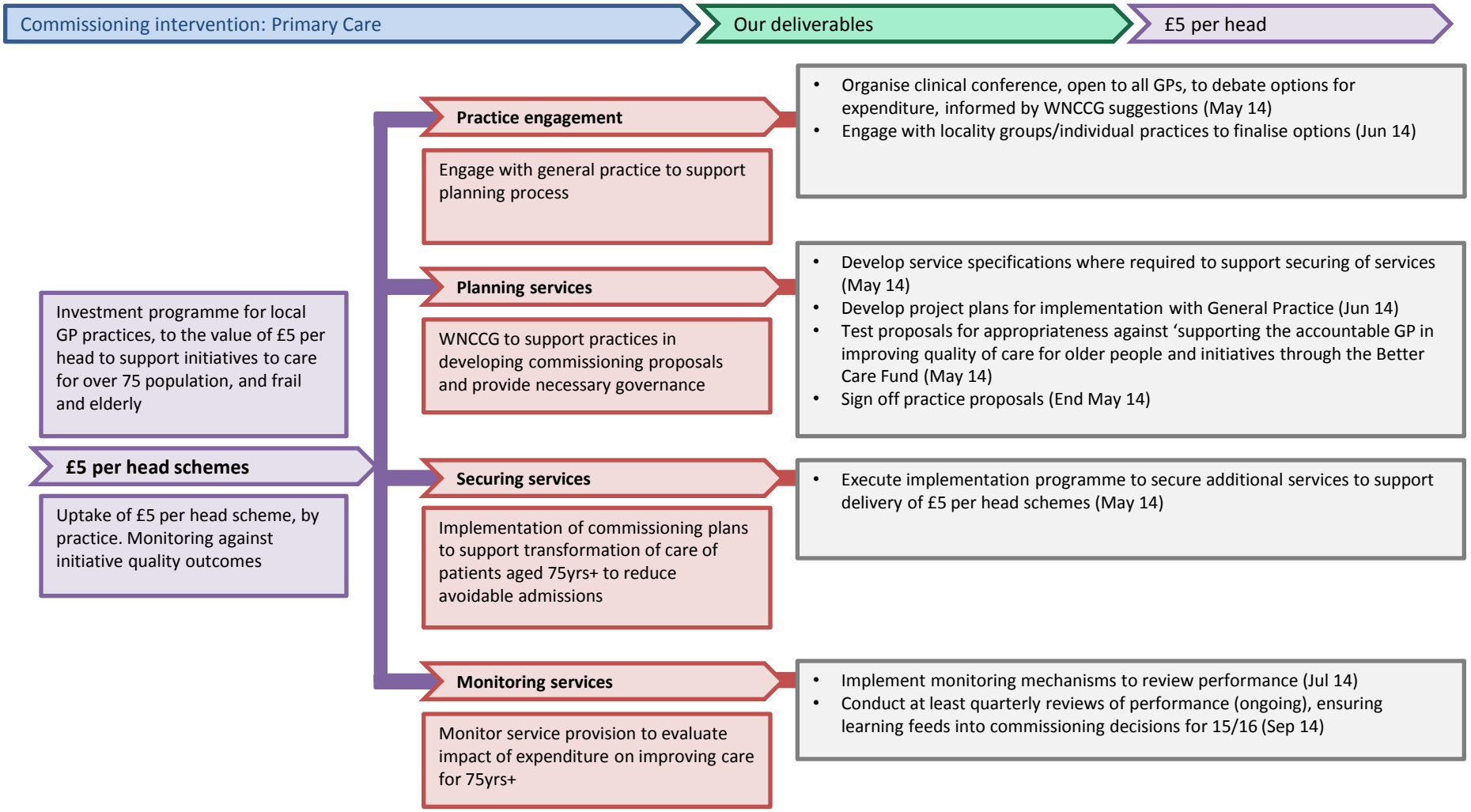
Ensure robust reporting, monitoring and payment process

- Learning from performance monitoring during 13/14, develop performance monitoring arrangements with NHSA CSU (Apr 14)
- Commence performance monitoring (Apr 14)
- Implement quarterly performance monitoring arrangements (Jun 14)

Re-commissioning for 15/16

Develop commissioning intentions, and ensure robust contracting for 2015/16

- Review current service specifications through the established Practice clinical reference group (comprising GP and Practice Managers, as well as CCG representation) (Sep 2014)
- Working alongside NHSE, issue commissioning intentions for 2015/16 (Oct 15)
- Contract conclusion 2015/16 (Feb 15)
- 2015/16 contract commencement (Apr 15)


Commissioning intervention: Primary Care
Our deliverables
£5 per head
Investment programme for local GP practices, to the value of £5 per head to support initiatives to care for over 75 population, and frail and elderly
£5 per head schemes
Uptake of £5 per head scheme, by practice. Monitoring against initiative quality outcomes
Practice engagement
Engage with general practice to support planning process
Organise clinical conference, open to all GPs, to debate options for expenditure, informed by WNCCG suggestions (May 14)
Engage with locality groups/individual practices to finalise options (Jun 14)
Planning services
WNCCG to support practices in developing commissioning proposals and provide necessary governance
Develop service specifications where required to support securing of services (May 14)
Develop project plans for implementation with General Practice (Jun 14)
Test proposals for appropriateness against 'supporting the accountable GP in improving quality of care for older people and initiatives through the Better Care Fund (May 14)
Sign off practice proposals (End May 14)
Securing services
Implementation of commissioning plans to support transformation of care of patients aged 75yrs+ to reduce avoidable admissions
Execute implementation programme to secure additional services to support delivery of £5 per head schemes (May 14)
Monitoring services
Monitor service provision to evaluate impact of expenditure on improving care for 75yrs+
Implement monitoring mechanisms to review performance (Jul 14)
Conduct at least quarterly reviews of performance (ongoing), ensuring learning feeds into commissioning decisions for 15/16 (Sep 14)

Commissioning intervention: Primary Care > Our deliverables > GP education

Targeted programme of GP education to provide support to primary care, promoting best practice and appropriate consistency of referral behaviour

GP education

Development and delivery of a programme of GP education sessions, GP participant feedback, monitoring of referral behaviour

Education strategy development

Evaluate short, medium and long term educational needs for general practitioners to support ongoing professional development. Develop strategy to facilitate education.

- In collaboration with GP Governing Body clinical lead, continue to develop and education strategy in line with national and local initiatives (Jun 14)
- Overarching aims to:
  - Use education as a tool to promote aims of WNCCG
  - Support ongoing professional development
  - Disseminate information about new pathways, treatments and best practice
  - Be responsive to future workforce needs

Education strategy execution

Plan for execution of GP education strategy, ensuring maximum engagement, uptake and impact

- Organise clinical conference, open to all GPs, to debate options for expenditure, informed by WNCCG suggestions (May 14)
- Establish a variety of forums to promote GP education (May 14)
- Engage with locality groups/individual practices to finalise options (Jun 14)

KEY DELIVERABLES	5 Outcome Domains					7 Outcome Ambitions							6 system characteristics					
	1	2	3	4	5	1	2	3	4	5	6	7	1	2	3	4	5	6
Primary Care (WNCCG, NHSE)														■				
Referral management (RMC)														■				■
Primary care QIPP delivery														■				
Local Enhanced Services (LES)			■					■						■	■	■		
£5 per head scheme			■					■	■					■	■	■		
GP education		■	■					■	■					■				

Commissioning intervention: Patient and public involvement

Commissioning intervention: Patient and public involvement

What we've done, and will do

Transforming participation in health and care

Individual care planning, personal health budgets

WNCCG 'stakeholder events' 2013/14, planned for 14/15 to inform needs, Patient feedback via provider contracts

WNCCG 'stakeholder events' 2013/14 which has informed 2013/14/15 commissioning, planned for 14/15 to support planned West Norfolk 'Alliance' work

NHS commissioners should:

- Make arrangements for and promote individual participation in care and treatment through commissioning activity.
- Listen and act upon patient and carer feedback at all stages of the commissioning cycle – from needs assessment to contract management.
- Engage with patients, carers and the public when redesigning or reconfiguring healthcare services, demonstrating how this has informed decisions.
- Make arrangements for the public to be engaged in governance arrangements by ensuring that the CCG governing body includes at least two lay people.
- Publish evidence of what 'patient and public voice' activity has been conducted, its impact and the difference it has made.
- CCGs will publish the feedback they receive from local Healthwatch about health and care services in their locality.

2 lay members on WNCCG governing body

WNCCG 'stakeholder events' 2013/14, planned for 14/15

WNCCG 'stakeholder events' 2013/14, planned for 14/15

TRANSFORMING PARTICIPATION IN HEALTH AND CARE: 'The NHS belongs to us all', September 2013, NHS England

Commissioning intervention: Patient and public involvement

WN 'Alliance' – stakeholder involvement

In the next 5 years West Norfolk will face significant challenges in delivering high quality health and social care which meets the needs of its population.

Effective, two-way communication and engagement is integral to the success of the West Norfolk 'Alliance'. Clear and open exchange between partners and their staff, patients and stakeholders is vital to create an innovative model of delivery that is fit for purpose and for the ongoing functional success of the partnership. Ensuring that different audiences have the correct information at the right time is crucial. Our goal will be to create a framework which will enable all sectors of the community to engage productively with the Alliance in a meaningful dialogue that influences service delivery.

In its' Communication and Engagement strategy the Alliance has committed to adoption of the following principles for user group/patient and public involvement, and communication:

- To ensure that user groups/patients and the public can share their experiences of health and care services and that feedback will be used to inform the development of services
- To provide opportunities for users/patients and the public to respond to, and comment upon, issues in order that they can influence decisions about system structures and ensure that proposed models are convenient and effective
- To ensure that patients and the public understand how their views will be used, which decisions they will be involved in, when decisions will be made and how they can influence the process, and publicise the ways in which their input has influenced decisions
- To provide clear and timely information about services which help people to access appropriate services

The Alliance communications and engagement opportunities will be:

- Timely
- Inclusive
- Designed for the respective audience and associated purpose
- Open and transparent
- Constructed to provide opportunities to influence decision-making processes
- Two-way, allowing for constructive feedback

A variety of mechanisms will be used to engage with the wider public, recognising the diversity of the West Norfolk population. These will include, but not be limited to traditional printed media, electronic/digital media, social media and face to face interaction.

Financials

Commissioning intervention: Financials

5 year financial summary

Description	*2013/14 Forecast £m*	2014/15 Plan £m	2015/16 Plan £m	2016/17 Plan £m	2017/18 Plan £m	2018/19 Plan £m
Revenue						
Programme Funding	*215.2*	215.9	223.3	227.2	231.1	235.1
Running Costs Allowance	*4.1*	4.1	3.7	3.7	3.7	3.7
Total Revenue	***219.3***	**220.0**	**226.9**	**230.9**	**234.8**	**238.8**
Baseline Expenditure (before savings plans)						
Programme Spend						
Acute Commissioning	*127.1*	124.7	126.0	128.2	128.7	129.2
Mental Health Commissioning	*16.4*	16.2	16.2	16.2	16.1	16.0
Continuing Healthcare	*14.0*	13.7	14.9	16.3	17.5	18.7
Community Commissioning	*19.5*	19.4	19.2	19.5	19.4	19.3
Prescribing / Primary Care	*36.1*	37.0	38.6	40.4	42.4	44.4
Non-Recurrent / Transformation Reserve	-	5.3	2.2	2.2	2.3	2.3
Better Care Fund	-	-	11.4	11.4	11.4	11.4
Other Reserves	-	3.0	5.0	9.2	13.8	18.4
Total	*213.1*	219.3	233.5	243.6	251.5	259.8
Running Costs	*4.1*	4.1	4.2	4.3	4.4	4.5
Total Expenditure before savings	***217.2***	**223.4**	**237.7**	**247.9**	**255.9**	**264.3**
Planned Surplus / (Deficit) before savings	***2.1***	**(3.4)**	**(10.7)**	**(17.0)**	**(21.1)**	**(25.5)**
Savings required to deliver 1% surplus						
Annual QIPP requirement	-	(5.6)	(7.4)	(6.3)	(4.2)	(4.4)
Cumulative total QIPP savings	**-**	**(5.6)**	**(13.0)**	**(19.3)**	**(23.5)**	**(27.9)**
Planned Surplus / (Deficit) for Year	***2.1***	**2.2**	**2.3**	**2.3**	**2.3**	**2.4**
Annual Savings (QIPP) requirement as a % of Programme funding	***3.3%***	***2.6%***	***3.3%***	***2.8%***	***1.8%***	***1.9%***

The 5 year financial plan reflects key assumptions from NHS England on funding growth and national tariff changes, and adheres to the required business rules ie:

- Delivery of a 1% surplus each year
- Establishment of a non-recurrent contingency reserve of 0.5% of funding
- Setting aside of 2.5% non-recurrent funding in 2014/15 (of which 1% is available for Transformational purposes), and 1% thereafter.

There is a step change in 2015/16 with the introduction of the Better Care Fund (BCF), whereby WNCCG is required to pool £11.4m of funding with Social Care, of which £3.6m is matched by an increase in funding to the CCG.

Running costs are expected to reduce by 10% in 2015/16, in line with national reductions to funding for the Running Costs Allowance. This reduction will be largely achieved via efficiencies within the Commissioning Support Unit.

The result of the CCG's financial model is an annual QIPP (Quality, Innovation, Productivity, Prevention) target of 2.6% (£5.6m) in 2014/15, growing to 3.3% (£7.4m) in 2015/16.

QIPP PLAN 2014/15 - 2018/19: 5 YEAR SUMMARY

Work Programme	Planned Savings per Year					Total Savings	*Total Savings*
	2014/15	2015/16	2016/17	2017/18	2018/19		
	£m	£m	£m	£m	£m	£m	%
Urgent Care & Long Term Conditions	1.6	1.3	1.0	1.0	1.1	6.0	*20%*
Planned Care	1.4	0.8	0.5	0.5	0.5	3.6	*12%*
Pathway Reviews	0.7	2.9	0.8	-	-	4.4	*15%*
Prescribing	1.3	1.3	1.3	1.4	1.5	6.7	*23%*
Contract Management *(see note)*	1.7	0.9	0.8	0.8	0.8	5.0	*17%*
Running Costs	-	0.5	0.1	0.1	0.1	0.8	*3%*
Unidentified QIPP	-	-	1.8	0.4	0.5	2.8	*10%*
Total Planned Savings	**6.7**	**7.6**	**6.3**	**4.2**	**4.4**	**29.3**	***100%***
QIPP Requirement	**5.6**	**7.4**	**6.3**	**4.2**	**4.4**	**27.9**	
Headroom / (Gap)	**1.1**	**0.2**	**0.0**	**0.0**	**0.0**	**1.4**	
Headroom / (Gap)	***20%***	***3%***	***0%***	***0%***	***0%***	***5%***	

Further detail of the 2014/15 & 2015/16 QIPP plans is shown on pages 87 & 89

Note: The annual savings for Contract Management include £0.8m of non-recurrent savings assumed each year

The annual QIPP requirements identified in the 5 year Financial Plan Summary will be met by delivery of a challenging QIPP plan, which is summarised by category in the above table. Best practice indicates that a QIPP plan should target at least 120% of the savings requirement, so as to give some "headroom" to allow for under-delivery of individual schemes. The CCG QIPP plan for 2014/15 achieves this level of headroom but it is not yet identified for subsequent years, and from 2016/17 onwards there is a level of unidentified QIPP savings.

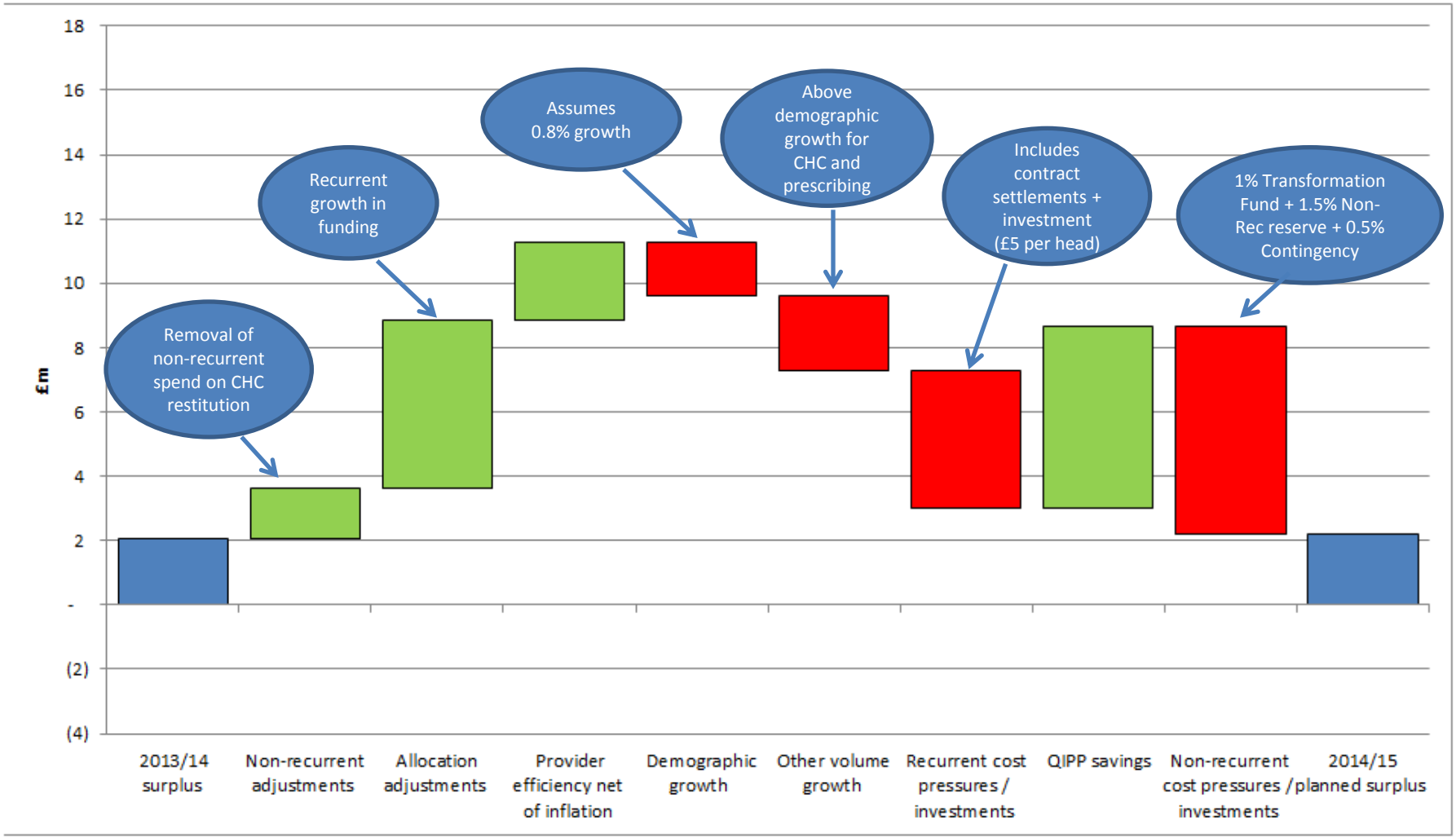
This table indicates that the main QIPP focus is in the following areas:

- Urgent Care & Long Term Conditions – the plan assumes a 2% reduction in emergency hospital admissions in both 2014/15 and 2015/16, with further reductions in A&E attendances and in length of stay. This will be supported by a range of initiatives, and is aligned to the aspirations under the Better Care Fund. This category also includes significant anticipated savings on the prices for Continuing Healthcare packages
- Pathway reviews – to be informed by the system-wide work of the West Norfolk Alliance
- Prescribing – the QIPP plan assumes annual cost efficiency of 4%, reflecting the fact that current prescribing spend in West Norfolk is an outlier locally and nationally.

Commissioning intervention: Financials

2014/15 financial movements

Movement between 2013/14 surplus and 2014/15 planned surplus



Commissioning intervention: Financials

2014/15 QIPP plan

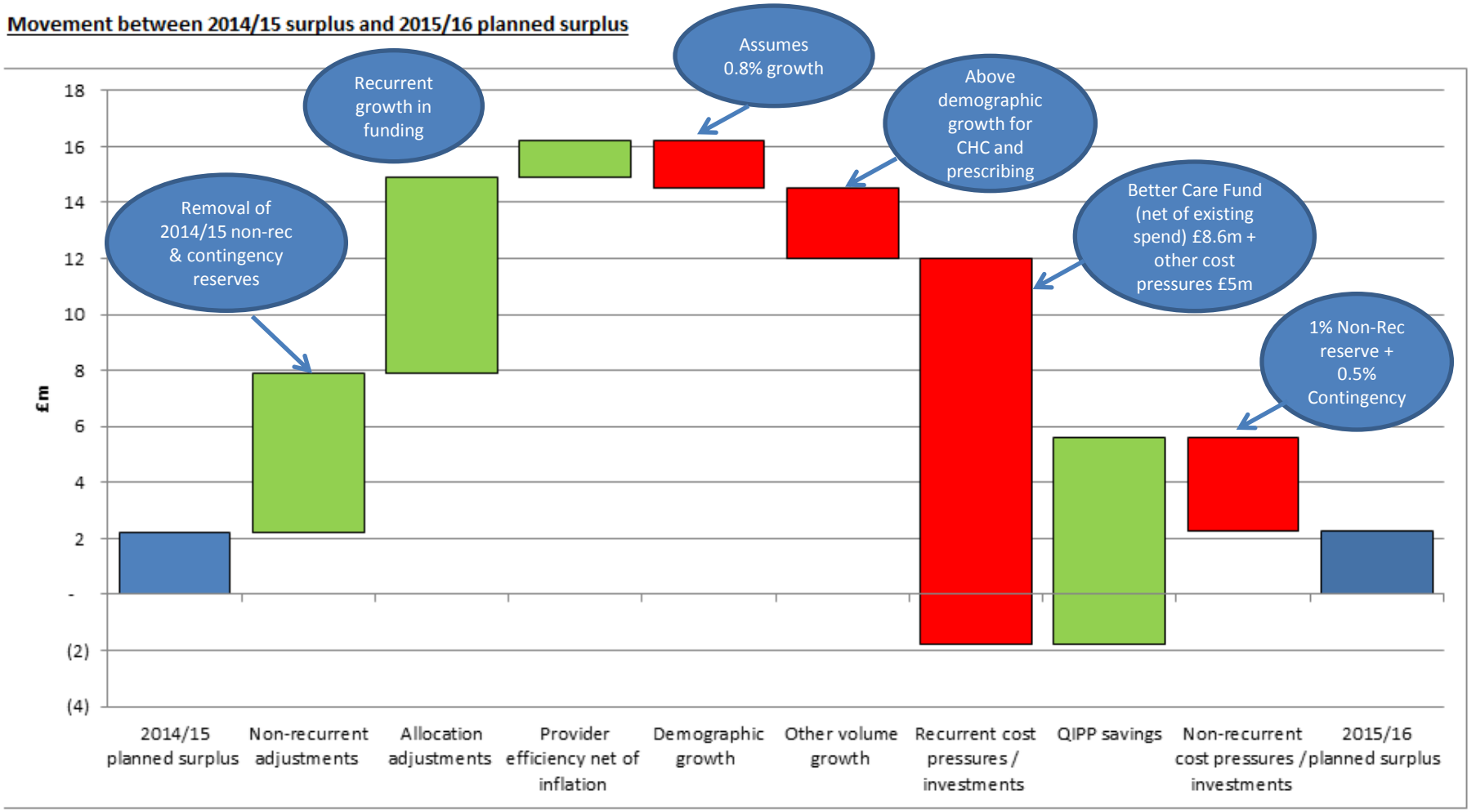
This table provides some detail behind the high-level figures shown on page 85.

Work Programme	Initiative	Ref	Effective Date	Rec/ Non-Rec	Planned Savings 2014/15 £000	Planned Savings Full Year £000
Urgent Care & Long Term Conditions	Maintain QEH emergency admissions at 13/14 levels	1.1	01-Apr-14	Rec	261	261
	Maintain QEH A&E attendances at 13/14 levels	1.2	01-Apr-14	Rec	30	30
	2% reduction in emergency admissions to the QEH as a result of existing Urgent Care initiatives enhanced by Better Care Fund (BCF) and practice action plans:					
	Gross savings (ie full cost of admissions)	1.3	01-Oct-14	Rec	760	1,520
	Reduction in marginal rate credit (70% of full cost)	1.3	01-Oct-14	Rec	(532)	(1,064)
	Reduction in emergency excess beddays as a result of practice plans and BCF initiatives	1.4	01-Oct-14	Rec	83	165
	2% reduction in A&E attendances as a result of practice action plans & BCF initiatives	1.5	01-Oct-14	Rec	75	150
	Continuing Healthcare - reduce baseline growth from 10% to 2%	1.6	On-going	Rec	953	953
	Sub-total				**1,630**	**2,016**
Planned Care	Maintain QEH elective admissions / day cases at 13/14 levels	2.1	01-Apr-14	Rec	173	173
	Maintain QEH outpatient attendances at 13/14 levels	2.2	01-Apr-14	Rec	178	178
	Maintain QEH other costs at 13/14 levels (eg direct access diagnostics)	2.3	01-Apr-14	Rec	126	126
	Practice-level reviews to reduce unwarranted variation (average £50k per practice)	2.4	01-Jul-14	Rec	825	1,100
	Reduction in volume of Pathology tests from review of GP requesting	2.5	01-Jul-14	Rec	100	150
	Sub-total				**1,402**	**1,727**
Pathway Reviews	Review of Pain Management service	3.1	01-Oct-14	Rec	160	320
	Impact of System Sustainability review	3.2	01-Oct-14	Rec	550	1,100
	Sub-total				**710**	**1,420**
Prescribing	Prescribing	4.1	On-going	Rec	1,253	1,253
	Sub-total				**1,253**	**1,253**
Contract Management	Contract challenges / fines	5.1	01-Apr-14	Non-Rec	500	-
	Performance management of CQUIN schemes (assumes 90% payment against targets)	5.2	01-Apr-14	Non-Rec	280	-
	Reduction in Pathology pricing following County-wide EPA procurement	5.3	01-Jan-14	Rec	400	400
	Cessation of contract with Referral Management Centre	5.4	01-Jul-14	Rec	150	200
	Review non-clinical contracts	5.5	01-Apr-14	Rec	250	250
	Transfer some costs of Wheelchairs services to specialist commissioners	5.6	01-Jul-14	Rec	150	200
	Sub-total				**1,730**	**1,050**
TOTAL PLANNED SAVINGS					**6,725**	**7,466**
QIPP REQUIREMENT					**5,621**	**5,621**
HEADROOM / (GAP)					**1,104**	**1,845**
Headroom / (Gap) %					***20%***	***33%***

Commissioning intervention: Financials

2015/16 financial movements

Movement between 2014/15 surplus and 2015/16 planned surplus



Commissioning intervention: Financials > 2015/16 QIPP plan

This table provides some detail behind the high-level figures shown on page 85.

It should be noted that these savings are in addition to those in the 2014/15 QIPP plan outlined on page 87.

Description	Effective Date	Rec/ Non-Rec	15/16 Savings £000	Full Yr Savings £000
Full year effect of 2014/15 schemes	**2014/15**	**Rec**	**1,520**	**1,520**
New schemes 2015/16:				
Prescribing	On-going	Rec	1,253	1,253
Continuing Healthcare - reduce baseline growth from 10% to 5%	On-going	Rec	597	597
Contract challenges / fines	01-Apr-15	Non-Rec	500	-
Performance management of CQUIN schemes	01-Apr-15	Non-Rec	280	-
Maintain QEH elective admissions / day cases at 13/14 levels	01-Apr-15	Rec	173	173
Maintain QEH emergency admissions at 13/14 levels	01-Apr-15	Rec	261	261
Maintain QEH A&E attendances at 13/14 levels	01-Apr-15	Rec	30	30
Maintain QEH outpatient attendances at 13/14 levels	01-Apr-15	Rec	178	178
Maintain QEH other costs at 13/14 levels (eg direct access diagnostics)	01-Apr-15	Rec	126	126
Running costs reduction (10%)	01-Apr-14	Rec	510	510
Impact of System Sustainability work	01-Apr-15	Rec	2,190	3,000
Total new schemes			**6,098**	**6,128**
TOTAL SAVINGS 2015/16			**7,619**	**7,649**
QIPP REQUIREMENT 2015/16			**7,384**	**7,384**
HEADROOM / (GAP)			**235**	**265**
Headroom / (Gap) %			***3%***	***4%***

Section 5: Clinical quality

Monitoring provider quality is a crucial responsibility for the CCG to ensure patient safety. We have taken a unilaterally firm line with our three main providers regarding approval of their quality impact assessments for their internal Cost Improvement Plans. We interpret our duty to include scrutinising not just the process that providers implement but the content of the plans and evidence that the consequences will not harm or reduce the quality of care for patients. We were also forerunners in our approach to developing detailed quality schedules in our 12/13 contracts, adding a much sharper focus to the required standards we expected from our providers, negotiated with substantial clinical input from both the CCG and providers.

During the first year since CCG authorisation, the CQC raised a number of serious concerns at the acute Trust in King's Lynn, culminating in 4 warning notices being issued in October, closely followed by Monitor placing the Trust in Special Measures in November. The CCG played a major part in the quality inspection programme, supporting and approving an integrated action plan. Prior to the CQC concerns being raised, the CCG had established a strong approach to addressing clinical quality, starting with contract negotiations in January to April 2013. A detailed quality schedule was developed, to agree the standards which must be met, with standard NHS contract enforcement consequences. In addition, local CQUINs were used to address some key quality concerns the CCG had that were having a significant negative impact on patient care and patient experience; recruitment and retention of nursing staff and effective discharge planning.

- The Trust was asked to implement exit interviews to ascertain the reasons for so many nurses leaving during the winter 2012/13 period.
- A target for each quarter was set for achieving discharges before midday.

The Head of Quality and Patient Safety and the Chief Officer undertook an unannounced quality visit in May 2013 and gave detailed feedback to the Director of Nursing. The CCG concerns were consistent with those highlighted later by the CQC and subsequently through the 3 day Regional Rapid Review in July, which the Chief Officer participated fully in. The resultant integrated action plan is regularly monitored through the local quality meeting with the Trust as well as the NHS England oversight group.

This approach has paid dividends as the CCG has developed a very constructive clinical relationship with the trust and has always been appraised of the concerns and risks regarding quality of care. We continue to work closely with the Trust and our Head of Quality and Patient Safety and our Governing Body Lead Nurse both meet regularly with the quality team and interim Director of Nursing to provide constructive challenge and offer support.

We adopt the same approach with all providers, including care homes, where a series of visits and meetings have taken place to assess the standards of care and provide feedback and recommendations. Quality is reported at every Executive and Governing Body meeting and takes precedence over other items. We encouraged fellow CCGs to adopt and actively promote the use of Quality Incident Reporting in primary care, which has given us direct patient evidence about lapses in quality that have been pursued formally with the provider in question. We encourage the public to raise concerns freely with us at our Governing Body meetings, where we either provide an immediate answer or a written response within 5 working days. In these ways, we have developed a reputation as a CCG with high expectations of the quality of care provided for our patients.

The Francis Report (2013) into failings at the Mid-Staffordshire Foundation Trust stressed that high quality care would not be best achieved through radical reorganisation but a re-emphasis of what really matters:

- A structure of clearly understood fundamental standards;
- Openness, transparency and candour throughout the system;
- Improved for compassionate caring and committed nursing;
- Strong and patient centred healthcare leadership;
- Accurate, useful and relevant information;

The main aims of the Francis Report recommendations are to:

- Foster a common culture shared by all in the service of putting the patient first;
- Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
- Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
- Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;
- Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
- Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

The Winterbourne report set out the type of care that people with learning disabilities, autism and behavioural issues should receive. These are:

- People should receive local personalised services that meet their needs, which should be planned from childhood;
- People should be supported in the community, in their home or close to their home and family;
- People should only go to hospital for assessment and treatment if it is necessary and they cannot get the support they need at home or in a community service;
- People that do have to go into hospital for assessment and treatment should receive good quality care as near to their home as possible;
- People should be moved on from hospitals as quickly as possible – either back home or on to other community support;
- Commissioners who place people with learning disabilities/autism in hospital or community support settings should have clear responsibility for each person;
- Commissioners should also make sure that people with learning disabilities/autism are able to see and speak to their families regularly;
- There should be local services that stop people with learning disabilities from having a crisis. If a crisis does happen then there should be local services to help people deal with the crisis.

The CCG has addressed these recommendations through an implementation plan, working with partners across health and social care. The quality governance structures and processes are outlined below.

The "NHS Nursing Strategy: Compassion in Practice" sets out the shared purpose for nurses, midwives and care staff to deliver high quality, embracing the six values; care, compassion, competence, communication, courage and commitment. It builds on the enduring values of the NHS, and the rights and pledges of the NHS Constitution. The strategy sets out six areas for action to be implemented over the next three years:

- Staying independent, maximising wellbeing & improving outcomes;
- Improving patient experience;
- Delivering high quality care & measuring impact;
- Building & strengthening leadership;
- Right staff, right skills, right place;
- Supporting positive staff experience.

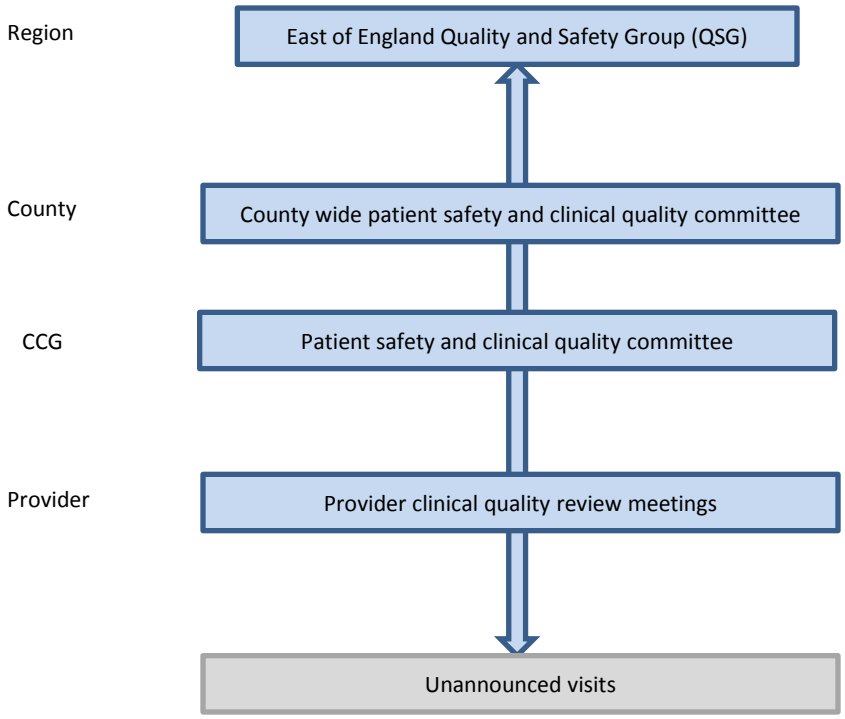
The CCG will ensure that all of our providers focus on the 'Six C's' putting the person being cared for at the heart of the care they are given. Where the local population is in need of NHS services, the CCG will seek to guarantee that they are respected and involved in care decisions, treated with dignity by a workforce who are competent, committed and have the courage to act as the patient advocate at all times. Through the Friends and Family Test, 'Patient Opinion' and Quality Incident Reporting the CCG will assess the patient's experience of compassionate care and this will continue to be regularly reviewed at the local Clinical Quality Review Meetings with Trusts and reported to the CCG Governing Body.

Clinical quality > Our approach to quality

The CCG has a statutory responsibility to ensure that all aspects of clinical quality and patient safety are embedded within the organisation, underpinned by a robust governance system. The CCG has a duty to commission services which have quality, safety, patient experience and continuous improvement as an integral element of the commissioning cycle. This is supported by DoH guidance: *Quality in the New Health System* (2012); *High Quality Care for All* (2008); and *Review of Early Warning Systems in the NHS* (2010) which challenges the NHS to go further in developing a health service which focuses systematically on improving quality and has quality as its organisational principle.

The CCG has a very strong quality and safety ethos, with a quality team comprising; Head of Clinical Quality and Patient Safety, a GP responsible for quality, safeguarding and information governance, the Nurse on the Governing Body, and a Quality Improvement lead. The team works closely with the performance team and communications staff (particularly around complaints). Quality is always the highest priority in the work of the CCG and all commissioning plans and decisions are scrutinised from a quality perspective before being ratified. The clinical quality team have strong support from the GPs on the Governing Body, for example through attending committees, reviewing plans and performance data, and making visits to clinical areas.

The WNCCG Patient Safety and Clinical Governance Framework



This monthly meeting reviews quality across all Trusts in the East of England and is chaired by NHS England Area Team Director of Nursing and Quality. The CCG reports to and regularly attends these meetings.

The Head of Clinical Quality attends the county-wide Patient Safety and Clinical Quality Committee (CWPSCQC). This provides a robust framework for sharing data/information and learning from key themes around Serious Incidents/Never Events across the five Norfolk CCGs. Feedback from the CWPSCQC committee is reported to the CCG Patient Safety & Clinical Quality Committee, Executive Team and the Governing Body.

WNCCG has established a Patient Safety & Clinical Quality Committee (WNPSCQC) which is chaired by the Nurse on the Governing Body to provide rigour and challenge to the Executive lead for quality. The WNPSCQ reports to the Governing Body and provides recommendations as appropriate to assure the Governing Body that quality and patient safety drive commissioning intentions for continuous quality improvement.

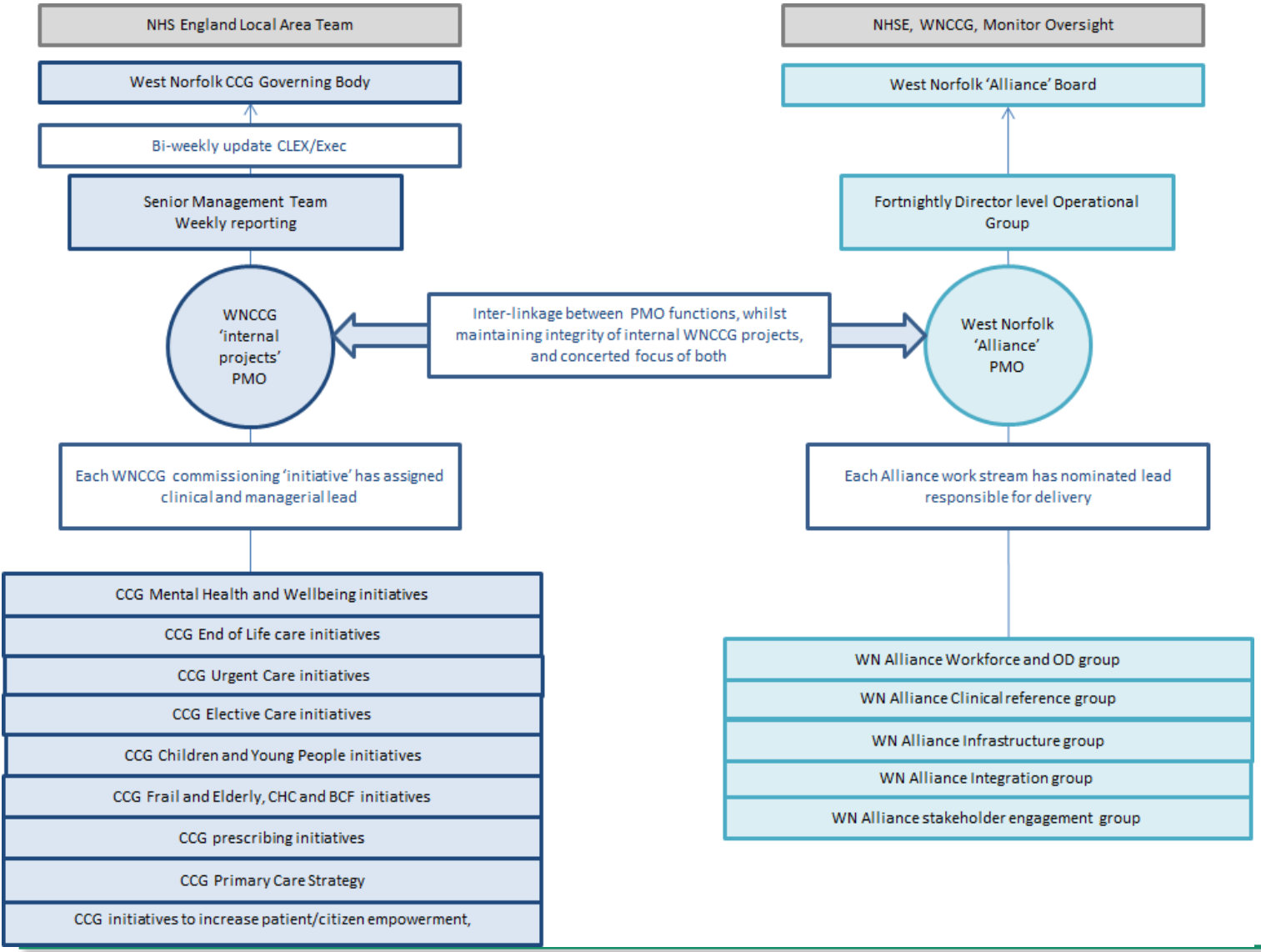
The Head of Clinical Quality chairs local Clinical Quality Review Meetings (CQRMs) with each of the 3 main providers, holding them to account for achieving the quality standards laid down in the quality schedule within the contract and reviewing their internal quality data regarding complaints, litigation, incidents to proactively drive the quality agenda at an operational level. A GP attends these meetings.

The Head of Clinical Quality, along with clinical colleagues within the CCG, undertakes announced and unannounced visits to nursing homes and Trusts to identify risks to patient safety and support actions to address them.

Section 6: Our governance and enablers

Our governance and enablers

Programme management



To manage both internal CCG 'Commissioning Intervention' delivery, and the West Norfolk 'Alliance' programme a programme management office (PMO) has been established. A PMO lead will work to coordinate and oversee timely management of the programmes of work.

Each project will be articulated within a robust Project Initiation Document (PID), with associated milestones, deliverables, quantified financial and activity impact and qualitative benefits as well as risks to delivery.

Delivery to time will be monitored via weekly Senior Management Team oversight, and reported to the Governing Body.

West Norfolk CCG: adapted from NHS England 'The NHS Standard Contract – A guide for clinical commissioners, 2013

Improved utilisation of the NHS Standard Contract is a key enabler to support delivery of the CCG's objectives.

Service specifications for all of our main providers were reviewed and refreshed during 2013/14 and will continued to be developed as appropriate, or at points of poor performance or service redesign.

Each provider contract has a quality schedule which encapsulates key national and local requirements, with CQUIN schedules devised to encourage stretch and innovation in the quality of delivery.

Performance management clauses within the contract will be robustly enacted 'in year', in response to poor performance. Heightened remedial actions are planned for areas of historic performance – for example PTL monitoring meetings to review RTT performance, UCWG meetings to review A&E performance etc.

Delivery of the NHS Constitution

The NHS is founded on a common set of principles and values that bind together the communities and people it services – patients and public – and the staff who work for it. The NHS Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Putting patients, the public and NHS staff first embodies the strategic values of WNCGG and underpins our approach to the commissioning cycle, in our planning for, securing and evaluating services. Quality at the heart of our commissioning process, our partnership working with local partners to deliver benefits for local communities and robust contract monitoring are some examples of this.

Under the Constitution's patient's rights and privileges include the delivery of:

- Maximum of 18 weeks from referral to treatment
- Maximum of 6 weeks for diagnostic tests from referral
- Cancer waits for referral and treatment
- Patient admission, transfer or discharge within 4 hours from arrival in A&E
- Ambulance response times

Achievement of these standards is monitoring through monthly provider performance review, contract reporting, and CCG performance reporting to the Governing Body and internal sub-groups. Provider failure to achieve these standards will result in appropriate CCG intervention, contractual escalation and support to ensure rapid return to target.

Health research is essential to continually improve health outcomes and the effectiveness of health services for patients. There is an expectation that the UK will be the first research-led health service in the world. Searching for and applying innovative approaches to deliver health care must be an integral part of the way the NHS does business). Doing this consistently and comprehensively will dramatically improve the quality of care and service for patients (Health Wealth and Innovation 2012).

The new Health and Social Care Act reflects these commitments and places a clear duty on the Secretary of State, the NHS England and Clinical Commissioning Groups (CCG) to promote research and champion innovation.

a) Research

In line with the research commitments, South Norfolk CCG has the responsibility for hosting the Norfolk & Suffolk Primary & Community Care Research Office, on behalf of all CCGs across Norfolk & Waveney, from April 2013. Patient and clinical involvement in research across West Norfolk CCG is robust. The CCG has a statutory duty to promote research including

- Participation in research
- Supporting research and using research evidence
- Proactive engagement with local partners
- Meeting treatment costs for patients taking part in research (including any Excess Treatment Costs)

In line with the research duty the CCG will:

- Agree a plan to enhance the research culture of the CCG-addressing leadership, education, use of evidence and partnership.
- Ensure provider contracts are fit for purpose in relation to the Research Governance Framework, Clinical Research Network (CRN) targets, and Quality Account arrangements.
- Chair the Norfolk and Suffolk Primary and Community Care Research Steering Group which oversees arrangement for Research Delivery through the Norfolk and Suffolk Primary and Community Care Research Office. This group has a mandate to agree strategic direction for research across Norfolk and Suffolk. The Research office supports the Research Design, Research Assurance, Study Delivery and Patient involvement in research across CCGs, academic organisations, primary and community Care providers and will deliver an agreed work plan

Through CRN involvement:

- Continue to support the establishment and development of the CRN; represent the interests of patients, commissioners, and primary care providers; work with CRN partners to support the delivery of the National Institute of Health Research (NIHR) performance framework and agree models of funding for enhanced patient and clinical involvement in research.
- Fully implement the research cost policy with NHS England, and Public Health England including agreeing processes for managing appropriate research treatment costs for provider organisations to ensure provider trusts identify research savings and reinvest these in new studies and where appropriate provide full business cases for additional research treatment funding from CCGs.
- Build on CCG leadership recommendation to enhance Research Dissemination particularly through GP Education routes. A new research dissemination process will be agreed with CCG leadership, Governing Body's.
- Work with R&D to Identify a research priority for a commissioned research call out for preparation of national research grant application (Research for Patient Benefit Grant) to include a systematic review that can be fed into commissioning programmes.

Where patient care is being provided which differs from the normal, standard, treatment for that condition (either an experimental treatment or a service in a different location from where it would normally be given) the difference between the total Treatment Costs and the costs of the "standard alternative" (if any) can be termed the *Excess Element of Treatment Costs* (or just "**Excess Treatment Cost**"), but is nonetheless part of the Treatment Cost, not a Service Support or R&D cost. *DH HSG(97)32*

b) Clinical Academic Reserve

East Anglian Health Commissioners have helped drive research and innovation through contribution to the Clinical Academic Reserve over 30 years. These monies have funded a range of clinical academic posts at Cambridge University and more recently in Norwich at UEA. Assessment of the need for continued funding and fit with CCG population priorities is underway.

The CCG has a duty to spend monies in line with local needs and is examining the contribution made to local research and innovation agenda in order to make a decision on continued CCG funding of the CAR. The CCG recognises the role that academic organisations have and dependent on the outcome of the on-going review will work to redistribute the funding to support CCG priorities, as informed by discussion with Cambridge University in February 2014.

Innovation

The CCG recognises the importance of the three stages of the innovation agenda –invention, adoption and diffusion and has a statutory duty to champion innovation and the adoption of innovation including:

- Setting out the CCG approach to innovation
- Ensure strong leadership and accountability for innovation within our organisation
- Being an active partner in the local Academic Health Science Network

In line with the innovation duty the CCG will:

- Increase its understanding of opportunities for innovation by joining and working with the East Anglian Innovation Hub.
- Work in collaboration with the Academic Health Science Network (AHSN) to support the delivery of innovation, adoption and spread of evidence for Diabetes, Dementia and Chronic Disease Management.
- For 14-16, the CCG will work with the Research Office and AHSN to develop a post that will support increased involvement in the adoption and spread of evidence for the CCG/AHSN priority areas.
- Through CCG officer time contribute to the delivery by AHSN working Groups-(Chris Coath will be able to provide additional information on the group he supports)
- Deliver the EPaCCS innovation Project which aims to do the following: Develop an options appraisal for an electronic end-of-life register for South Norfolk CCG ,engaging with stakeholders, agreeing a pilot area with the GPs involved and working with them on how the register will be implemented and used, establish robust governance arrangements. The EPOC project was funded from the Innovation fund with the support of the AHSN.
- Use the collaborations such as AHSN that were developed through the EPaCCS Project to identify funding streams for the Friends and Family Test Early Adoption Wave project which aims to develop a set of quality indicators and dash board for community care providers (fractured neck of femur rehabilitation pathway) using the work of Kings Fund and CQC and align patient data within these core indicators. This will help providers, commissioners, patients and carers.
- Review and strengthen CCG leadership and CCG innovation plans
- Through the Norfolk and Waveney CCG Chief Officers meetings support the cross CCG representation by West Norfolk CCG on the AHSN Partnership

NHS
Norwich
Clinical Commissioning Group

Operational Plan 2014 - 2016

April 2014

Document Control Sheet

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National background and context

This section gives an overview of the national context in which Norwich Clinical Commissioning Group (NCCG) is working and key areas of healthcare policy guiding our planning and commissioning process.

Introduction

NHS England's publication *"Everyone Counts: Planning for Patients 2014/15 to 2018/19"*[1] establishes the approach for CCGs to work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable, high quality care for all.

This document emphasises the need for an outcomes focused approach to planning, aligned to the NHS National Outcomes Framework, and for Clinical Commissioning Groups (CCGs) plans to reflect stretching local ambition over the next 5-year period.

NCCG Strategic Plan 2014/15-18/19

Norwich CCG (NCCG) has joined together with North Norfolk CCG (NNCCG) and South Norfolk CCG (SNCCG) to work as one strategic unit of planning particularly in relation to the interface with the principal acute services provider, the Norfolk and Norwich University Hospitals NHS Foundation trust (NNUHFT). We are committed to working with all providers, local government partners, patients and the public to develop a strong, robust and ambitious 5-year strategic plan. This collaborative plan will secure the continuity of sustainable high quality care for everyone in North, Norwich and South Norfolk and is due for publication in June 2014.

Organisations in Norfolk are already committed to creating and delivering an integrated health and care system that supports our population to remain living independently with a good quality of life for as long as possible. All partners are committed to delivering high quality person-centred services, and agree that the only way to do this effectively is to work together to remove barriers, share the financial commitments and risks and ensure that we spend as much as possible of our budgets on integrated care.

The current national, regional and local position provides a significant opportunity for planning transformational change in the system, integrating service provision where it is appropriate and radically re-thinking how care can be provided in to the populations of North, Norwich and South Norfolk CCGs.

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[1] http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

To do this, the three CCGs and all our local health services, primary and community care services, District and City Councils, Norfolk County Council, our local GPs and our voluntary sector and communities need to develop a common, united vision.

However, this transformational change is taking place when the health and social care system in Norfolk is facing a number of major challenges over the next few years including:

- Workforce and staffing – significant recruitment and retention difficulties in certain key areas and an ageing workforce;
- Seven day working leading to further staffing and resourcing issues;
- The impact of the Care Bill[2]
- Significant financial constraints – against a background of an ageing population, an increase in long term conditions, rising costs and increased public expectations

In order to address these issues and to ensure that high quality local services are available where possible North Norfolk, Norwich and South Norfolk CCGs, Norfolk County Council and local District and City Councils are proposing to work together to commission integrated services in their area of Norfolk.

The strategic planning will consider all options to ensure resilient, viable, high quality services are available for North, Norwich and South Norfolk residents. It is therefore imperative that this is co-produced with providers, patients/service users and other stakeholders and develops a joint approach between health and care for assessment and care planning. The development of our 5-year Strategic Plan will be informed by the use of the Better Care Fund.

Our draft 5-year strategic plan on a page is contained in *Appendix 1*

Better Care Fund (BCF)

The £3.8 billion national *Better Care Fund*[3] (formerly the Integration Transformation Fund) was announced by the Government as part of the Comprehensive Spending Review in June 2013. It requires local areas to formulate joint plans for integrated health and social care, and to set out how the single 'pooled' budget will be used to facilitate closer working between health and social care to provide consistent, joined-up, high quality services for everyone and achieves the best outcomes for local people.

In order to access the BCF, CCGs and Local Authorities (LAs) must submit a five year delivery plan for approval by Government.

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[2] http://services.parliament.uk/bills/2013-14/care.html
[3] https://www.gov.uk/government/publications/better-care-fund

In addition to the Norfolk Health and Wellbeing Board (H&WBB) and individual partner organisations, the process of developing the delivery plan is supported by NNCCG and SNCCG, under the governance of the System Leadership Partnerships that bring together relevant commissioners and providers.

The BCF provides an opportunity to rapidly progress the delivery of the vision of the Norfolk H&WBB. In particular the focus is on early intervention and prevention, ensuring services are integrated at the point of delivery, that there are seamless services, including mental health (MH), and a focus on reducing loneliness and social isolation for older people.

The Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and quality of life. It will also support the aim of providing people with the right care, in the right place, at the right time, including a significant expansion of care in community settings. This will build on the existing work of Norfolk CCGs and the LA. Further detail around the use of the Better Care Fund locally, and the 5-year delivery plan that underpins it, is set out in Appendix 1.

NHS Outcomes Framework

The *NHS National Outcomes Framework 2014/15*[4], together with the *Adult Social Care*[5] *and Public Health Outcomes*[6] *Frameworks* together support the Government's desire to improve integration of services. These document set the national policy context and describe a range of indicators by which performance and outcomes for the NHS will be measured. These policy documents support NCCG's desire to improve integration of services.

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on:

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

[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256456/NHS_outcomes.pdf
[5] https://www.gov.uk/government/publications/adult-social-care-outcomes-framework-2014-to-2015
[6] http://www.phoutcomes.info/

Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

The *Public Health Outcomes Framework* consists of two overarching outcomes that set the vision for the whole public health system of what is to be achieved for the public's health. The outcomes are:

Outcome 1	Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life
Outcome 2	Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

These outcomes have been translated into **seven specific, measurable ambitions**, or critical indicators of success, which form the foundation of this Operational Plan, and against which the CCG will demonstrate significant improvement:

Ambition 1	Securing additional years of life for people with treatable mental and physical health conditions
Ambition 2	Improving health-related quality of life for people with LTCs, including Mental Health
Ambition 3	Reducing the amount of time people spend in hospital by having better more integrated care in community
Ambition 4	Increasing the proportion of older people living at home independently following discharge from hospital
Ambition 5	Increasing the number of people with physical and Mental Health conditions who have a positive experience of hospital care
Ambition 6	Increasing the number of people with a positive experience of care outside of hospital, in General Practice and in the community

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

Additionally, NHSE has identified **three more key measures** where there is an expectation of significant focus and rapid improvement:

NHSE key measure 1	Improving health through promoting healthy environment and lifestyles
NHSE key measure 2	Reducing health inequalities between communities and within communities
NHSE key measure 3	Moving towards parity of esteem, ensuring an ***equal*** focus of improving mental health and physical health

Improving the health of local people

In November 2013, NHSE published *"A Call to Action: Commissioning for Prevention"*[7] which suggests prevention programmes can be important enablers for reducing acute activity and capacity over the medium term, and sets out a five-step framework intended to support CCGs in commissioning for effective prevention:

	1 Analyse key health problems	2 Prioritise & set common goals	3 Identify high-impact programmes	4 Plan resources	5 Measure & experiment
Mature	• Local of analysis of deaths, chronic disability & risk factors in place, with understanding of sub-populations & potential future trends • Performance bench-marked nationally	• Small set of priorities focused on top health problems • Priorities supported by all major players local health economy • Priorities are quantified, including early detection	• Jointly commissioned primary & secondary initiatives highly focused on risk factors & key causes of morbidity and mortality • Early detection initiatives identified	• Reallocation is meaningful & phased realistically • Innovative use of health economy-wide funding including ITF • Investment linked to reduction in acute capacity over time	• Outcome & process metrics in place to measure progress on each prevention priority & programme • Experimental approaches where evidence base is poor that can be evaluated
Emerging	• Local analysis of causes of premature deaths, chronic disability & risk factors is in place • Collaboration with peers in the area/region to understand relative performance	• Priorities are focused on the big problems but set organisation- by-organisation • Some key players are not engaged in prevention goals • Quantified targets are not yet shared	• Isolated primary & secondary programmes driven by different organisations • No early detection activities outside nationally mandated programmes (e.g. screening)	• Targets for reallocating resources over time established • Funding for priorities provided organisaiton- by-organisation; little joint commissioning • Plans in place to deploy ITF	• Outcome & process metrics in place to measure progress on each prevention priority but tend to be long-term • Innovations are difficult to evaluate
At the start	• Data on premature deaths, chronic disability & risk factors are national only • Understanding of performance v peers is anecdotal	• Priorities attempt to embrace too much • Priorities are driven by legacy activities rather than epidemiology • Priorities are not translated into targets	• Prevention initiatives are limited to national screening, QOF-driven activities & other centrally driven initiatives	• Priorities not backed up by reallocation in resources • Funding driven by what's been done in the past rather than future needs	• Difficult to measure progress against preventative priorities • Measures are very long-term (e.g survival rate) and reactive (e.g. prevalence)

NCCG will proactively work with Norfolk H&WBB partners, utilising the principles outlined in the above framework, to deliver the Health and Wellbeing Strategy[8] including those areas of the strategy focusing on health improvement and prevention.

[7] http://www.england.nhs.uk/wp-content/uploads/2013/11/call-to-action-com-prev.pdf
[8] http://www.norfolk.gov.uk/view/NCC122775

As part of the development of a combined 5-year strategic plan with NNCCG and SNCCG 9 areas of intervention have been agreed to support the ambitions and outcomes framework. They are as follows:

Intervention 1	Development of primary care localities
Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Intervention 3	Proactive use of predictive modelling and risk stratification
Intervention 4	Easy to access, seven day health and social care provision for people with complex mental and physical health and care needs
Intervention 5	Enable independence, self care and self management
Intervention 6	Improved support for people with Dementia and their carers
Intervention 7	Deliver major redesign of urgent care system
Intervention 8	Ensuring effective end of life pathways and support
Intervention 9	Ensuring effective workforce planning

Reducing health inequalities

Health inequality can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mortality rates between people from different socioeconomic groups. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned.

NCCG is committed to improving its approach to equality and diversity linked to health inequalities, and has set out four equality objectives:

- Patients and carers experience joined-up healthcare, ensuring access to the right services at the right time
- The CCG will improve use of equality data and information about NCCGs population and communities to inform its work
- The CCG will improve the way that the Governing Body and Leadership Team can learn from healthcare experiences of diverse and marginalised individuals, groups and carers
- Senior leaders and other managers provide leadership, support and motivation for their staff to uphold the CCG's value of equality of opportunity to improve the health of those most in need

It is acknowledged that significant changes to the way health service are delivered will be required if the above outcomes and ambitions are to be fulfilled. Thus, NHSE has identified **six characteristics (models of care)** from the 'Call to Action' work that a high quality, sustainable health and care system will need to have in place within five years:

NHSE Model of care 1	A new approach to ensuring citizens are fully included in all aspects of service design and change, and patients are empowered in their own care
NHSE Model of care 2	Wider primary care provided at scale
NHSE Model of care 3	A modern model of integrated care
NHSE Model of care 4	Access to highest quality urgent and emergency care
NHSE Model of care 5	A step change in the productivity of elective care
NHSE Model of care 6	Specialised services concentrated in centres of excellence

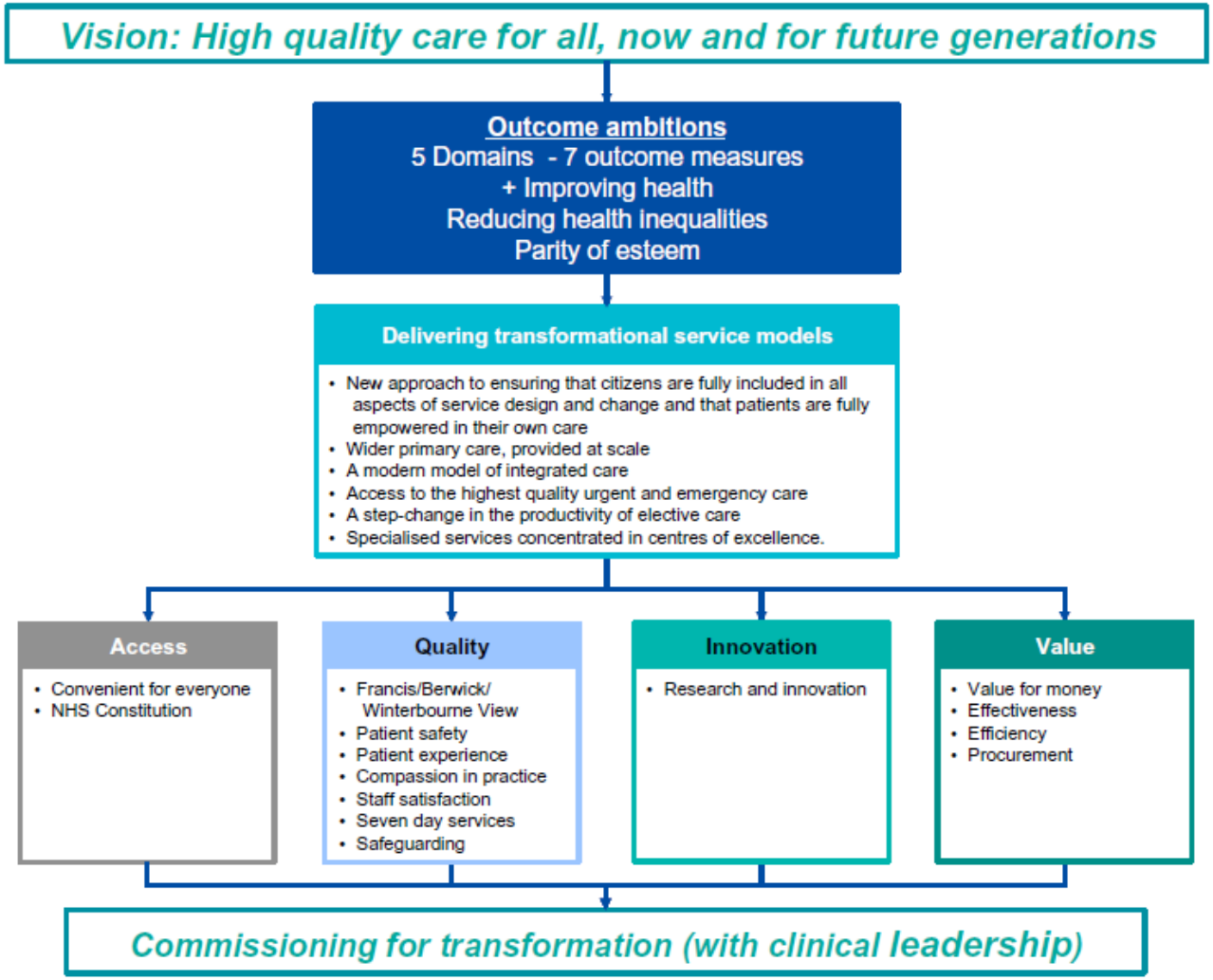
This Operational Plan sets out the CCG's approach to implementing each of these 'models of care'

Finally, there are **four essential elements** that will apply to all of the characteristics of a successful and sustainable health economy. The CCG will continue to place significant focus on these elements and articulates later in this plan how they will be implemented to drive up outcomes for patients and local communities the essential elements are:

Quality	Access	Innovation	Value for Money
Focusing on: • Patient safety • Patient experience • Compassion in practice • Staff satisfaction • Seven day services • Safeguarding (adult and child)	Focusing on: • Disadvantaged and minority groups • Extending access in primary care	Delivering change through: • Innovation • Strategic partnerships • Communication technologies inc clouds and big data • Adopting and promoting best practice • Continual research and evaluation	Focusing on: • Effectiveness Efficiency • Improved procurement • Continuous improvement

Please see Figure 1 overleaf for a pictorial summary.

Figure 1: summarises the national framework through which NHSE's overarching vision and ambitions will be delivered, and which the CCG will deliver locally for the people Norwich.



Strategic clinical networks

Strategic clinical networks (SCNs) hosted and funded by the NHS England (NHSE) established in April 2013 cover conditions or patient groups where improvements can be made through an integrated, whole system approach. These networks help NHS commissioners to reduce unwarranted variation in services and encourage innovation.

The conditions or patient groups covered by the East of England SCNs are:

- Cancer
- Cardiovascular disease (including cardiac, Stroke, Diabetes and renal disease)
- Maternity and children's services
- Mental health, Dementia and neurological conditions

NCCG clinical leaders play an active part in these networks and support the development of quality improvement in local services. Two areas of specific focus are reducing mortality and morbidity for people with stroke and diabetes.

NHS Constitution

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it. **The NHS Constitution**[9] establishes the **principles** and **values** of the NHS in England. It sets out **rights** to which patients, public and staff are entitled, and **pledges** which the NHS is committed to achieve, together with **responsibilities** which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Under the Constitution patient's rights and privileges include the delivery of:

- Maximum of 18 weeks from referral to treatment;
- Maximum 6 weeks wait for diagnostic tests from referral;
- Cancer waits for referral and treatment;
- Patient admission, transfer or discharge within 4 hours from arrival in A&E;
- Ambulance response times.

NCCG has embraced these rights and pledges within its Operational Plan and sets out its plans to commission sufficient services to ensure it can deliver those rights and pledges for patients on access to treatment.

[9] https://www.gov.uk/government/publications/the-nhs-constitution-for-england

Mandated in the Standard NHS Contract[10] is the requirement for the provider to comply with the NHS Constitution. This is set out in Service Condition No 1, and stipulates that the Parties must abide by and promote awareness of the NHS Constitution, including the rights and pledges set out in it. The Provider must ensure that all Sub-Contractors and all Staff abide by the NHS Constitution.
Specifically, set out in the Particulars, within the Quality Requirements (QR) is:

- The requirement for patients to start consultant-led non- emergency treatment within a maximum of 18 weeks of a GP referral. The provider is also required to take all reasonable steps to offer a range of alternatives if this is not possible
- The requirement for patients to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected;

As well as the lever to apply financial consequence for failing to meet the mandated Operational Thresholds, there are supportive local Thresholds to hold Providers to account. These include sanctions that can be applied if planned operations are cancelled if escalation is required under General Condition 9 of the Contract, the Provider is required to agree a Remedial Action Plan, and actions will be set out to ensure remedy accommodating demand and peaks in activity.

Delivering improved outcomes for local people

NHSE is asking NCCG to review its strategic and operational plans that were developed as part of the 'Authorisation' process completed in 2013 (the process whereby CCGs were formally ratified).

NCCG's *'Health and Well-being Strategy, 2012-2016[11]'* gave a four-year strategic overview of the health and social care priorities for the population of greater Norwich, and detailed the commissioning priorities and intentions of NCCG within the local health economy. This overview was also captured in a visual matrix in NCCG's 2013 'Plan on a Page'.

'Everyone Counts: Planning for Patients 2014/15 to 2018/19' provides NCCG with the opportunity to refresh its *Integrated Commissioning Strategy* 2012-2016 and develop a robust and ambitious five-year plan (through to 2018/19).

[10] http://www.england.nhs.uk/nhs-standard-contract/

Norfolk Health and Wellbeing Board

The H&WBB provides a focus for bringing together social care (for adults and children), public health and the CCG's priorities; its high-level membership reflects this with representatives including Directors of Community Services, Children's Services, Public Health, as well as representation from NCCG and the other Norfolk CCGs. It is chaired by the leader of the County Council.

The H&WBB's strategy for Norfolk has helped to inform our Joint Strategic Needs Assessments (JSNAs) which formed the evidence base for our 2013-16 strategy and this 2014-16 Operational Plan.

The priorities for the H&WB are:

- Promote healthy lifestyles
- Strengthen investment in prevention and early intervention
- Promote integration of care pathways
- Reduce health inequalities

NCCG along with SNCCG and NNCCG already have plans in place to jointly develop our 5-year strategy, which is due for publication in June 2014.

Collaborative working with District Councils

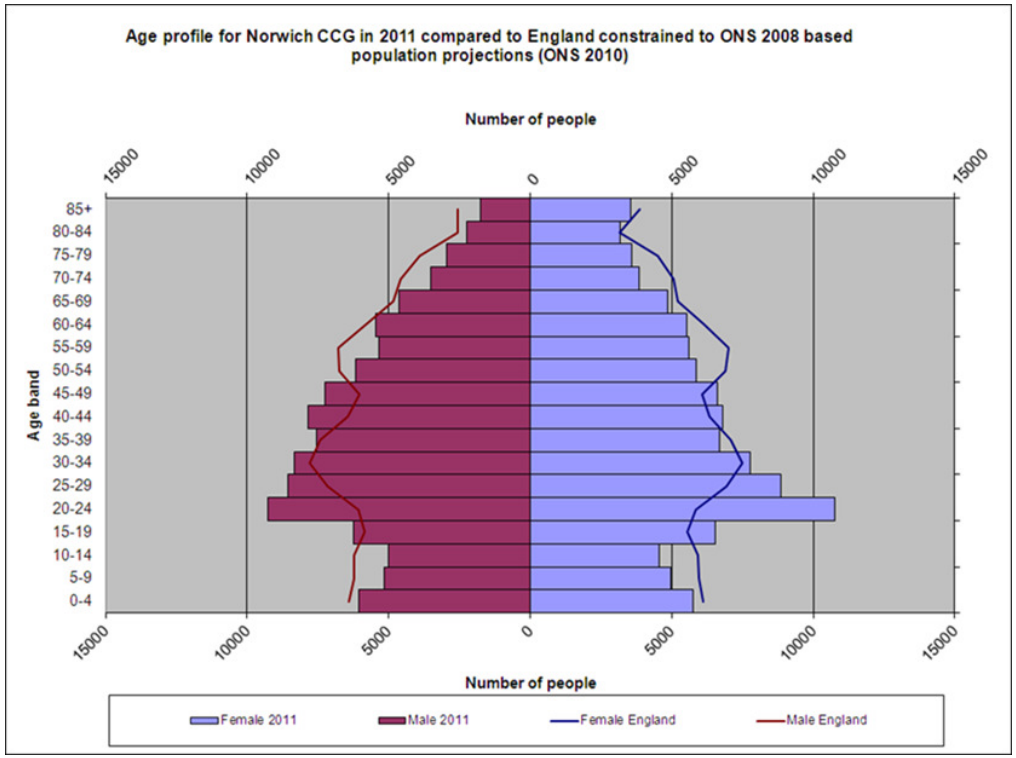
A key approach by NCCG is to work in partnership with Norwich City and Broadland District Councils to help deliver a number of commissioning initiatives, in particular around tackling adult and child obesity.

Going forward the CCG is fully committed to continued working and development of a package of bespoke initiatives with District Councils. This will be developed under the auspices of a localised H&WB. This is key to delivering the objectives of integration and the Better Care Fund. District Councils have rich insights into the needs of their communities and are well placed to support the local NHS to identify opportunities for early intervention to support people at home and avoid unnecessary secondary care admission.

The health and wellbeing profile (overleaf) has been developed by the public health team based at Norfolk County Council and led by the Consultant in Public Health Medicine aligned to the CCG. It is designed to help the CCG, local government, providers of health services, and partner organisations understand the health needs of different communities within Greater Norwich, and inform our work to improve people's health and reduce health inequalities.

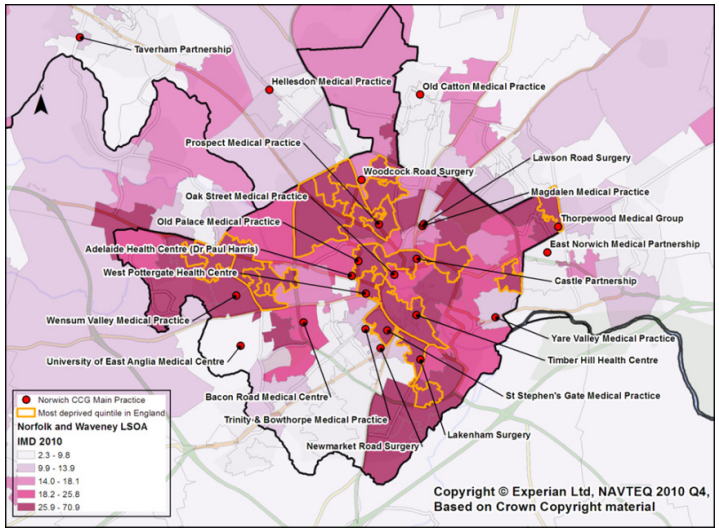
Our population

- Norwich CCG has a registered population of approximately 208,600 people. This includes males: 103,500, (49.5%); females: 105,100 (50.5%).
- There are 23 general practices in Norwich CCG; practice list sizes range from 1,887 persons to 17,028 persons with an average list size of 8,922 persons.
- Norwich has a youthful age profile, with large proportions of younger people (particularly 20 to 29 year-olds) in the population compared with the county rate.
- 69% of the population are of working age; well above county and national rates.
- Norwich has lower proportions of children and older people particularly in comparison with Norfolk as a whole.
- Over the next 20 years, Norwich is likely to see much larger increases in working age population as a proportion of the total population.
- Norwich has the highest number and proportion of people belonging to ethnic minorities in the county.



Deprivation

- Deprivation is higher than average and Norwich city is the 70th most deprived district in England.
- Norwich CCG has 1 practice in the most deprived quintile in England, 2 practices in the most deprived 10 in Norfolk and Waveney
- Out of the ten per cent most deprived LSOAs in England in terms of the IMD, 27 are in Norfolk and seven of these are in Norwich. If we look at the most deprived quintile in England, 23 LSOAs fall in this category.
- The 23 Norwich LSOAs in the most deprived 20% in England have the following characteristics on average:
    - over a third of people (35.4%) are income deprived
    - one in five of women aged 18-59 and men aged 18-64 (20.3%) are employment deprived
    - Nearly 1 in 2 children (48.8%) live in families that are income deprived
    - 37.5% of older people are income deprived
- The most deprived MSOAs in Norwich include Mancroft, Milecross, Lakenham and Wensum these are areas with greatest health need.
- At 32.5%, the proportion of children affected by income deprivation in Norwich is higher than that of Norfolk as a whole (based on 2007 Indices). This means that close to 7000 children in Norwich live in poverty.



Index of Multiple Deprivation 2010, Norwich by Lower Super Output Area.

Life expectancy

- Life expectancy for men is lower and for women higher than the England average for people resident in Norwich. Life expectancy for both men and women is higher than the England average for people resident in Broadland.
- Life expectancy is 6.7 years lower for men and 3.2 years lower for women in the most deprived areas of Norwich than in the least deprived areas (Health profile 2012). Life expectancy is not significantly different for men and women in the most deprived areas of Broadland compared to the least deprived areas.
- Over the past ten years, death rates from all causes has fallen. The early death rate from heart disease and stroke have improved in Norwich and Broadland. They are now similar to the England average in Norwich and better than England average in Broadland.
- There is a 3 fold variation between practices for cancer mortality among females. Although the male premature cancer mortality (DSRs) are significantly worse than county, regional and national averages, the variation is less than that observed for females at approximately 2 fold.
- Premature circulatory mortality has been increasing among females over the 4 year period observed (05-07 to 08-10). This is in contrast to county, regional and national trends. There is also a 5 fold variation in circulatory mortality between constituent practices.

The Life Course – Key Stages

Children and young people

- 78% of children in reception year are of a healthy weight. However, although this rate is better than county and national averages, it drops to 68% by Year 6
- Overall, levels of obese and overweight children in Year R and Year 6 in Norwich are average compared to the rest of the county. About 17% of Year 6 children are classified as obese.
- Compared with National rates, a low percentage of pupils spend at least 3 hours per week on school sport.
- Levels of teenage pregnancy are higher than county, regional and national averages.
- GCSE attainment for Norwich is the worst among local authorities in East of England.
- It is estimated there are 1,245 children in Norwich with a diagnosable mental health condition and a similar number are estimated to have emotional or behavioural problems.
- The extent of drug and substance misuse by young people aged between nine and 17 years in Norwich is above the average for Norfolk and regionally.

Working age

- An estimated 24% of adults smoke and 22% are obese.
- There are 194 deaths from smoking each year.
- In Norwich, only 1 in 10 adults participates in regular physical activity.
- Although the proportion of mothers who smoke during pregnancy in Norwich is not significantly different from the national average, this remains a key issue that needs to be addressed.
- Hospital admissions related to smoking are high, and lung cancer registrations are above the national average.
- There were 2,326 hospital stays for alcohol related harm in 2009/10
- Hospital admissions for alcohol-related harm in Norwich are significantly lower than the England average, although alcohol-specific admissions for females are higher.
- 3.7% of people in Norwich are diagnosed with diabetes, which is lower than the England average, although with undiagnosed cases the rate is estimated to be 5.6%, and rising over the next few years.
- Over the next ten years, the rate of people in Norwich living with the effects of COPD is expected to be consistently lower than that seen nationally.
- On average, 348 people in Norwich are diagnosed with cancer each year, with slightly more men diagnosed than women. Breast, lung, large bowel (colorectal) and prostate cancers account for over half of all the cancer diagnoses.
- Levels of diagnosed depression for Norwich Consortia patients for 2009/10 show an increase to 9.1% from 7.2% in 2008/09. This is a national trend and the overall increase is similar to that of Norfolk as a whole.
- Norwich has the highest rate of deaths from suicide and undetermined injury among those aged under 75 in Norfolk. Norwich rates are also higher than the average for the region and for England.
- Norwich has the lowest estimated rates of CHD across Norfolk, with the number of people living with ill health caused by CHD forecast to remain the same over the next ten years. A similar picture is seen for those living with the effects of stroke.

Older people

- Estimates show in Norwich, 554 men have dementia (one of the lowest across Norfolk), which is expected to rise to 850 by 2030. The figure for women is estimated at 1,060 and projected to increase to around 1,300 by 2030.
- The potential high cost of falls and frequency that they occur highlights the importance of prevention. Norwich has a high rate of Excess winter deaths compared to regional and national averages.

Communications and Engagement with Stakeholders

Empowering patients

NCCG fully recognises that the people in Norwich want to be:

- fully engaged in making positive choices about their own health and lifestyles;
- participating in the shaping and development of health and care services;
- have access to data and advice about health and services;
- be able to choose which health services they can use and how to access them.

NCCG will continue to use a range of ways to ensure patients and the wider public have a much greater say in how health services are organised, and to support patients and their carers in having a greater say in how their personal care is delivered. The CCG will continue to consult with patient forums and local representative groups. NCCG have developed an inclusive approach to decision-making processes through Board and public meetings and other stakeholder events.

The CCG will continually improve the quality of the services commissioned by both listening and responding the views of patients, carers and the wider community and utilising co-producing in service evaluation and design.

NCCG recognises that communicating effectively is important to everything we do. We aspire to the highest levels of honesty, openness and transparency, and actively promote both its successes and opportunities to improve. The well-established communications service has strong networks of communications professionals in all the provider organisations, and the CCG continues to build those networks with partners.

NCCG is in the process of consulting with key stakeholder organisations and patients to:

- Inform on why NCCG is producing their strategic and operational plans
- Ensure the role of carers is fully supported in all our strategies and plans
- Explain and discuss some of the commissioning intentions NCCG has developed
- Involve stakeholder views in the development of these detailed plans
- Ensure that at every stage of the planning and commissioning process there is a parity of esteem between physical and mental health[12]:

The CCG is fully committed to ensuring an equal focus on improving mental health and physical health, so as to make sure that people with

[12] http://www.england.nhs.uk/2013/11/25/martin-mcshane-4/

mental health problems do not experience inequalities as a result.

Steps that the CCG will take include:

- Improving access to mental health services and make shorter waiting times a priority;
- Working with providers and service users to redesign services and pathways to ensure that mental health service users will experience more joined up care at the appropriate time;
- Commissioning of mental health and learning disability services that are fully integrated into the wider health and social care system. This will include increased investment to better support mental health service users at our local acute hospitals;
- Embed the principle of *Parity of Esteem: Transformative Ideas for Commissioners* into all commissioning activity, to ensure that the mental health needs of our local population are considered at all times and resources allocated appropriately;
- Ensuring that mental health service user have a seamless transition through Mental Health Services, without the need of a GP's intervention or re-referral;
- Develop seamless pathways to Child and Adolescent Mental Health Services (CAMHS) with a view to providing support for children with mental health needs and improving service quality and waiting times and transition to mainstream Mental Health Services, if required; and
- Commission a Mental Wellbeing Service in conjunction with other Norfolk CCGs, which acts on the feedback received from local stakeholders and service users to provide support to people to overcome challenges such as mild depression and anxiety so that they can get back to work and other meaningful activities.

We also us a range of tools to gain real-time experience feedback from patients and carers .

Engagement with communities

NHS Norwich CCG has taken a multi-faceted approach to involvement and engagement of individuals, stakeholders and communities:

Many of the NCCG GP Practices already have established patient participation groups (PPGs). These groups consult with their patients on a regular basis providing a formal mechanism for patients to air their views on experiences, insights and choices. The will help to influence future commissioning intentions of the organisation.

The CCG has established the **NHS Norwich Community Involvement Panel (CIP)**

The CIP is involved in a number of aspects of engagement within the CCG from informing and co-producing involvement activity advising on how to involve and when to involve communities to sitting on our internal Clinical Action Teams. By working in a co-productive way with members of our community the intention is to ensure that the CCG has developed and embedded co-production in the planning and

development of services within the CCG and are working towards rolling this out within the Norfolk health commissioning system when working in partnership with our neighbouring CCGs. Examples of this include **Health and Wellbeing Strategy Consultation** - a three month consultation to allow patients, public and stakeholders to share their views with us on the proposed strategy including open meetings and a structured voluntary sector event, critical involvement in Mental Health IAPT specification and re-procurement.

Patient experience, quality and safety

Response to Francis, Berwick and Winterbourne view

In February 2013 the Francis report[13] established that proper accountability, a "zero tolerance" approach to breaches of "fundamental standards" and a "common culture" that puts patients first- these were the themes underpinning the 290 recommendations that form the heart of the report. The negative aspects of culture in the system were identified as including a lack of openness to criticism, a lack of consideration for patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions about the judgments and actions of others, an acceptance of poor standards and a failure to put the patient first in everything that is done.

To change that, there needs to be a relentless focus on the patient's interests and the obligation to keep patients safe and protected from substandard care. This means that the patient must be first in everything that is done: there must be no tolerance of substandard care; frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations.

NCCG is committed to working with all our providers of NHS healthcare to ensure that our patients receive the best possible care, have a positive experience of healthcare and are treated safely. To ensure this is embedded throughout all our commissioned services we have developed and implemented a robust action plan that reflects the following key principles:

Quality and safety first (getting the basics right)

- We will ensure that the services we commission will demonstrate how safety issues such as infection control, management of serious untoward incidents, treatment interventions and the prevention of pressure ulcers are addressed.
- The minimum standards set by the Care Quality Commission (CQC) should not be the only standard for contracting services. As the CCG our aim will always be to contract for best practice standards.
- The care that we commission needs to be of the highest standard and clinically effective and take into account National Institute of Clinical Excellence (NICE) quality standards and new innovations in clinical care and service delivery.

[13] https://www.gov.uk/government/news/francis-report-on-mid-staffs-government-accepts-recommendations

- The CCG is committed to ensuring that children and vulnerable adults are not at risk from being abused or neglected and receive the care they require. Safeguarding is an important function through commissioning and through the delivery of care from those contracted by us.

Ensuring robust accountability

- We will scrutinise and ensure we have the capacity to undertake audits, inspections and investigations of individual/ group cases and clinical services.
- We will ensure our Clinical Leaders will be at the heart of our Quality and safety surveillance.
- Clinicians from the CCG will be visible on provider sites and will work in partnership with the hospitals and community services providing care to patients.
- We will at all times be accountable for the scope and quality of all the services that we commission.

An open culture (transparency, openness and candour)

- Patient feedback on the services that we commission will be routinely collected and published. We will use this data to act like a smoke alarm to detect service failures. We will also highlight patients who receive good care as well as bad.
- We will use this feedback to address issues of concern with any of our providers.
- As a CCG we will welcome complaints, be open in acknowledging service difficulties, and encourage providers to do the same.
- We will make comparable information freely available at hospitals, surgeries and care homes and we will help patients to make judgments based on objective data about standards & outcomes.
- We will have active and on-going engagements with patients, the public and all interested stakeholders. We will use their feedback and patient stories to both challenge and improve clinical services.

The CCG is actively working with the public, patients, patient group and patient advocates; other commissioners, health regulators, employers and representatives of the professions to ensure mechanisms are in place whereby we are made aware of poor and unsafe practice so we can act quickly to protect patients.

Through joint working with the LA and NHSE Area Team, NCCG is seeking to ensure openness, transparency and candour throughout the system about matters of concern. These are discussed regularly by the CCG's Governing Body and with other stakeholders, e.g. at the Norfolk Quality Strategic Alliance and Local Area Quality Surveillance Group.

Contracts that work for patients and clinicians

- We will make it clear the standard of services that we expect to be delivered by all of our providers.
- We will ensure that enhanced quality standards are embedded in our contracts and that we incentivise providers to constantly improve and deliver the highest possible care.
- We will ensure that quality standards are agreed by the doctors and nurses who deliver the service.
- The contract standards will be monitored and both the sanctions and incentives will be understandable and acceptable to clinical leaders and patients who receive clinical services.
- We will ensure clinical leadership is in place in all of our providers services.

Contract specifications and incentives e.g. CQUIN, are being used to enable improvement in local services and to encourage and enhance the local providers of services to pursue high quality effective services. The CCG will continue to monitor quality information generated by providers collected through inspections carried out at Quality Improvement Visits and from investigations of incidents and from complaints.

Providers are held to account for necessary improvements and action plans and to report on themes and trends in their Boards and Annual Reports and Quality accounts. The CCG also chair monthly Clinical Quality Review meetings (CQRM) with our main NHS providers, this includes Norfolk Health & Care Trust (NCHC), Norfolk & Norwich University Hospital Foundation Trust (NNUHFT), Norfolk & Suffolk Foundation Trust (NSFT) and Out of Hours/111. This enables commissioners to work collaboratively and effectively together to identify early or potential concerns around the quality and safety of clinical services.

Berwick Report

Following on from the Francis Report, In August 2013 the Berwick Report[14] made further recommendations regarding patient safety in the NHS in England. It made a number of recommendations to help the NHS make care safer. The CCG's response to each of those recommendations is set out overleaf:

Francis Recommendations	NCCG response
The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning:	Learning from incidents and serious incidents is routinely scrutinised by the Quality and Patient safety team. The CCG Governing Body and Clinical Executive overview and scrutiny of trends and themes occurs and the monitoring of improvement plans and quality standards and performance supports and triangulates findings.
All leaders concerned with NHS healthcare –	The CCG engages in Quality Improvement visits

[14] https://www.gov.uk/government/publications/berwick-review-into-patient-safety

political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support:	to engage with providers and increase visibility of commissioners. This ensures commissioned services are of a high quality and risk and issues subject to early warning trigger systems.
Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.	The CCG is committed to the active engagement of patients and the public in our work. We work closely with all our providers to ensure this approach is reflective in the services we commission this is evident through the Friends and Family test ,Patient Opinion and local patient survey data that we review each month at our Clinical Quality Review Meetings (CQRM). We also are working with NCHC to develop a community hospitals quality dashboard with a range of indicators that will aim to triangulate patient feedback/ information about the clinical care they have received.
Government, Health Education England and NHS England should assure that sufficient staff are available to meet the NHS's needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.	A fundamental element of our clinical quality review process is to ensure that organisations have capacity to deliver safe services through well trained and adequate staffing resource. We do this by reviewing with our providers their Cost Improvement programmes, workforce plans and any transformation proposals to ensure any potential impact on clinical care has been fully assessed as safe.
Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executive	NCCG ensures that the providers of services have in place adequate training and support to their staff to ensure that good quality care and patient safety approaches are adopted and are part of the service specification of its commissioned services. Further to this to support the training and education of staff through partnership working and planning through HEE and locally in relation to CPS e.g.

	contract with HEIs (UCS)
The NHS should become a learning organisation. Its leaders should create and support the capability for learning and therefore change, at scale within the NHS. Transparency should be complete, timely and unequivocal. All data on quality and safety ... should be shared in a timely fashion with all parties who want it, including... the public	NCCG's Integrated Performance Report, which reports on clinical quality and patient safety issues is presented monthly to the Leadership Team and also to the public meeting of the Governing Body (GB). The report is also made available to members of the public on the CCG's website.
All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.	NCCG uses a model of co-production /co-design with patients and their represenatives groups. Their views significantly influence commissioning and procurement decisions. Patients aslo play a part in many of our internal commissioning structures.
Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff.	The CCG will continue to monitor the implementation of patient safety alerts issued through NHSE in monitoring of its local contracts and quality measures with providers.
We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.	The CCG will ensure it collaborates in the use and requests for information from providers in support of quality, safety and regulation by Care Quality Commission (CQC) e.g. through quality surveillance groups and shared intelligence. It will utilise datasets and metric available through the NHSIC to monitor and benchmark the quality of local services.

The Winterbourne view report[15]

The Winterbourne report set out the type of care that people with learning disabilities/autism and behavioural issues should receive. These are:

- People should receive local personalised services that meet their needs, which should be planned from childhood
- People should be supported in the community, in their home or close to their home and family;
- People should only go to hospital for assessment and treatment if it is necessary and they cannot get the support they need at home or in a community service;
- People that do have to go into hospital for assessment and treatment should receive good quality care as near to their home as possible;
- People should be moved on from hospitals as quickly as possible – either back home or on to other community support;
- Commissioners who place people with learning disabilities/autism in hospital or community support settings should have clear responsibility for each person;
- Commissioners should also make sure that people with learning disabilities/autism are able to see and speak to their families regularly;
- There should be local services that stop people with learning disabilities from having a crisis. If a crisis does happen then there should be local services to help people deal with the crisis.

The CCG has reviewed the cohort of Norwich Winterbourne clients as per Winterbourne concordat.

All clients had a joint review by the CCG, Norfolk and NCC. All clients have discharge dates and are aided to access supported living arrangements in Norfolk, where appropriate. A joint Winterbourne sub-group will feed into a joint commissioning forum to ensure the needs of the learning disability client within Norfolk have the right services in place to ensure they are supported to live as independently as possible. The Winterbourne concordat will also provide a backdrop for improving services for other vulnerable groups including children and young people.

Patient safety

The scrutiny of information and metrics by the CCG of measures including the safety thermometer, never event and serious incident data and the other quality metrics enables the consideration and of emerging themes and trends in patient safety and harm to patients. The CCG cooperates with, and participates in, the emerging patient safety collaborative being set up by NHSE whose aim is to provide a network of patient safety learning and improvement to continually improve care at the front line and to reduce the likelihood of harm to patients.

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[15] https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

The increase in reporting of harm and in particular the reporting of medicines related incidents will continue to be promoted through contractual and quality improvement discussions with providers and stakeholders. Monitoring of the levels of reporting through the National Reporting and Learning System (NRLS) and through Serious Incident reporting routes will support the NHS Outcomes framework aim of higher reporting. NCCG will continue to work closely with commissioned providers to reduce levels of harm by increasing awareness of best practice and innovative approaches to service delivery. In particular we are focusing on four national high impact actions: Pressure ulcer prevalence, Catheter acquired urinary tract infections (CAUTI), Falls, Venous Thrombo Embolism (VTE) .In addition we are focusing closely on the early identification and treatment of Sepsis.

Infection control

Over the coming year we will build on learning from local reviews with our providers by continuing to optimise the use of root cause analysis of all incidents, including those in the infection control review process for MRSA and C Difficile to identify lessons learned and action required to prevent recurrence. We have refreshed all our quality schedules with each provider to ensure latest infection control guidance is reflected in contracts which will monitored through local audit and observation of practice .We will also continue to participate in the East of England Quality Surveillance group to identify early warnings of service and quality failings, in order to address the risks to patient that the potentially raise.

We continue to strive in Norfolk to achieve zero MRSA bacteraemia cases for 2014-15 as per national guidance. A substantial effort to achieve this end continues throughout Norfolk in terms of implementation of robust Infection Prevention &Control (IP&C) standards in all areas of healthcare. This is reflected in our ongoing excellent performance for MRSA bacteraemias in acute trusts i.e. No acute hospital bacteraemias for 23 months.

Through the Post Infection Review process for some of our most recent community MRSA bacteraemia cases it is apparent that best practice has been met at each stage of the patient journey and unlikely that any other interventions would have made a difference to the patient outcome in terms of developing the bacteraemia. Therefore the question can be posed ‘have we begun to reach an irreducible minimum’?

Norfolk will continue to exercise 100% efforts in ensuring the highest standards in IP&C across the health economy to strive to achieve zero MRSA bacteraemias for 2014/15Patient Experience

Patient experience metrics are reviewed contractually for all commissioned providers identifying trends and themes of the complaint and feedback received and whether there are month on month improvements. Evidence is provided through ward to board that complaints and patient voices remain an integral part of business with providers.

The Friends & Family Test (FFT) is applicable to all providers’ inpatient areas, Accident & Emergency (A&E), paediatrics, obstetrics and gynaecology, and outpatient clinics. An increase in the number of patients asked is being incentivised through the national CQUIN for 2014/15. This will include FFT staff surveys, as well as annual staff surveys and recruitment that are focused on each organisations values and behaviours. SNCCG are also working closely with NCHC to design a Community hospitals quality dashboard that will incorporate the FFT along with Patient Opinion and local patient survey information to provide a robust quality indicator for a number of clinical pathways. It is hoped

that this help inform future application of the Friends and Family test across other areas of the NHS. The CQUIN for FFT is driving zero detractors and this will be concentrated within inpatient areas of all providers. This will provide an additional dimension for providers to review patient safety, clinical quality, and patient experience metrics to improve the overall patient satisfaction in their experience of care.

The CCG will continue to focus on feedback from patients and staff, ensuring whistleblowing policies are known and understood and that staff trust the organisation has a no blame culture.

Patient experience of vulnerable patients will be improved through learning from serious incidents, complaints and serious case review findings.

Joint working through the *Domino* initiative and urgent care network with all providers and CCGs will continue to ensure admission prevention strategies and early supported discharge are in place.

Development of specific feedback mechanisms related to each vulnerable group will continue to be integral to capturing issues important to them as well as capturing carer feedback. Adult safeguarding forums and information sharing mechanisms with Healthwatch, CQC, NCC and the CCG will continue and be strengthened by joining the quality monitoring of providers, particularly in the care home sector and supported living

All patient experience feedback from both the provider and the CCG is reported monthly through the Quality Committee.

Compassion in practice

The "NHS Nursing Strategy: Compassion in Practice"[16] sets out the shared purpose for nurses, midwives and care staff to deliver high quality, compassionate care, and to achieve excellent mental and physical health and wellbeing outcomes. It builds on the enduring values of the NHS, and the rights and pledges of the NHS Constitution. The strategy sets out six areas for action to be implemented over the next three years:

- Staying independent, maximising wellbeing & improving outcomes;
- Improving patient experience
- Delivering high quality care & measuring impact;
- Building & strengthening leadership
- Right staff, right skills, right place;
- Supporting positive staff experience

[16] http://www.england.nhs.uk/nursingvision/

NCCG will ensure that local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans and how the 6Cs[17] are being rolled out across all staff groups through the Clinical Quality Review meetings held monthly each month but more importantly by direct observation of practice during site visits to clinical areas as part of our ongoing programme of visits to providers.

Safeguarding

The Norfolk-wide system has reviewed its adult safeguarding strategy as well as developing a system-wide action plan of implementation. This will include information sharing mechanisms and aligning clinical incident and serious incident reporting to NCC, identifying reporting thresholds in line with the national guidance, and 'No secrets' guidance which is facilitated by the health sub group chaired by all Norfolk CCGs.

NCCG are also ensuring the following actions are undertaken with regard to safeguarding:

Adult safeguarding

- Adult safeguarding training will be standardised against the Bournemouth competency framework. The MCA/DOLS competency framework will be developed and rolled out as a Norfolk-wide system within health.
- Reporting mechanisms in the form of Key Performance Indicators (KPIs) will be clearly set out in each contract with providers and reporting on all aspects will take place monthly.
- Quality Inspection visits are in place to review safeguarding systems and processes s, as well as asking staff and patients for feedback.
- Safeguarding referrals and lack of reporting will be monitored through quality sub group meetings that fit within the contractual process.
- Workshops and training to raise awareness of the Prevent strategy within the healthcare will take place with a DVD-based training package called HealthWRAP – Workshop to Raise Awareness of Prevent. The workshop, aimed at any NHS staff; front line staff, managers and clinicians, is designed to help make them aware about their contribution in preventing vulnerable people being exploited for terrorist purposes. The workshop improves understanding of the processes used by terrorists to radicalise individuals and ensures staff are aware of who to contact within their organisation to discuss any concerns. Numbers of staff who access this training will be monitored through the contractual process.
- All providers have this new guidance built into quality schedules which will be monitored going forward via the CQRM process.

NCCG's response to Winterbourne View, requires an end to all inappropriate healthcare placements for every person with a Learning Disability and/or Autism with complex needs and challenging behaviour by June 2014, and that they receive the right care in the right place, in accordance with the Winterbourne Concordat.

[17] http://www.england.nhs.uk/wp-content/uploads/2012/12/6c-a5-leaflet.pdf

For all detained patients with a Learning Disability within private hospitals, both the CCG and NCC have undertaken a joint review of all placements. Where appropriate, discharge dates into community settings and access to supported living arrangements in Norwich, have been established.

The Winterbourne View Concordat Steering Group meets regularly and reports on the progress of stepping down patients from hospital to community settings. The process of managing the stepping down of patients is overseen by the Winterbourne View Subgroup which is attended by the locality case managers. A comprehensive list of patients is reviewed and projected dates for the stepping down of each patient are discussed in depth where the reasons for the individual remaining in their current residency are justified. The Subgroup will also feed into a joint commissioning forum to ensure the needs of those with learning disabilities within Norfolk have the right services in place to ensure they are supported to live as independently as possible.

The Winterbourne Concordat will also provide a backdrop for improving services for other vulnerable groups including children and young people.

Childrens safeguarding

The last 12 months have been characterised by change and the re-focussing of priorities within the safeguarding and looked after children agenda. As a consequence a Children's Services Improvement Plan has been developed following the three Ofsted inspections that found services across the County Council failing in their delivery of services to children. The Norfolk Safeguarding Children Board (NSCB) had reviewed both the structure and processes for delivery of the safeguarding agenda and has recently set three priority areas of practice:

- Neglect;
- Child sexual abuse; and
- Child sexual exploitation

Health services, both commissioners and providers, are crucial within the partnership framework and participation in the children's safeguarding agenda has been formalised by the development of the Norfolk Health Safeguarding Children's Advisory Group chaired by the Director of Quality and Safety for NHS Great Yarmouth and Waveney CCG, with representation from all CCGs and NHS providers. The Designated Child safeguarding Team reports quarterly to NHS Norwich CCG through the Quality Alliance on issues both general and specific to the individual area, in terms of expanding on the plans for looked after children and their transition into adulthood.

Staff satisfaction

Staff satisfaction as a metric is not only necessary for healthcare providers to encourage staff engagement but to accelerate it; evidence from a wide range of sources highlight that:

- Patient satisfaction is consistently higher in Trusts with better rates of staff health and well-being.
- There is a link between higher staff satisfaction and lower rates of mortality and hospital-acquired infections.
- Stress and burn out are more frequent in the NHS than other sectors.

Steps we can take to increase staff engagement include;

- Articulating values in plain English and showing how they translate into behaviours, this forms part of compassipon in practice, with value based recruitment.
- Giving frontline staff the voice to implement changes to services and solutions to problems when they arise.
- Train staff to be able to deliver in an emotional setting, allowing training for reflective practice.
- Developing leaders ensuring that they have the right managerial skills. This will include clinical staff.

Staff voices are heard through annual surveys but the development of the Family and Friends test to ensure that the staff voice is heard continueously. This will provide a staff voice identifying trends and themes and the ability to triangulate this information with other quality and safety metrics provide live measurement of both staff and patients.

The Quality improvement visit programme will be the opportunity for commissioners to fufil their duty to patients and public for the quality of commissioned services.

7 Day working

The CCG has agreed with Providers the action that they will take during 2014/15 to deliver the clinical standards set out in the NHS Services, Seven Days a Week Forum Review. An initial gap analysis will be completed by 30 September 2014 and further, more detail actions agreed as a result. This commitment is included within the 14/15 Standard NHS Contract Service Delivery Improvement Plan.

Governance

The following section describes the governance arrangements and supporting business processes for the delivery of the strategic and operational plans, including information on:

- the decision making and planning arrangements within NCCG, and how this supports delivery of quality services;
- the agreed programme management approach to track delivery of the Quality, Innovation, Productivity and Prevention (QIPP)

programme;
- Responsibilities and accountability for performance delivery, including financial balance and activity levels.

Governance arrangements

The CCG Governing Body (GB) meets bi-monthly in public and has prime responsibility for the scrutiny and approval of strategic and operational plans. The agenda and minutes of each meeting are published on the CCG website, so they are accessible to all. The GB is supported by a weekly senior management team meeting and a finace, audit and quality committees. In addition, we have good links with all of our local stakeholders through a dedicated full time engagement lead.

Governing Body

In accordance with statutory legislation, the GB has responsibility for:

- ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance (its main function);
- determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish; (2006 Act)
- Approving any functions of the group that are specified in regulations. (2006 Act)

As a member of the CCG‘s GB, each individual will share responsibility as part of the team to ensure that the CCG exercises its functions effectively, efficiently, economically, with good governance and in accordance with the terms of the CCG constitution as agreed by its members. Each individual is there to bring their unique perspective, informed by their expertise and experience.

Individual members of the group’s GB will bring their unique perspective, informed by their expertise and experience. This will underpin decisions made by the group’s GB and will help ensure that as far as reasonably practicable:

- the values and principles of the NHS Constitution are actively promoted;
- the interests of patients and the community remain at the heart of discussions and decisions;
- the group’s governing body and the wider CCG acts in the best interests of the local population at all times;
- the CCG commissions the highest quality services and best possible outcomes for their patients within their resource allocation; and
- Good governance remains central at all times.

The GB has appointed within its constitution an audit, remuneration and quality and patient safety assurance committee as formal committees

of the GB as such, minutes from meetings will be published in the public domain as part of the GB papers

Council of Members (CoM)

The CoM meets quarterly and responsibilities include ratifying the vision, values and strategic direction of the CCG as a whole. The CoM is made up of the practice representative from each member practice. Members of the GB are invited to update members as to the work of the CCG and are held to account by the membership accordingly.

GB Assurance Framework (GBAF)

GB Assurance Framework (GBAF) provides the Norwich CCG with a simple but comprehensive method for the effective and focused management of risk. Through the GBAF the CCG GB gains assurance that risks are being appropriately managed throughout the organisation.

The GBAF identifies which of the organisation's strategic objectives may be at risk because of inadequacies in the operation of controls, or where the CCG has insufficient assurance. At the same time it encompasses the control of risk, provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the GB to determine how to make the most efficient use of resources and address the issues identified in order to improve the quality and safety of care. The GBAF also brings together all of the evidence required to support the Annual Governance Statement.

The GBAF is seen as a working document and is updated regularly by the Senior Management Team, monitored by the Audit Committee and reported to the GB at each of its meetings.

Research and innovation

Health research is essential to continually improve health outcomes and the effectiveness of health services for patients. There is an expectation that the UK will be the first research-led health service in the world. Searching for and applying innovative approaches to deliver health care must be an integral part of the way the NHS does business). Doing this consistently and comprehensively will dramatically improve the quality of care and service for patients (Health Wealth and Innovation 2012).

The new Health and Social Care Act reflects these commitments and places a clear duty on the Secretary of State, the NHS England and Clinical Commissioning Groups (CCG) to promote research and champion innovation.

Research

In line with the research commitments, Norwich CCG supports South Norfolk CCG as host of the Norfolk & Suffolk Primary & Community Care Research Office, on behalf of all CCGs across Norfolk & Waveney and has signed up to Memorandum of Understanding. Patient and clinical involvement in research across Norwich CCG is strong and the CCG's statutory duty to promote research would include:

- Participation in research
- Supporting research and using research evidence
- Proactive engagement with local partners
- Meeting treatment costs for patients taking part in research (including any Excess Treatment Costs[18])

In line with the research duty the CCG will:

- Agree a plan to enhance the research culture of the CCG-addressing leadership, education, use of evidence and partnership.
- Ensure provider contracts are fit for purpose in relation to the Research Governance Framework, Clinical Research Network (CRN) targets, and Quality Account arrangements.
- Support the recruitment of a Norwich Research Champion and agree arrangements for the role to link into the governing body.
- Through its Research Champion support the Norfolk and Suffolk Primary and Community Care Research Steering Group which oversees arrangement for Research Delivery through the Norfolk and Suffolk Primary and Community Care Research Office. This group has a mandate to agree strategic direction for research across Norfolk and Suffolk. The Research office supports the Research Design, Research Assurance, Study Delivery and Patient involvement in research across CCGs, academic organisations, primary and community Care providers and will deliver an agreed work plan \\inf-fs-1-v1\snccg\Departmental Documents\R&D\R&D Policies & Corporate Docs\Workplan\Workplan updated Feb13.docx
- Through the agreed CCG Chief Officer representation (South Norfolk CCG on behalf of Norfolk and Waveney CCGs) on the new CRN-Eastern Partnership Board continue to support the establishment and development of the CRN; represent the interests of patients, commissioners, and primary care providers; work with CRN partners to support the delivery of the National Institute of Health Research (NIHR) performance framework and agree models of funding for enhanced patient and clinical involvement in research.
- Fully implement the research cost policy with NHS England and Public Health England including agreeing processes for managing appropriate research treatment costs for provider organisations to ensure provider trusts identify research savings and reinvest these in new studies and where appropriate review full provider business cases for study specific research treatment funding from CCGs.

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[18] Where patient care is being provided which differs from the normal, standard, treatment for that condition (either an experimental treatment or a service in a different location from where it would normally be given) the difference between the total Treatment Costs and the costs of the "standard alternative" (if any) can be termed the *Excess Element of Treatment Costs* (or just "**Excess Treatment Cost**"), but is nonetheless part of the Treatment Cost, not a Service Support or R&D cost. *DH HSG(97)32*

- Enhance research dissemination particularly through GP Education routes and through the CCG Research Champion. A new research dissemination process will be agreed with CCG leadership, Governing Body and Norfolk and Suffolk Primary and Community Care Research Office.
- Through its clinical/commissioning executive work with research design leads and UEA academics to develop a research proposal for submission to Research for Patient Benefit programmes for an increased understanding of palliative care. The systematic review generated to support this research submission will be fed into commissioning programmes.
- Using Research Capability Funding identify additional commissioning priority areas for research call-outs to academic organisations.

Innovation

The CCG recognises the importance of the three stages of the innovation agenda –invention, adoption and diffusion and has a statutory duty to champion innovation and the adoption of innovation including:

- Setting out the CCG approach to innovation
- Ensure strong leadership and accountability for innovation within our organisation
- Being an active partner in the local Academic Health Science Network

In line with the innovation duty the CCG will:

- Work in collaboration with the Academic Health Science Network (AHSN) to support the delivery of innovation, adoption and spread of evidence for Diabetes, Dementia and Chronic Disease Management.
- For 14-16, the CCG will work with the Research Office and AHSN to develop a post that will support increased involvement in the adoption and spread of evidence for the CCG/AHSN priority areas.
- Through CCG officer time contribute to the delivery by AHSN working Groups.
- Use the collaborations such as AHSN to identify funding streams for early adoption projects.
- Review and strengthen CCG leadership and CCG innovation plans.
- Through the Norfolk and Waveney CCG Chief Officers meetings support the cross CCG representation by West Norfolk CCG on the AHSN Partnership

Commissioning and planning

At specific times in the year, the CCG will review its medium to long-term strategic plans and set out its annual commissioning and operational plans.

Built into this process is an annual programme of patient and public engagement that will give all of our stakeholders and partners the opportunity to understand and contribute to planning decisions. This will be coordinated through the CCGs Community Involvement Panel (CIP).

The Norwich approach to commissioning is based on a “bottom-up” delivery from the current General Practice list based services, through Primary Care clusters of approximately 50,000, developing GP co-operation, with fast and assessable community based nursing and therapy, mental health and social care and care coordination, plus wider primary care links including community pharmacy. In addition whole City services will develop to include a Norwich specific Intermediate Care model and where appropriate community based specialist models.

A project plan and supporting milestones are the main delivery mechanism for the CCG. This will also form the basis for monitoring and reporting through the main work programme areas, Healthy Norwich, Integrated Care, Operation Domino, QIPP and Quality Improvement as below:

Healthy Norwich – there are 12 key schemes designed to improve the health and wellbeing of the people of greater Norwich, to be implemented in partnership with Norfolk Public Health, Norwich City Council, and Broadland District Council. They include weight management and physical activity, reducing drug and alcohol misuse, reducing excess winter deaths, housing support, and increasing the uptake of health screening. We also plan to continue investing in voluntary and community schemes to improve health and wellbeing.

Integrated care – there are 16 key schemes set out under the Better Care Fund. Together these represent an ambitious whole system transformation plan, bringing Primary, Community, Mental Health, Social Care, and Voluntary and Community Services into a single integrated model.

Operation Domino – a programme of work across Central Norfolk to continue improvements in the urgent care system. There are 12 key schemes being considered for investment by Central Norfolk CCGs, designed to build on the significant improvements in urgent care delivered by Operation Domino over the last 18 months.

QIPP (Financial Efficiency) – The CCG hast identifed approximately £6.5 million of savings to remain in financial balance. The QIPP plan schemes are designed to meet this financial challenge without impacting on services to patients. The schemes will be detailed in the financial plan. They include reducing waste in the prescribing of medicines, reducing avoidable planned and unplanned hospital activity, and streamlining the system for assessing and reviewing packages of continuing healthcare.

Quality improvement – 6 schemes have been identified, designed to continually improve the quality of local health services. The schemes include embedding Patient Opinion into all main NHS contracts, reducing variation in clinical care, and improving our understanding of the support needs of patients coping with long term health conditions.

Commissioning Intentions 2014/15-15/16

The following section sets out NCCG's commissioning intentions for 2014/15 and beyond. The detailed projects which support these intentions and which reflect the key programme areas as above will continue to provide high quality, sustainable and efficient services to the local population are set out below.

As part of the development of a combined 5-year strategic plan with NNCCG and SNCCG, 9 areas of intervention have been agreed to support the ambitions and outcomes framework and will form part of our strategic plan on a page. They are as follows:

Intervention 1	Development of primary care localities
Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Intervention 3	Proactive use of predictive modelling and risk stratification
Intervention 4	Easy to access, seven day health and social care provision for people with complex mental and physical health and care needs
Intervention 5	Enable independence, self care and self management
Intervention 6	Improved support for people with Dementia and their carers
Intervention 7	Deliver major redesign of urgent care system
Intervention 8	Ensuring effective end of life pathways and support
Intervention 9	Ensuring effective workforce planning

In addition we will continue to have a focus on Healthy Norwich.

Healthy Norwich is an exciting partnership programme working with Norwich City Council and Norfolk Public Health as a member of the World Health Organisation.

Becoming a healthy city means working together on all of the things which improve people's health and wellbeing, including ensuring everyone has a good start in life, higher educational attainment, greater employment prospects, better housing conditions, and good transport facilities.

Core work programmes include 1) Diet, Nutrition and Health weight 2) Screening and Prevention 3) Physical Activity 4) Sexual Health 5) Education, Training and Employment 6) Healthy Urban Environment and 7) Smoking, Drugs and Alcohol.

There are a number of key components of care that need to be considered as many people will use a multitude of services and the quality, capacity and responsiveness of these will affect each other and the outcome. These components also describe a pathway of care and support through the system in Norwich:

- Healthy active population and supporting independence
- Living well with single 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 re-ablement after acute illness or injury
- High quality-quality nursing and residential care for those who need it
- Choice, control and support towards the end of life
- Integration to provide person centred co-ordinated care

(David Oliver, Catherine Foot, Richard Humphries,2014,Making our health and care systems fit for an ageing population,v1, The Kings Fund)

NHS Norwich CCG has established a strong vision and model for the delivery of integrated care, focused around primary care hubs in the city. Our Commissioning intentions are grouped around these nine areas of intervention.

Intervention 1	Development of primary care localities
Principle	GP Practices will be supported to develop locality clusters around populations of approximately 50,000 registered patients (4 localities within the Norwich CCG boundary). These practices will cooperate to develop shared Primary Care services for older patients, and those with long term conditions; with a particular focus on keeping patients independent, well, and at home. Enhanced care for nursing homes, coordinated domiciliary visits, and a shared model of seven day access will be developed.

Intervention 2	Implementation of integrated community care teams (based on primary care locality footprints)
Principle	Integrated Community Services - Community, Mental Health, and Social Care Services will be reshaped to the same locality footprints. The locality model will enable a multi-disciplinary approach to care, and build relationships, coordination, and mutual confidence between provider organisations. Through improved communication technology and the development of care coordination (below) we will place the responsible GP at the heart of an integrated virtual health and care team.

Intervention 3	Proactive use of predictive modelling and risk stratification
Principle	Practices will be supported to identify and manage patients at high risk of hospital admission through the implementation of risk stratification modelling. We will work with our technology partner to incorporate Primary Care and Social Care data into the model. The model will be launched in 2014, and developed and refined in preparation for the Better Care Fund investments in 2015.

Intervention 6	Improved support for people with Dementia and their carers
Principle	Increased awareness and diagnosis rates across Norwich practices with improved supporting networks

Intervention 8	Ensuring effective end of life pathways and support
Principle	Choice, control, care and support towards the end of life

Intervention 9	Ensuring effective workforce planning
Principle	Ensuring capacity and capability of Primary care workforce

NHS Norwich CCG will support the development of our localities into 4 city teams. It is our intention that each locality will have the following:

- A named development manager whose role will be to support the locality in the development of community based teams
- A named representative (either managerial or clinical)
- A clinical lead for each locality
- The same 'core' services commissioned by the CCG
- The option of developing other services or ways of working depending on the needs of their population, the wishes and interest of member practices and stakeholders
- Include key delivery partners from across all sectors

There are a number of activities that will be considered by the city teams either as part of the 'core service' or as part of the option to develop enhanced services depending on the needs of the locality.

Medibites Education programme	Enhanced Primary Care for care Homes	Sustainable Workforce Development	Re-procurement of Community Mental health (including IAPT)
Integrated Diabetes Care	Falls Prevention	Integrated Heart failure Service	Risk Stratification
7 Day Case Management for Patients with Complex Health and Care Needs	Care Co-Ordination Teams (CCG Localities)	Unified Electronic Patient Record	Communication Technology, Virtual Team
Integrated End of Life care	Integrated dementia care	Sustainable Workforce Development	

Further prioirities include:

Intervention 4	Easy to access, seven day health and social care provision for people with complex mental and physical health and care needs.
Principle	Access to 7 day service will become normal practice do reduce the burden of urgent/ unplanned care or the need for a rapid response. Introduction of seven day social care and community nursing teams into Primary Care Localities, working as part of the integrated health and care teams.

There will be cross overs with our locality development as city based teams are established. Our ambition is to build on the existing out of hour's service for community based social care so that we can offer joint working to ensure seven-day cover as part of a dialogue between NCC and NCH&C on integration of staff. For social care, a first step will be to consider extended hours opening to supplement the out of hour's service already provided. NCC re-ablement staff are already able to arrange and switch on social care packages of care when needed outside normal office hours.

This area of work will also look as Discharge planning and Intermediate care. NCCG and Social care will work together to ensure that patients can leave hospital once their clinical treatment is complete, with good post discharge support in the community to reduce the likelihood of further re-admissions.

There are a number of activities that will be considered to deliver this:

Seven Day Social Care Assessment & Care Management (Community)	Seven Day Supported Discharge & Intermediate Care Management	Intermediate Bed Management

Intervention 5	Enable independence, self care and self management
Principle	We will develop a partnership approach to patients, families, and communities in Norwich, investing to equip patients and carers with the knowledge and skills for sustainable self-care, and ensure health professionals work with patients to develop self-management plans, including lifestyle changes. We will provide better and more accessible information, advice and advocacy so that people are better placed to arrange their own care including through use of personal budgets.

It is our ambition that people should be able to enjoy long and healthy lives, feeling safe at home and connected to their community. This also includes our Healthy Norwich partnership programmes.

Development of Voluntary and Community 'Pre-	Norwich Information Hub	Supporting Self Care	Expansion of Personal Budgets

Primary' Intervention Fund to maintain health, wellbeing, and independence			
Tier 2 Weight Management	Tier 3 Weight Management	Norwich Walking Programme	Push the Pedalways
Health Norwich Micro-Funding Initiative	Implementation of Norwich Alcohol Strategy	Winter Preparedness	Reducing Self Harm
Increase uptake in Screening Opportunities	Housing Support	SkyRides	

Intervention 7	Deliver major redesign of urgent care system - Operation Domino
Principle	The Central Norfolk Urgent care system has been undergoing a process of transformation coordinated through the Operation Domino project programme. When completed the programme will allow patients and staff to make informed decisions regarding the health and the support they require using accessible and accurate information. They will be provided integrated support when they need it, day or night, and can expect to be offered the help they need by the right person with the ability to provide the right service at the right time, first time, every time. Home based rehabilitation and care services will be the norm and people will only be in hospital if the service cannot be provided in the community. Patient's voice, creativity and innovation will be used to continually improve and evolve the system.

Access	Ambulance Handover Liaison	Re-procurement of Norfolk 111 inc mental health screening	Reprocurement of Primary Mental Health A&E liaison service
Care Out of Hours	Immediate Assessment Team	Urgent Care Unit, including Mental Health pathways	Troponin Pathway
System Flow	Stroke Care Pathway Development	Clinical Decision Unit,	Whole System Mapping & Dashboard

Discharge	7 Day Social Care Liaison	Early Supported Discharge for Complex	Placement without Prejudice for CHC Eligible Patients

		Care	

A full PMO function is in place to monitor, coordinate and report on the Domino programme delivery.

Specialist commissioning

The CCG will work closely with NHS England specialist commissioning lead partners plus other CCGs and commissioners across Norfolk and Waveney to ensure that services are planned and developed across the system. This will that providers are seeing and treating sufficiently high numbers of patients to meet specified clinical standards, in line with the need to concentrate specialist services in 15-30 centres of excellence linked to Academic Health Services Networks. The local Norfolk and Waveney Health system has established a local Stroke Network that will coiordinate discussions regarding the future of stroke services across Norfolk and Waveney.

Elective pathway developments

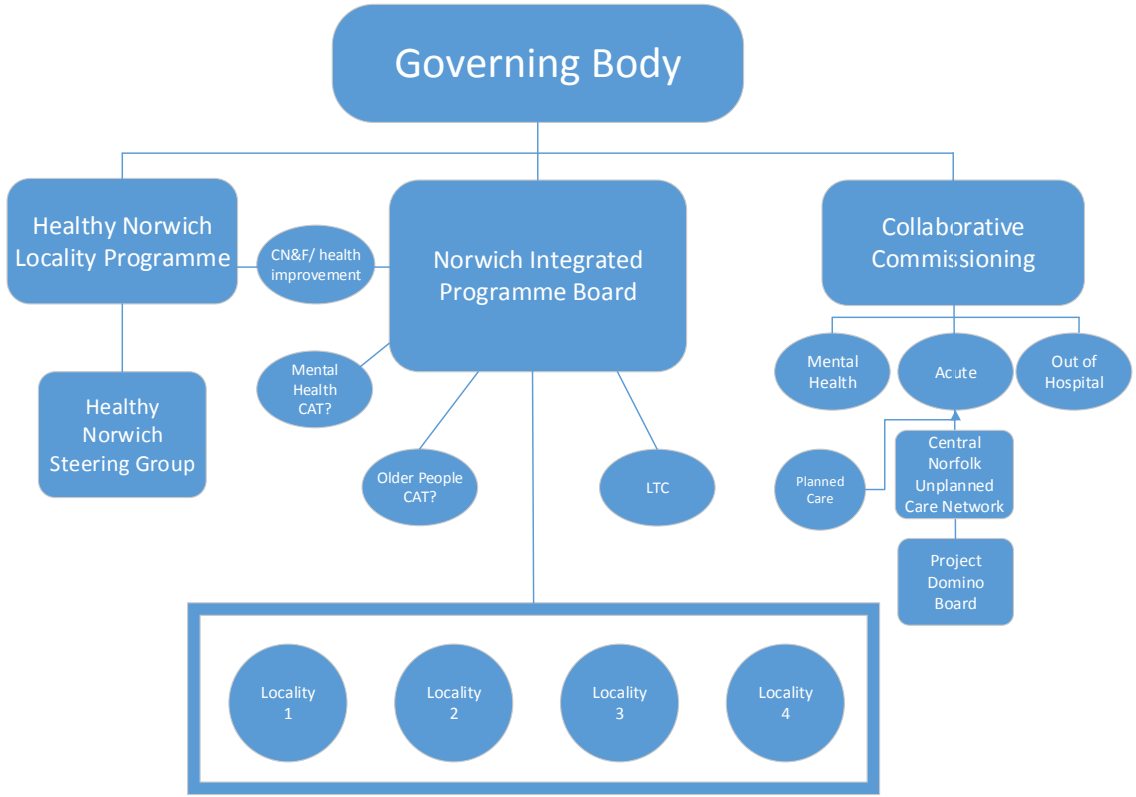
The CCG through the Acute Commissioning Collaborative Board is reviewing a range of elective pathways to ensure that local providers deliver optimum service for our patients in the most cost and clinically effective ways. The ACB is focussing on Orthopaedic pathway review from including orthopaedic triage, plus individual pathways such as Shoulder, Spinal etc. Other pathways will be subject to on-going review as identified through the Commissioning for Value reports.

Implementation and delivery of the plan

NHS Norwich CCG will put in place the MSP project management approach to ensure management and delivery of the initiatives and outcomes required across the programmes. The CCG has appointed a QIPP project director to ensure full PMO oversight of all QIPP programmes. In addition to the PMO support for the Central System wide Domino programme, the CCG has in place a PMO function to monitor and report on the operating action plans attached as appendix to the Operating Plan, with formal reporting through the Senior Management Team (SMT), Governing Body and where system wide the appropriate Commissioning Boards and the Urgent Care Network.
Clinical and managerial responsibility will be attributed across the programmes of work, with a CCG wide workshop to finalise arrangements planned for mid-April.

The main programme areas, Healthy Norwich, Operation Domino and the Integrated Care programme for the City, each has agreed governance structures with formal processes for considering and signing off initiatives and monitoring and reporting progress.

- Integrated Care – the key transformation programme focusing on a practice based, locality organised programme of change and redesign. This programme will be clinically led from clinicians across Norwich CCG, focusing wherever possible on a locality level of transformation. The CCG will continue to work with other CCGs through the Collaborative Commissioning contracting and commissioning arrangements and feed into appropriate networks and structures.
- The final operating and governance structures have yet to be finalised however they will be based on the current successful Clinical Action Team (CATs) that have been in place for 2 years and will ensure managerial and clinical lead and respoinsibility for all programmes and supporting projects. A draft structure is however provided below:



Operation Domino – redesign of the Central Norfolk Urgent Care system

A full PMO and governance structure has been implemented to ensure the delivery of the Operation Domino programme. The Central Norfolk Unplanned Care Network is the main monitoring body, with representation from both providers and commissioners. This is supported by the Capacity Palnning Group in ensuring operationational delivery throught the year.

Domino One

The original Project Domino (1) was initiated in October 2012 by Norwich Clinical Commissioning Group, acting on behalf of Central Norfolk CCGs, and with the sanction and oversight of the Central Acute Commissioning Board and Central Norfolk Unplanned Care Clinical Network.This initial work was designed to make the existing urgent care system work more safely and efficiently, but did not attempt to challenge the current system infrastructure and operating foundations.

Project Domino Two

Project Domino (2) is a continuation of the initial recovery plan addressed in Domino (1). A Senior Think Tank event was held with providers and commissioners to begin creating a vision of the future state of the Unplanned and Emergency Care System. At this meeting a set of guiding principles were developed to support the development of Project Domino (2):

- It should be simple for people to access, understand and navigate
- It should provide accessible information which enables the individual to have choice, self-determination and control where appropriate
- Care should be provided by the right person, in the right service, at the right time, first time.
- Home based rehabilitation and care services should be the norm. People should only be in hospital if the service can't be provided in the community
- Quality services should be provided 24/7 with minimum variation in services out of hours
- Services should be integrated around the patient
- People should die well and in the right place of care
- Patients' voice, creativity and innovation should be used to continually improve and evolve the system.

"When this programme is completed people will be able to make informed decisions regarding the health and the support they require using accessible and accurate information. They will be provided integrated support when they need it, day or night, and can expect to be offered the help they need by the right person with the ability to provide the right service at the right time, first time, every time. Home based rehabilitation and care services will be the norm and people will only be in hospital if the service cannot be provided in the community. Patient's voice, creativity and innovation will be used to continually improve and evolve the system."
<u>Outcomes</u>

1. People will have easy access to the unplanned care system and up to date information to support decisions about their urgent care needs.
2. People will be able to access help and support will be provided by integrated services when needed, day or night, any day of the week, by the right person, who is able to provide the right service at the right time, every time.
3. People will be able to receive their on-going rehabilitation and integrated support provided in their home.

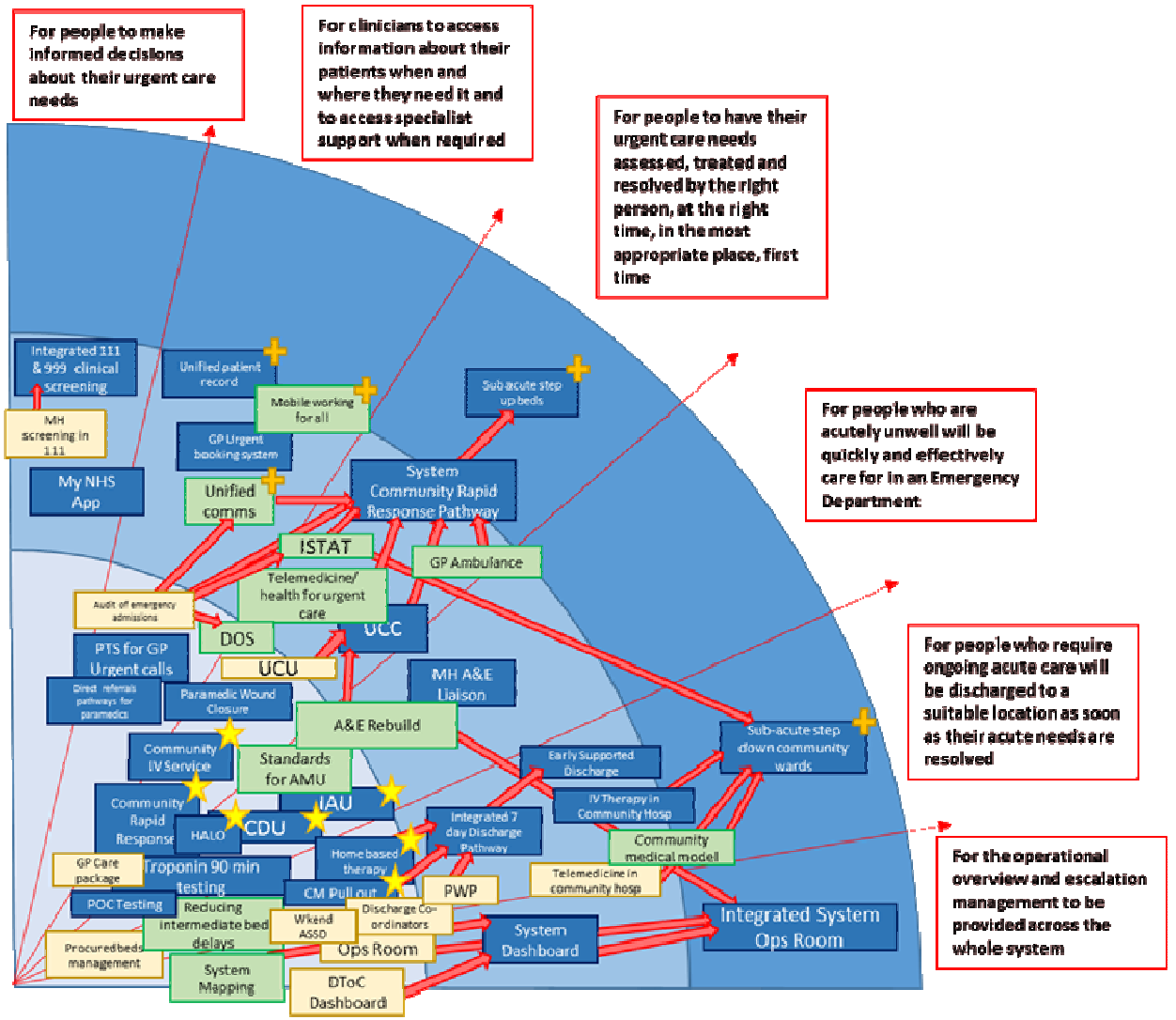
Measures

1. Number of people attending A&E with requirements which could be supported elsewhere.
2. Number of emergency admissions to the NNUHFT.
3. Number of people waiting in A&E for more than 4 hours.
4. Number of Ambulance handovers taking more than 15 mins.
5. Number of people dying in line with their PPoC.
6. Number of Elective Surgeries cancelled on the day of surgery.
7. Friends and Family Test.
8. Number of people re-engaging the Unplanned Care System on a frequent basis.
9. Number of patients who no longer required Acute Services but are waiting for Health and Social Care Support.
10. Length of stay for patients requiring on-going rehabilitation and support
11. Number of patients accessing supported discharge services
12. Functional Improvement scores
13. Number of patients discharged to their normal place of residence
14. Number of patients re-admitted following home based rehabilitation or re-ablement

Domino 2: 3 year plan on a page

Key

- Pilot/scoping project
- Enabling project
- New capability
- Sustainable funding required
- Links between projects
- Dependency on other programmes



GLOSSARY –

A&E	Accident and Emergency
AQP	Any Qualified Provider
AT	Area Team
BCF	Better Care Fund
BDC	Broadland District Council
BMI	Body Mass Index
C2C	Consultant to Consultant
CCG	Clinical Commissioning Group
CFT	Community Foundation Trust
CHD	Coronary Heart Disease
CIC	Community Interest Company
COF	Commissioning Outcomes Framework
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CQC	Care Quality Commission
CQUIN	Contracting for Quality and Innovation
DES	Directly Enhanced Service
DIST	Dementia Intensive Support Team
DoH	Department of Health
DSR	Directly Standardised Rates
ECG	Electrocardiogram
EEAST	East Anglian Ambulance Services NHS Trust
EIT	Early Intervention teams
EoE	East of England
ERPHO	East of England Public Health Observatory
FRR	Financial Risk Rating
FOI	Freedom of Information
FT	Foundation Trust
GP	General Practitioner
HCAI	Healthcare Associated Infection
HES	Hospital Episode Statistics
IAPT	Improving Access to Psychological Therapies
ICO	Integrated Care Organisation
IMD	Index of Multiple Deprivations
IM&T	Infomation Management and Technology
JHWS	Joint Health and Wellbeing Strategy
JPUHFT	James Paget University Hospital Foundation Trust
JSNA	Joint Strategic Needs Assessment
KPI	Key Performance Indicator
LES	Locally Enhanced Scheme
LTC	Long Term Conditions
MFE	Medicine for the Elderly
MIU	Minor Injuries Unit

MONITOR	NHS Foundation Trust Regulator
MRSA	Methicillin Resistant Staphylococcus Aureus
MSOA	Middle Layer Super Output Area
NCC	Norfolk County Council
NCHC	Norfolk Community Health and Care services provider organisation
NHSM&E	NHS Midlands and East
NHSN	NHS Norfolk Primary Care Trust
NHS NCB	NHS National Commissioning Board
NHSN&WC	NHS Norfolk and Waveney PCT Cluster
NICE	National Institute for Health and Clinical Excellence
N&W CSU	Norfolk & Waveney Commissioning Support Unit
NNUHFT	Norfolk and Norwich University Hospitals Foundation Trust
NQB	NHS National Quality Board
NSFT	Norfolk and Suffolk NHS Foundation Trust
N&W CSU	Norfolk and Waveney Commissioning Support Unit
OOH	Out of Hours
PALs	Patient Advice and Liaison Service
PbR	Payment by Results
PCT	Primary Care Trust
PMS	Primary Medical Services
PPG	Patient Participation Group
PROMS	Patient Reported Outcome Measures
QALY	Quality Adjusted Life Year
QEHKLFT	Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
RMC	Referrals Management Centre
RTT	Referral to Treatment
SLA	Service Level Agreement
SPA	Single Point of Access
SCN	Strategic Clinical Network
SNCCG	South Norfolk Clinical Commissioning Group
SNDC	South Norfolk District Council
SPOT	Spend and Outcome relative to other CCGs
TIA	Transient Ischaemic Attack
TOP	Termination of Pregnancy
2ww	Two Week Wait
VTE	Venous thrombo-embolism
WSH	West Suffolk Hospital
Y&HPHO	Yorkshire & Humber Public Health Observatory

Report to Norfolk Health and Wellbeing Board
6 May 2014
Item 7

Clinical Commissioning Groups: Extracts from Draft Annual Reports 2013 -14

What is the role of the HWBB in relation to this paper?

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a:

- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it
- Duty to assess how well the CCG has discharged its duties to have regard to the JSNA and JH&WBS

Key questions for discussion

Q.1 What has been the overall contribution of each of the CCGs towards delivering the priorities of the Joint Health and Wellbeing Strategy?

Q.2 Is this reflected appropriately in the reviews in the CCGs draft Annual Reports?

Actions/Decisions needed

The Board is asked to:

- Comment on the extracts provided of the CCGs draft Annual Reports 2013/14
- Make any other general comments as to form and content of the CCGs Annual Reports

Report to Norfolk Health and Wellbeing Board
6 May 2014
Item 7

Clinical Commissioning Groups: Extracts from Draft Annual Reports 2013 -14

Report by Norfolk's Clinical Commissioning Groups

Summary

This report provides relevant extracts of the Clinical Commissioning Groups (CCGs) draft Annual Reports 20013/14. It brings together the reviews prepared by each of the CCGs of the extent to which the CCG has contributed to the delivery of the joint health and wellbeing strategy. The report provides an opportunity for the Board to comment directly on these draft reviews and, if it wishes to do so, more generally on the form and content of the CCGs draft annual reports.

Action

The Board is asked to:

- Comment on the extracts provided of the CCGs draft annual reports 2013/14
- Make any other general comments as to form and content of the CCGs annual reports

1. Background

1.1 Clinical Commissioning Groups (CCGs) are required to publish an annual report in accordance with Directions issued by NHS England. The NHS England Annual Reporting Guidance states that, amongst other things, the annual reports must contain a review of the extent to which the CCG has contributed to the delivery of the joint health and wellbeing strategy. The Guidance also states that in preparing this review the CCG must consult the Health and Wellbeing Board (H&WB).

1.2 In addition, the Guidance states that the Board may give directions to clinical commissioning groups as to the form and content of an annual report and that the CCGs must give a copy of its annual report to the Board.

2. CCGs Draft Annual Reports 2013-14

2.1 The CCGs are currently drafting their annual reports in accordance with the detailed Guidance issued at the end of March 2014 and these are due to be published in June, at which point they will be in the public domain.

2.2 For the purposes of today's discussion, each of the CCGs were invited to submit their review of the extent to which the CCG has contributed to the delivery of the joint health and wellbeing strategy and these extracts from the draft annual reports are attached in the appendices as follows:

- Norwich CCG – Appendix A
- North Norfolk CCG – Appendix B
- South Norfolk CCG – Appendix C
- Great Yarmouth & Waveney CCG – Appendix D
- West Norfolk CCG - Appendix E

2.3 In terms of the overall form and content, each CCG has drafted its annual report in accordance with detailed NHS guidance and 'final drafts' were submitted to external auditors on April 23rd 2014. The breadth of the annual report is potentially wide and in many cases the CCGs have taken the approach that 'less is more' in order to keep the size of the document manageable. At this stage, it may be that the Board would wish to offer comments in general about overall form, content, etc.

3. Action

3.1 The Board is asked to:

- Comment on the extracts provided from each of the CCGs draft annual reports 2013/14
- Make any other general comments as to form and content of the CCGs annual reports

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Name	CCG	Email
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IN TRAN communication for all

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Norwich CCG

The following is a short extract of the NHS Norwich CCG draft Annual Report which describes about our membership of the Norfolk Health and Wellbeing Board and which demonstrates our commitment to supporting its priorities. Due to the length of the entire document, all sections have necessarily been kept brief. There is considerable reference throughout the Norwich CCG Annual Report to its various partnership working with Norfolk County Council's social care and public health departments and the CCG's priorities and ambitions for the Better Care Fund.

Integrated Commissioning

Norwich CCG hosts an integrated commissioning team, which has worked across health and social care boundaries to develop more coordinated services. Milestones achieved by our integrated commissioning team include:

- a campaign to raise awareness of staying healthy and warm this winter
- a Norwich Falls Reference Group to review the existing falls pathways and prevention/management services
- a new service commissioned by Norfolk County Council from Cotman Housing Association to work with older people. During its first full year it supported 234 people, of whom two-thirds are now living at home without support
- a new integrated community equipment service for Norfolk and Waveney
- a new Carers Support Service, commissioned from Crossroads Care East Anglia as prime contractor for the Carers Agency Partnership, with funding from social care and Norfolk CCGs.

Norfolk Health and Wellbeing Board

The CCG is a committed participant at the Norfolk Health and Wellbeing Board and has contributed to developing its three-year strategy, which focuses on:

- Priority 1 Giving Every Child the Best Start in Life

  Our Children and Families Clinical Action Team has helped develop cycling and walking projects across Norwich and we have commissioned an enhanced children's community nursing service.

- Priority 2 Reducing the Prevalence of Obesity

  We have put in place Tier 2 and Tier 3 weight management programmes. Please also see page xx to read about Healthy Norwich.

- Priority 3 Improved Quality of Life for People with Dementia and their Carers

  We are working with Public Health who will be completing a Dementia Health Needs Assessment for Norfolk at CCG level, due in June 2014. There has been pleasing level of response from Practices to increasing care via a Direct Enhanced Service

The Better Care Fund

In 2015/16 the CCG will contribute £12,245,000 towards the Norfolk Better Care Fund (BCF). This is a Government scheme that transfers NHS resources into a pooled fund under the overall control of Health & Wellbeing Boards. The fund will operate from April 2015.

The Better Care Fund Plan is a single plan for Norfolk, built from individual CCG level plans developed with Norfolk County Council. The total value of the Better Care Fund for Norfolk is £62.4 million from April 2015, of which the NHS Norwich CCG will be contributing £12.25 million. This represents an increase of approximately £8 million over and above the £4.2 million current investment of NHS Norwich CCG health resources into social care. This additional £8 million transfer will be split equally between the protection of social care service provision, and investment in new integrated services. This equal split will create significant financial challenges for both the CCG and the County Council, and the two organisations will work closely on system transformation and service integration during 2014/15 to ensure that we develop an integrated care model that will improve the quality of care and reduce overall cost.

North Norfolk CCG

Extract from Annual Report and Accounts 2013/14

NHS North Norfolk CCG's Chair, Dr Anoop Dhesi, is a member of the joint Health and Wellbeing Board with Norfolk County Council officials and other strategic partners. The Board leads the development of the Joint Health and Wellbeing Strategy, which is informed by the Joint Strategic Needs Assessment, and drives the integration of health, social care and other public sector services. The Board has agreed three overarching goals (drive integration; reduce inequalities; and promote healthy lifestyles and prevent problems) and three priorities through which it will progress those goals (early life (0-5); obesity; and dementia).

The Board has also established a Healthy Communities project to help local people:

- identify the health and wellbeing issues that matter most to them;
- raise awareness of the factors affecting their wellbeing; and
- take the lead in shaping services and activities which meet local need.

Healthy Communities in North Norfolk have been established in the market towns of Cromer, Fakenham and North Walsham.

South Norfolk CCG

The following is a short extract from the NHS South Norfolk CCG draft Annual Report which describes about our membership of the Norfolk Health and Wellbeing Board and which demonstrates our commitment to supporting its priorities. Due to the length of the entire document, all sections have necessarily been kept brief. There is considerable reference throughout the Report to its various partnership working with Norfolk County Council's social care and public health departments and the CCG's priorities and ambitions for the Better Care Fund.

Reducing inequalities for patients / Contributing to the Norfolk Health & Wellbeing Board Strategy

The Marmot Review identified social factors as the determinants of poor health. The CCG has therefore worked with Public Health in the development of the Healthy Communities projects in Wymondham and Diss, as well as supporting the original Healthy Town project in Thetford.

The CCG has also worked with partners on the Norfolk Health and Wellbeing Board to develop its three-year strategy up to 2017 and aligning its work to the Board's priorities:

Priority 1 Giving Every Child the Best Start in Life
In partnership with the community provider and children's services the CCG is reviewing the Looked After Children pathway. The CCG is fully engaged with the implementation of the forthcoming Children and Families Bill.

Priority 2 Reducing the Prevalence of Obesity

A Healthy Weight strategy has been drafted with Public Health, which will help identify commissioning requirements in the future. The CCG is also working collaboratively with North Norfolk CCG to implement a local Tier 3 weight management service by September 2014.

Priority 3 Improved Quality of Life for People with Dementia and their Carers
The CCG will seek to increase dementia diagnosis rates and ensure Primary Care colleagues are able to access information about services and support for people with Dementia, among other initiatives.

The CCG has worked with Norfolk County Council, neighbouring CCGs and local district councils to develop the Better Care Fund. This is a pooled budget to integrate health and social care services from 2015/16 onwards. The CCG's contribution towards this fund in 2015/16 is expected to be £14m. The Norfolk-wide fund will be in excess of £62m
It builds on the significant work already undertaken around integration across Health and Social care to date and will require providers across health and social care to innovate and collaborate more than ever before.
South Norfolk integration priorities:

- Development of integrated health and social care teams at Primary Care level
- Enhance integrated health and social care for people with dementia
- Supporting independence, wellbeing and self care
- Joined up services to support rehabilitation and re-ablement
- Support for people with mental health needs
- Prevention and reduction of falls
- Supporting quality end of life care

Great Yarmouth & Waveney CCG

Section 2.2.1: Our first year

NHS Great Yarmouth and Waveney CCG has enthusiastically embraced its new status as an NHS statutory organisation, with a new and exciting remit to make clinically led and clinically based decisions about how we buy services for our population. The CCG was authorised without conditions in the first wave of CCG authorisations. Our annual report contains more detail about the specifics of these activities. Overall, we have had a very successful first year, with excellent progress made in designing and implementing transformational services for our population, whilst maintaining financial balance in a very challenging financial climate.

The CCG has worked alongside its GP member practices, and Clinical Executive Committee, to design innovative services for our population, including our ground-breaking out of hospital team, which will provide personalised care to patients, helping them to remain in their own homes wherever possible and reduce the numbers of times patients need to be admitted as emergencies to hospital.

We have also developed strong links with other public sector bodies who commission services for the people of Great Yarmouth and Waveney. These bodies are Norfolk County Council, Suffolk County Council, Great Yarmouth Borough Council and Waveney District Council, together with NHS England, who commission primary care services. Working alongside other stakeholders and the public, we have worked up and agreed a common vision of an ICS. This is our means of ensuring that we provide quality care to all of our population and integration of the ways in which patients are cared for (rather than many contacts with many different agencies). This integration will also increase the efficiency and effectiveness of the care we give our population, as well as maximising scarce resources.

The CCG has been a full participant in working with our partners across the Norfolk and Suffolk Health and Wellbeing Boards in the development of the Joint Health and Wellbeing Strategies. This has included participation in discussion at full Health and Wellbeing Board meetings, as well as a number of sub groups established to assist in working on the finer detail of the plans. The CCG's commissioning intentions support the aims of both the Norfolk and Suffolk Joint Health and Wellbeing Strategies.

Suffolk Health and Wellbeing Strategy is available here: http://www.suffolk.gov.uk/your-council/decision-making/committees/suffolk-health-and-wellbeing-board

Norfolk Health and Wellbeing Strategy is available here: **LINK TO BE ADDED AFTER 6 MAY**

West Norfolk CCG

West Norfolk Clinical Commissioning Group (WNCCG) review of it's contribution to the delivery of the Joint, Norfolk Health and Wellbeing Strategy (April 2014)

It is a requirement that Clinical Commissioning Groups (CCGs), as part of their 2013/14 Annual Report, 'review the extent to which the CCG has contributed to the delivery of any joint health and wellbeing strategy to which it was required to have regard under section 116B (1) (b) of the local Government and Public Involvement in Health Act 2007' (2013/14 CCG Annual Report guidance, NHS England). Here follows a brief summary on behalf of West Norfolk CCG.

Health and wellbeing boards were established under the Health and Social Care Act 2012 to act as a forum in which key leaders from the health and care system could work together to improve the health and wellbeing of their local population and to promote integrated services. WNCCG recognises the Norfolk Health and Wellbeing Board as a key vehicle to engage strategic leaders from health and care on a county wide basis, and is an active participant in the board; WNCCG representative Dr Ian Mack being 'vice chair' of the board.

WNCCG has mirrored this collaboration at local West Norfolk health and care system level, through the West Norfolk 'Alliance' of health and care providers and commissioner partners at Chief Executive level, committed to innovation in health and care delivery, and via the development of a West Norfolk health and wellbeing strategy led by WNCCG and Kings Lynn Borough Council.

During 2013/14 the Norfolk Health and Wellbeing Board developed and agreed shared intentions to drive forward health and care integration and reduce inequalities, and to deliver this with focus on 3 local priorities; Improving care for Early Life (years 0-5), improving care and prevention of obesity, and supporting early diagnosis and appropriate treatment for people with dementia.

Examples of WNCCG's contribution to deliver improvements in these areas during 2013/14 included:

- Being identified as an Integration Pioneer, one of a select few areas identified as national pioneers of integrated health and care delivery. This status offers national government support to accelerate integration through sharing of expertise, resource and offering ability to test established process and regulations
- Working with providers to develop Dementia Champions to promote dementia care, and using contractual quality incentives to require providers to improve their early assessment, diagnosis and appropriate referral and treatment for those with dementia
- Work to review the obesity pathway for the population of West Norfolk, to ensure that appropriate interventions at all levels are available, and that early support and prevention is promoted through the Norfolk's 'Living Well' Health Trainer service
- Work to lead improvements in commissioning of children's services, driving change in service provision through our role as 'Chair' of the Norfolk wide 'Women and Children's Commissioning Board'. Work within West Norfolk included work with healthcare partners to improve integration of acute and community paediatric

provision, and to enhance Paediatric acute urgent care over the winter period via additional investment

- Targeted commissioning with Public Health colleagues to reduce inequalities, via the commissioning of health and wellbeing services tailored to particular population groups with specific access and health needs

Health & Wellbeing Board – Budget Report

Cover Sheet

What is the role of the H&WB in relation to this paper?

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, as below:

- Duty to prepare a Joint Strategic Needs Assessment (including a Pharmaceutical Needs Assessment) and a Joint Health & Wellbeing Strategy
- Duty to encourage integrated working between commissioners of health and social care services
- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Joint Health & Wellbeing Strategy and what contribution has been made to the achievement of it
- Duty to assess how well the CCG has discharged its duties to have regard to the JSNA and Joint Health & Wellbeing Strategy

Key questions for discussion

Q.1 Are we content that these are the right areas of focus, given that this is a reduced sum from 2013/14?

Q.2 How else could the Board use its allocation of monies to drive forward its stated goals – Integration, Prevention, and reducing Inequalities?

Q.3 Is the Board content with the monitoring/reporting arrangements for these activities?

Actions/Decisions needed

The Board needs to:

- Consider the report and endorse the proposals.

Health & Wellbeing Board – Budget Report

Report by the Head of Planning, Performance and Partnerships

Summary
This report sets out the Health & Wellbeing Board's funding arrangements, outlines expenditure to date and proposals for 2014-15.

Action
The Health & Wellbeing Board is asked to consider the report and agree proposals for 2014/15.

1. Background

1.1 The Health & Wellbeing Board (H&WB) does not directly control significant health and health care spending. The £1.4 billion health and social care budget for Norfolk is the responsibility of key organisations on the Board, who in turn commission services to improve health and health care of Norfolk's residents.

1.2 In previous years, Norfolk County Council (NCC) has agreed to allocate a proportion of its monies raised through second homes council tax to support health & wellbeing. On setting the budget in February 2014, the County Council allocated its share of monies raised through second homes council tax to support the 2014-15 revenue budget, thereby reducing the need for savings elsewhere.

1.3 However, at its meeting on 14 April 2014, NCC's Cabinet agreed to allocate the sum of **£275k**, which had become available due to a forecast underspend in unallocated second homes income, to support health and wellbeing for the period 2014/15.

1.4 This paper reports spending against last year's allocation (section 2) and puts forward proposals for this year's funding (section 3).

2 Health & Wellbeing allocation 2013-14

2.1 Last year the sum allocated for 2013-14 for the health and wellbeing agenda was £370k. These funds were allocated as follows:

Locally-led health improvement	£290,000.00
Voluntary Sector Engagement Project	£70,000.00
H&WB communications & engagement	£10,000.00

2.2 From its 2011/2012 monies, the H&WB used £290k to fund the roll-out of Healthy Towns activities. This programme of health improvement activity continues until August 2014 and the Board will receive a final report at its meeting in October.

2.3 Last year the H&WB allocated a further sum of £290,000 to locally-led health improvement activity. The Board also agreed that discussions would take place with local partners about how this funding might best be used – for example, it could be used to provide capacity for an accelerated roll out of the projects as outlined in the Community Led Health Improvement Programme, or for other locally based health

improvement initiatives (eg from CCGs) against which this funding could be used as match funding.

2.4 Following preliminary discussions with local partners, it was confirmed at the H&WB meeting in October 2013 that the funding would be used to commission activities that will result in a demonstrable improvement in:

Either:

- The three overarching goals and three priorities of the developing Joint Health & Wellbeing Strategy 2014-17

Or

- One or more of the 11 priorities identified in the existing Joint Health & Wellbeing Strategy 2013-14

2.5 In addition, the allocation would be aimed at encouraging and further developing:

- Empowered communities able to proactively influence and lead on improving their own health and wellbeing
- The capacity of the community and voluntary sector to contribute to the achievement of health and wellbeing outcomes
- Good and effective working relationships between partners at a local level,
- Increased awareness of, and share learning about issues faced, and approaches taken, across Norfolk

2.6 It was agreed that the funding would be:

- Split on the basis of the Public Health (PH) Allocation formula - which builds in accepted national information on comparative health needs

- Allocated to city, district and borough councils - to work with their local partners to commission activities in line with the aims and outcomes outlined above.

2.7 The funds were distributed accordingly and, at its meeting on 16 July 2014, the H&WB will consider a report from each of the city, district and borough councils outlining the outcome of this work together with details of spend.

Voluntary Sector Engagement Project

2.8 At its meeting in April 2013, the H&WB considered a report about the Voluntary Sector Engagement Project (VSEP) which had been set up to support the engagement and involvement of the voluntary and community sector (VCS) in the changing landscape of health, wellbeing and clinical commissioning.

2.9 The H&WB noted that the project was focused on ensuring best use was made of the skills, expertise and capacity of the voluntary and community sector (VCS) by facilitating and supporting positive engagement with the public sector. The project was managed by Voluntary Norfolk.

2.10 The project had been funded through NCC's proportion of 2nd Homes monies which the Council had allocated to support health & wellbeing. The H&WB endorsed the contribution being made by the project to the emerging health and social care agenda, and the work of the Board, and agreed an allocation of £70k for 2013/14.

2.11 The H&WB also decided to set up a small Steering Group to provide the strategic lead and oversee the project for the year ahead. Debbie Bartlett, Head of Planning Performance & Partnerships, NCC, was appointed Lead Officer for the sub-group.

2.12 A report on the current focus of this project and key activities over the last 12 months is at item 9 on this agenda.

Health & Wellbeing Board communications and engagement

2.13 In the development of the refreshed Joint Strategic Needs Assessment (JSNA) and Joint Health & Wellbeing Strategy (JH&WBS), it was envisaged there would be a need for communications and engagement and £10k was committed for this purpose. In practice, there has been minimal call on this funding during development so far and so it remains committed for this purpose and will be available to support the communications and engagement activity around the new JH&WBS 2014-17

3 Funding proposals for 2014-15

3.1 It is proposed that the allocation of **£275k** for 2014/15 is used in broadly the similar way as previous years.

Locally-led health improvement

3.2 For 2014/15, it is proposed that **£200k** is used to:

- Provide further support to the Healthy Towns initiatives to extend the original programme
- Continue the support provided in 2013/14 for locally –led health improvement activity to be used by partners to commission activities that will result in a demonstrable improvement in the H&WB's strategic priorities

Voluntary Sector Engagement Project

3.4 It is proposed to provide a further **£70,000** funding towards the VSEP to enable continued support in securing the active engagement of the voluntary sector in the work of the Health and Wellbeing Board during its second year with statutory responsibilities

Health and wellbeing board communications, engagement and Board development

3.5 It is proposed to earmark **£5k** to support Board development and contingency.

4. **Action**

4.1 The Health & Wellbeing Board is asked to:

- Consider the report and agree proposals for 2014/15.

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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Voluntary Sector Engagement Project (VSEP)
End of year update report 2013/14

Cover Sheet

What is the role of the H&WB in relation to this paper?

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, as below:

- Duty to prepare a Joint Strategic Needs Assessment (including a Pharmaceutical Needs Assessment) and a Joint Health and Wellbeing Strategy
- Duty to encourage integrated working between commissioners of health and social care services
- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it
- Duty to assess how well the CCG has discharged its duties to have regard to the JSNA and JHWS

The Health & Wellbeing Board has commissioned the VSEP to support the engagement of the voluntary and community sector (VCS) in its work and in the changing wider health and wellbeing agenda.

Key questions for discussion

Q.1 Are the proposals for future work of the VSEP, as outlined in section 3, the right focus for the coming year?

Q.2 What do Board members wish to see as the project deliverables?

Q.3 Is the Board content that the governance arrangements for this project, ie the VSEP Steering Group (see section 1.3) are appropriate for the next 12 months?

Actions/Decisions needed

The Board needs to consider the recommendations made in Section 4:

- Endorse the work of the VSEP over the last 12 months as set out in this Paper and in Appendix 1.
- Offer any comments on the focus of the work for the coming year as discussed by the VSEP Steering Group (Section 3) – including agreeing a presentation on Social Value for the July meeting of the Board.
- Request partners to the Board to distribute the Directory of Voluntary Sector Forums to their relevant leads (Appendix 2).
- Support the continued funding by the Board of the Project.

Voluntary Sector Engagement Project (VSEP) End of year update report 2013/14

Report by the Head of Operations, Voluntary Norfolk

Summary
This report outlines the work of the Voluntary Sector Engagement Project (VSEP) in bringing the active engagement of the voluntary sector into the work of the Health and Wellbeing Board and the wider health and wellbeing agenda. It outlines the focus of the project, sets out key activities over the last 12 months and identifies areas of future work.

Action
The Health and Wellbeing Board is asked to:

- Endorse the work of the VSEP over the last 12 months as set out in this Paper and in Appendix 1.
- Offer any comments on the focus of the work for the coming year as discussed by the VSEP Steering Group (Section 3) – including agreeing a presentation on Social Value for the July meeting of the Board.
- Request partners to the Board to distribute the Directory of Voluntary Sector Forums to their relevant leads (Appendix 2).
- Support the continued funding by the Board of the Project.

1. Background

1.1 Through commissioning the VSEP, the Health & Wellbeing Board has supported the engagement of the voluntary and community sector (VCS) in the changing landscape of health, wellbeing and clinical commissioning. The project developed from related work with what was the Norfolk County Strategic Partnership. Using Second Homes Council Tax monies the Board took over responsibility for the project in 2012. The project is delivered by Voluntary Norfolk.

1.2 Last year's report had attached to it a case study from Regional Voices profiling the Board's approach to the VCS as a good practice example. Recently Regional Voices contacted us again; they continue to be impressed by the concrete support demonstrated to VCS engagement in the work of the Board demonstrated by funding the VSEP.

1.3 At its meeting in April last year the Board received and accepted a project Update Report and also agreed to set up a VSEP Steering Group drawn from Board members. The Steering Group has met twice and comprises: Cllr Yvonne Bendle, Harold Bodmer, Lucy Macleod, Richard Draper, Mark Taylor and Debbie Bartlett. It is attended by Linda Rogers & Claire Collen (Voluntary Norfolk).

2. Overview of the work of Voluntary Sector Engagement Project

2.1 The VSEP supports local voluntary and community organisations (VCOs) to engage with the work of Health and Wellbeing Board and the wider health and wellbeing agenda.

2.2 Over 3,000 voluntary groups in Norfolk are delivering services and support that contribute to health and wellbeing, especially to vulnerable individuals and communities. Services typically are community-based and focused on preventing and reducing inequality – two of the Board's underpinning themes. Some are organisations directly commissioned to deliver public services – but many are not. The VSEP ensures that there are open channels of communication with the wide range of VCOs to support their integration with the health and wellbeing agenda.

2.3 Through the Project's work the Board has:

- effective communication channels with a wide range of voluntary and community organisations for dialogue through consultation and engagement activities
- the benefit of expertise and insight from the three voluntary sector representatives
- access to specialist knowledge on issues impacting on vulnerable people e.g. welfare reform, mental health
- opportunities for evidence gathering with the VCS to inform service planning e.g. collaborative research to feed into the JSNA

2.4 For voluntary and community organisations the Project means the sector is:

- better informed about the strategic context in which they operate in relation to Board activity – including the work of the JSNA
- better placed to contribute their frontline knowledge and specialism to service planning and delivery through engaging with Board partners
- more knowledgeable about ways that their services meet the Board's priorities
- more equipped to spot and engage with opportunities as they arise.

2.5 Set out below is a summary of the three main strands of the Project's focus: information and communication, capacity building and strategic voice and advocacy, whilst an update on specific recent VSEP's activity is attached at **Appendix 1.**

Information and Communication

2.6 The VSEP bulletins, updates and website help raise awareness of current health, social care and wellbeing issues and keeps the Board's health and wellbeing agenda real and relevant for the sector so they can respond. Specifically:

- for VCOs the bulletins provide information on:
  - local and national strategic and operational drivers
  - changes in guidance and developments in best practice
  - opportunities to engage with public sector partners working on the Board's agenda
- for public sector partners they offer alerts to topical health and wellbeing issues from the perspective of VCOs.

2.7 We are often asked, by both public partners and VCS colleagues, for information about voluntary organisations operating in specific fields or localities, or for the

names of public sector leads. The VSEP maintains up-to-date contact details of over 300 CEOs/senior managers as well as an updated list of public sector contacts.

2.8 The project uses established forums and networks to communicate the health and wellbeing agenda widely to the sector. In order to raise awareness of some of these forums with Board members, the project has recently produced a **Directory of Norfolk's Voluntary Sector Specialist Forums** which brings together details of the main county-wide forums, their primary purpose and focus, membership and contact details. It is attached at **Appendix 2.**

Supporting the capacity of the VCS to engage

2.9 As mentioned above, the project focuses on ensuring there are effective mechanisms and routes in place so that knowledge, experience and expertise sitting within the VCS can feed into and help shape the priorities and plans of public partners involved in the Health and Wellbeing Board and help inform the work of the JSNA.

2.9 To enable this to happen the project works closely with the VCS forums and informal VCS networks to increase awareness of cross-cutting health and wellbeing related issues such as social value, and welfare reform. It raises awareness of current debate and issues being considered by the Health and Wellbeing Board by, for example, ensuring Board papers are accessible and by leading/collaborating on multi-sector events. Last year's welfare reform workshop for Board members is an example of this.

2.10 The Project is also able to quickly set-up 'task and finish' groups to respond to new ideas. For example, a Social Value Working Group has been established in response to VCOs' request that the sector play a leading role in discussions with commissioners on ways to implement the Social Value Act in Norfolk. This could have a significant impact on maximising health and wellbeing outcomes beyond the VCS.

Strategic voice and advocacy

2.11 The VSEP enables and facilitates opportunities for VCS representatives to deliver a 'whole sector' viewpoint rather than that of individual organisations. This helps ensure the VCS contribution is informed and relevant to the Board's work. Examples of this include the pre-meetings with the three VCS Representatives, as well as feedback to the Joint Health, Social Care & Voluntary Sector Strategic Forum to whom the Representatives are accountable.

2.12 The project also ensures that information, including Board minutes and decisions, are communicated to the wider VCS constituency, thus contributing to a better understanding of Board activity and transparency of Board processes.

2.13 Through the VSEP, the views of the wider VCS are gathered providing background for the representatives at Board meetings and guiding other interventions. Forum meetings, feedback from events and day to day contact with a wide range of organisations are all opportunities for gathering this intelligence and providing the coordinated information to support the VCS input to Board discussion and activity.

2.14 The VSEP works collaboratively with a range of partners, both to deliver joint events and to undertake collaborative research through use of the Project's specialist VCS

contacts. An example of the former was the event (in September 2013) for learning disability and mental health organisations in both the voluntary and private sector. Organised in conjunction with Norfolk Independent Care & Commissioners for Learning Disabilities & Mental Health, a joint Action Plan with recommendations for strategic and operational actions has been produced (currently awaiting feedback from Community Services). An example of research work is that undertaken with the Norfolk Drug & Alcohol Partnership resulting in a report (published June 2013) which identified the VCS's contribution to the substance misuse agenda. More recently the VSEP has been working collaboratively with Healthwatch to build closer relations between the VCS and Healthwatch.

3. Forward work areas

3.1 At its last meeting (25 Feb 2014), the VSEP Steering Group discussed proposals for future areas of work. These are outlined below alongside the Steering Group's comments. The Board is asked to consider these and offer any additional comments.

Area	**Proposal**
1. Learning Disabilities Forum	Support forum to establish itself, including engagement with commissioners. Provides an informed and collective voice on learning disabilities to feed into work of the Board.
Steering Group Comment Agreed this was a useful development and should be supported.	
Area	**Proposal**
2. 'Closing the Gap' - Priorities for essential change in mental health (DoH, Jan 2014)	Closing the Gap sets out 25 priorities on mental health care and support for the next 2 years. Involves a range of agencies who have a role to play in achieving change. The cross-cutting nature of mental health relates to a number of actions in the HWB strategy for 2014-17. The Mental Health Provider Forum, and the lead commissioner for Mental Health, want to run a workshop on how Norfolk can respond to the challenges and ambitions and the VSEP has been asked to work on delivering this.
Steering Group Comment Support engagement with this. Very important to involve wider partners, e.g. Child & Adolescent Mental Health Service, Children's Services and also housing. Public Health will seek to cross-match the HWB Action Plans for mental health with Closing the Gap priorities. Helps to support the integration agenda of the HWB.	
Area	**Proposal**
3. Implementation of effective **Social Value** principles to inform HWB work on prevention, inequality & integration.	Consider how the HWB could raise understanding of the benefits of incorporating social value to service planning and commissioning.

Steering Group Comment
Because the Board brings together so many partners it is well placed to sponsor and promote the adoption of social value principles. It was agreed to propose a presentation on Social Value for the July meeting of the Board

Explanatory Note:
The Government's ***definition of social value*** *is:*
"a concept which seeks to maximise the additional benefit that can be created by procuring or commissioning goods and services, above and beyond the benefit of merely the goods and services themselves".

The general understanding of 'social value' is "the additional environmental, social and economic benefits that can be accrued to communities above and beyond the delivery of the service". These kinds of benefits or additional value might come, for example, from reducing crime; increasing community cohesion; involving local apprentices who were previously unemployed.

The essence of the Social Value Act is that it places an onus on commissioners to use criteria for awarding contracts that are not just economic. Its success depends on both statutory and voluntary organisations agreeing the concept and understanding how to recognise social value, identifying where it occurs and how it can be included in the commissioning process.

Area	**Proposal**
4. Scope development of a **flexible model for funding** services from the VCS.	Given the lead role of the Older People's Strategic Partnership in the Dementia priority, and likely expectations on the VCS in relation to Better Care Fund objectives, it is timely to consider what mechanisms, other than formal tendering, can best support effective commissioning and purchasing of VCS services that makes best use of scare resources and delivers sustainability.

Steering Group Comment
Agreed this was an important piece of work and provided a platform for supporting VCS integration to the HWB.
Concern that tendering is wasteful of resources and not the most effective way of purchasing the sorts of services the VCS can provide.
Obesity is an area in which a creative approach to involving the VCS as an equal partner would be very apt. (Cited Scottish model where the voluntary sector is considered an equal partner both at a strategic level, and at a commissioning level with allocated funding.)
Need to shift money into the front-line, low level, preventative work which is best delivered by VCOs.
The VCS need to be very much part of the decision-making process in the Better Care Fund.
The VSEP Steering Group should examine the extent to which the VCS is as an equal partner in commissioning and funding decisions.
Action - CC to produce a paper reflecting discussion and scoping out a model.

4. Conclusion

4.1 The VSEP provides an effective link for the Health and Wellbeing Board and its partner organisations to the voluntary sector. This gives added value to Board activity because it benefits from the expertise, front-line knowledge and understanding of a sector working closely with vulnerable individuals and communities most at risk of inequality.

4.2 Whilst VCOs differ in their capacity and desire to engage at a strategic and policy development level, this project supports and facilitates engagement by interpreting policies and issues in a voluntary sector relevant way. The sector's impact on the health and wellbeing of Norfolk residents goes far deeper than simply through the delivery of commissioned health and wellbeing services. Voluntary and community action is integral to the County's vitality.

4.3 The VSEP provides an effective route into VCS networks and the wider sector which helps that contribution to be more closely aligned to the work and priorities of the Board. The VSEP offers a focused pro-active communication channel to stimulate mutual understanding and appreciation of the context within which both the Board and voluntary sector organisations are working to improve the lives of residents.

5. Action

5.1 The Health and Wellbeing Board is asked to:

- Endorse the work of the VSEP over the last 12 months as set out in this Paper and in Appendix 1.
- Offer any comments on the focus of the work for the coming year as discussed by the VSEP Steering Group (Section 3) – including agreeing a presentation on Social Value for the July meeting of the Board.
- Request partners to the Board to distribute the Directory of Voluntary Sector Forums to their relevant leads (Appendix 2).
- Support the continued funding by the Board of the Project.

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

Name	Tel:	Email
Linda Rogers	01603 883801	Linda.rogers@voluntarynorfolk.org.uk
Claire Collen	01603 883840	Claire.collen@voluntarynorfolk.org.uk

IN TRAN communication for all

If you need this Agenda in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Appendix 1

Activity Update to VSEP Steering Group
(covering period 30 Sept 2013 – 25 Feb 2014)

Health & Wellbeing Board

Activity	Update
• Facilitate meetings and communications between VCS HWB Reps. Includes Board pre-meets, supporting activity between meetings, briefing notes.	• On-going
• Produce Directory of VCS Specialist Forums	• Draft produced for discussion at VSEP Steering Group Feb 2014
• Participation in HWB Strategy Group & JSNA Officer Working Group.	• On-going
• Working with Healthwatch.	• Joint session to build closer relations between Healthwatch and the voluntary sector being held 29 April. • New chair of HW will address Mental Health Provider Forum (in March) • Exploring joint work on assessing impact on health & wellbeing of NCC budget.

Information & Communication

Activity	Update
• VSEP Bulletins. Most recent: - 15 Jan: County Council Budget Proposals - 24 Jan: Learning Disabilities Forum; Impact funding cuts on welfare; Care Bill; Immigration Bill; Palliative Care - 7 Feb: Report from latest HWB; Hate Crime Event - 13 Feb: Overview of Better Care Fund & 'first cut' proposals; JSNA & Child Poverty; Wellbeing & Health Policy	• Circulated to 100 senior VCS chief executives/senior managers & 60 public sector leads in NCC, the CCGs, district councils and others. • On-going. Bulletin in new e-format. Allows tracking which shows above average 'open' and 'click' rate & good forwarding rates.
• Working with voluntary sector forums, specifically - Advice & Advocacy Strategic Partnership - Mental Health Forum - Learning Disabilities Forum Also attend Older People's Strategic Partnership to keep updated & informed.	• On-going. • Mental Health – Joint Action Plan following event with Norfolk Independent Care (in Sept) written, circulated, presented to Harold Bodmer. Follow up work needed. • Learning Disabilities - recently established by VSEP to provide co-ordinated voice and strategic engagement with commissioners

• Maintenance of data sets of VCS specialist organisations, VCS networks, key public sector contacts	• On-going
• NCC On-line Social Care Directory	• On-going. VSEP working collaboratively with NCC Directory Governance Group to ensure relevance for the VCS. • Promoting use of directory to VCOs.

Social Value

Activity	**Update**
Social Value Act Event held Oct 31, King Centre, Norwich.	• VCS Working Group established to develop VCS approach and initiate dialogue with commissioners.

CCGs/Integrated Commissioning Teams

Activity	**Update**
• Integrated Commissioning Locality Provider Forums	• Review agendas & minutes and attend where relevant & capacity allows.
• Clinical Commissioning Groups	• Current activity includes reviewing CCG websites and ensuring relevant CCG Papers coming to the Board are communicated to the VCS.

Directory of Norfolk's voluntary sector specialist forums

(March 2014)

VOLUNTARY NORFOLK

Forum	Page
Introduction and Purpose	3
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INTRODUCTION and PURPOSE

This Directory brings together in one place information about the main county-wide voluntary sector forums operating in specialist fields. The forums are led by voluntary sector provider organisations – although many involve public sector colleagues. The forums provide an important route for engagement between the voluntary sector and public sector decision-makers and commissioners.

The purpose of the Directory is to help build an understanding about the focus and specialist nature of each forum, give an idea of who the member organisations are, and provide contact details. Additionally, the Directory provides:

- a resource for members of Norfolk's Health and Wellbeing Board to tap into for dialogue and engagement with specialists in the voluntary and community sector (VCS)
- an understanding of where the VCS is currently involved in decision-making structures (and where they are not)
- VCS contact details for strategic, policy and commissioning leads in Norfolk County Council, the Clinical Commissioning Groups, District Councils and associated partners
- smaller VCS groups and organisations with help to understand the wider strategic picture.

The forums all work across three levels:

Operational

- increase knowledge about the work and services of organisations working in the same or similar fields
- explore areas for potential joint work such as referral mechanisms, training or development needs
- share information and updates on key developments (national and local)
- respond to the implications of cross-cutting challenges and opportunities affecting service delivery

Strategic

- develop strong relationships with commissioners and have structured engagement with public sector partners to ensure the views of the voluntary sector are included in key developments
- co-ordinate representation on strategic and operational partnerships
- build understanding of the role and contribution of the voluntary sector

Voice and Advocacy

- bring knowledge of services impact through front-line experience and feedback from users
- raise awareness of unmet need and identify gaps in services
- challenge policy, procedural or other barriers that limit access or delivery of services
- identify, share and champion areas of innovation and good practice in order to strengthen services in the county

Other forums and further information

There are other forums and networks which are not included here:

- public sector led partnerships
- locality-based voluntary sector networks or forums
- specialist county-wide user-led groups
- VCS infrastructure organisations

The VSEP will often hold information about such forums, so for this, or for anything else connected with the forums listed in this document please contact:

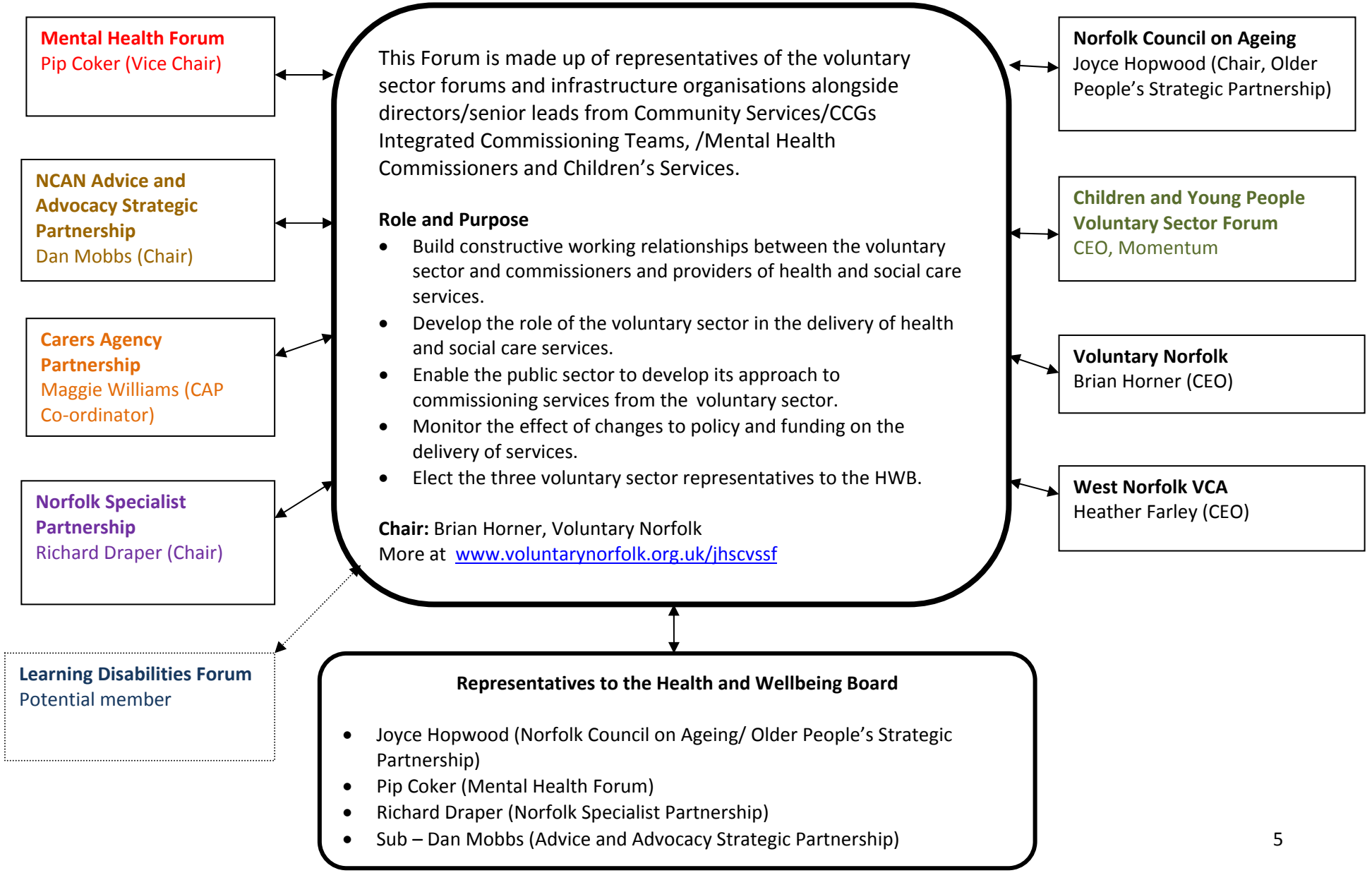
claire.collen@voluntarynorfolknorfolk.org.uk

Voluntary Sector Engagement Project

Voluntary Norfolk

Date: 18 March 2014

Joint Health, Social Care and Vol Sector Strategic Forum



Carers Agency Partnership (CAP)

1.	***Purpose:*** *Who is the forum for? What are its main purposes? (This could be an extract from the terms of reference.)* A forum for the voice of voluntary sector organisations working with carers, the CAP's role extended when it became a delivery partnership in July 2013 as a result of winning the commission by Norfolk County Council and the Norfolk Clinical Commissioning Groups.
2.	***Meetings:*** *Generally how often does the forum meet?* The CAP Partnership meets every two months and the CAP Steering Group meets quarterly.
3.	***Membership:*** *Please list current membership (with web address/emails). Include public sector members where relevant.* The Carers Agency Partnership is led by Crossroads Care East Anglia, who are the main contractor. CCEA subcontracts to the other partners, who are: • Age UK Norfolk, • Norwich and Central MIND, • Great Yarmouth and Waveney MIND, • West Norfolk MIND, • Norfolk Carers Support, • West Norfolk Befriending and West Norfolk Carers. The Carers Council for Norfolk is supported through the CAP contract via WNC.
4.	***Influence:*** *Over the last 12 months or so, has the forum been able to influence decision-makers in the public sector e.g. commissioners, or other voluntary or public sector partnerships? Please give examples as appropriate:* • CAP has facilitated carers' consultation meetings for NCC's budget proposals • CAP is involved in the Joint Health, Social Care and Vol Sector Steering Group, which interfaces with NCC • CAP is involved in the Norfolk Specialist Partnership which engages with statutory bodies and Norfolk's voluntary sector • CAP works with each CCG and with NCC Health and Social Care • CAP is involved in contributing to the public health needs assessment work • CAP produces monitoring information quarterly which is passed to JSNA • CAP works closely with statutory partners to help shape services for carers • CAP works with NSFT to ensure the mental health agenda is informed • The Carers Council Norfolk provides the service users voice and CAP actively seeks opinion to inform work such as the Carers Strategy for Norfolk • CAP works closely with Healthwatch

5.	***Outcomes:*** *In last 12 months or so, what difference do you think the forum, as a collective voice, has been able to make that individual members, acting alone, would have found difficult? Please give examples:* • The carers' voice is informing the revised Carers Strategy for Norfolk • CAP put forward a position statement as an outcome of the public consultation in response to NCC's budget proposals – positive outcome in budget decisions announced in Feb • CAP is taking the carers' voice forward in ensuring carers' assessment process works well • CAP is working with CCGs on integration work
6.	***Effectiveness:*** *Is the forum achieving what it wants to? If not, what would help it be more effective?* • CAP is six months old and is settling down well as a partnership. • Information is building on numbers of carers finding out about the service, especially carers who are new • We aim to inform debates around service provision and support in the wake of service and budget cuts, with a focus on dementia and mental health at present • More resources would help meet demand!
7.	***For more information:*** *Please give the name and contact details of the chair or secretariat, their email and/or tel* Maggie Williams, Manager CAP Maggie.williams@crossroadseastanglia.org.uk See also www.norfolkcarersinfo.org.uk
6.	***Date completed and by whom:*** 14.02.14, Maggie Williams

Children and Young People Voluntary Sector Forum

1.	***Purpose:*** • **Representation:** To elect representatives onto appropriate partnerships to ensure that the views of the voluntary sector are included in key developments. • **Information**: using existing and new networks to ensure that all organisations both large and small are able to receive up to date information about key developments affecting those working with children and young people. • **Consultation**: providing a central resource to facilitate and undertake consultation with voluntary and community organisations and their service users. • **Lobbying**: to provide a means whereby the collective voice of the voluntary sector can help promote the work of the sector and influence all appropriate decision-makers. • **Partnership**: to improve partnership working between statutory and voluntary organisations, and within the voluntary sector, enabling a strategic approach to service planning, design, resourcing, commissioning and delivery and avoiding duplication of work. • **Capacity building**: to encourage best practice in working with children, young people and their families for voluntary and community organisations.
2.	***Meetings:*** The Forum holds quarterly county-wide meetings. There are additional meetings of various sub-groups relating to specific areas of work.
3.	***Membership:*** 79 organisations are members. Full list: www.momentumnorfolk.org.uk/assets/member-list.doc Members may: • be either a charity or community group (i.e. have a group of trustees) • work with a specific age group, families or all ages up to 18 (24 with special needs) • provide a service open to all or a targeted group (e.g. faith, BME) • provide a wide variety of activities or be focused (e.g. sports clubs) • support people dealing with a specific issue (such as drugs or special needs) • cover a very local area (e.g. parish), operate across Norfolk, or part of a national organisation • provide a service for adults as well as children, or be entirely focused on young people.
4.	***Influence:*** Please give examples as appropriate: • Shaping of the Norfolk Safeguarding Children's Board: ensuring voluntary sector representation and engagement – full member of the NSCB, Leadership Group and sub groups • Shaping of the Children's Services sub groups and improvement – full member of the Children's Service Improvement Board. • Ensured working with and investing in voluntary sector is a measure of improvement • Evidence of services delivery to and meeting the need of Looked after Children in

	Norfolk • Influence of the Early Help agenda • Universal Access Provision • Member of the Joint Health, Social Care and Voluntary Sector Strategic Forum.
5.	***Outcomes:*** • As above in the evidence of influence • Voice and representation of the membership and voluntary and community sector supporting children, young people and their families • Networking • Peer support • Partnership working • Key messages http://www.momentumnorfolk.org.uk/forum/default.asp?pageno=22 • Conferences looking at key issues – 2013 conference focussed on Welfare Reform
6.	***Effectiveness:*** Well respected and recognised forum and voice for the voluntary and community sector organisations and services in Norfolk working with children, young people and families.
7.	***For more information:*** T: 01603 819135 E: forum@momentumnorfolk.org.uk. W: www.momentumnorfolk.org.uk/forum/
6.	***Date completed and by whom:*** 12th February 2014 Julia Redgrave – CEO, Momentum (Norfolk) on behalf of Chair and Forum members Please note Momentum (Norfolk) provide the secretariat support for the Forum.

Learning Disabilities Provider Forum

1. ***Purpose:***
Who is the forum for? What are its main purposes? (This could be an extract from the terms of reference.)

The forum is recently established (Jan 2014). It is for voluntary organisations working with people with learning disabilities across all age ranges. Terms of reference are yet to be agreed, but the main purposes are to:

- increase knowledge about the work and services of other LD organisations in the county
- explore areas for potential joint work/referrals
- share information and updates on national and local drivers
- respond as a collective voice to policy issues and changes affecting operational implications
- look at cross-cutting challenges and opportunities (e.g. personal budgets)
- have structured engagement with public sector partners, particularly LD commissioners

2. ***Meetings:*** *Generally how often does the forum meet?*
Bi-monthly.

3. ***Membership:***
Please list current membership (with web address/emails if possible). Include public sector members where relevant.

About with Friends	Hamlet Centre
Assist Trust	Mid Norfolk Mencap
Autism Anglia	NANSA
Broadland Meridian	Opening Doors
Build	Stepping Stones
CSV (Community Service Volunteers)	Thornage Hall
Equal Lives	Voluntary Norfolk

Service users and commissioners will also be members.

4. ***Influence:***
Over the last 12 months or so, has the forum been able to influence decision-makers in the public sector e.g. commissioners, or other voluntary or public sector partnerships?
Please give examples as appropriate:

At its first meeting the Autism Self Assessment ratings were discussed (as a consequence of the circulation of the HWB Paper in Jan). A number of concerns were raised about the ratings and these have been fed through to the Adult Autism Steering Group (on which one of the forum members has a place).

5. ***Outcomes:***
In last 12 months or so, what difference do you think the forum, as a collective voice, has been able to make that individual members, acting alone, would have found difficult?
Please give examples:

6.	***Effectiveness:*** *Is the forum achieving what it wants to? If not, what would help it be more effective?*
7.	***For more information:*** *Please give the name and contact details of the chair or secretariat, their email and/or tel* Chair: Anne Ebbage, aebbage@autism-anglia.org.uk
6.	***Date completed and by whom:*** 18 March 2014: claire.collen@voluntarynorfolk.org.uk

Mental Health Provider Forum

1. ***Purpose:***

Who is the forum for? What are its main purposes? (This could be an extract from the terms of reference.)

The Forum is open to MH providers (large, medium and smaller niche providers) across Norfolk. Meets regularly on common issues and opportunities impacting on services for people with mental health needs. Role includes:

- developing strong relationships with public sector partners, including MH commissioners
- co-ordinating representation from the Forum at appropriate strategic and operational partnerships
- raising awareness of unmet need and challenging policy, procedural or other barriers to accessing or delivering services
- identifying, sharing and championing areas of innovation and good practice in order to strengthen services in the county

Membership is drawn from organisations working in the age range 16 to 65 years (so does not include specific older people's organisations e.g. local Age UKs.)

2. ***Meetings:*** *Generally how often does the forum meet?*

Bi-monthly. Try to meet in a range of members' venues.

3. ***Membership:***

Please list current membership (with web address/emails if possible). Include public sector members where relevant.

Aspergers East Anglia	Broadland Meridian
Beat – Beating Eating Disorders	Cruise Bereavement Service (Norwich)
Eating Matters	Equal Lives
Homegroup – Stonham	Julian Support
MAP (Mancroft Advice Project)	MH Befriending Service (Voluntary Norfolk)
Mind (Great Yarmouth and Waveney)	Mind (Norwich and Central)
Mind (West Norfolk)	Pregnancy Choices Norfolk
Relate Norfolk and Suffolk	Rethink
St Martin's	Strong Roots

	Sue Lambert Trust	Together (for Mental Wellbeing)
	Voluntary Norfolk	

Public Sector Members:

- Commissioners from the Joint Mental Health and Learning Disabilities Team
- Norfolk and Suffolk Foundation Trust

4. ***Influence:***

Over the last 12 months or so, has the forum been able to influence decision-makers in the public sector e.g. commissioners, or other voluntary or public sector partnerships? Please give examples as appropriate:

- The MHPF is member of the Joint Health, Social Care and Voluntary Sector Strategic Forum (and through that sits on the Health and Wellbeing Board). Has raised cross-cutting issues about operational implications for providers and service users of Personal Budgets – including circulating a Paper setting out areas for action written by the forum.
- Members keen to work more pro-actively with commissioners to jointly tackle/co-produce solutions. Currently a potential opportunity to co-produce the Norfolk take on the DoH's paper 'Closing the Gap: Priorities for essential change in mental health'.
- Submitted response to the Budget Cut proposals.

5. ***Outcomes:***

In last 12 months or so, what difference do you think the forum, as a collective voice, has been able to make that individual members, acting alone, would have found difficult? Please give examples:

- The Forum rep to the Joint Health, Social Care and Voluntary Sector Strategic Forum is one of the three vcs reps to the Health and Wellbeing Board. Issues around mental health have been raised on a consistent basis, resulting in mental health being given a higher profile than might otherwise have been the case.
- Survey of unmet mental health needs undertaken with provider members – Report lodged with the JSNA.
- Jointly with Norfolk independent Care, a voluntary and private sector mental health and leading disability event for providers was held in Sept 2013 from which an Action Plan to improve the planning and delivery of such services has been developed.

6. ***Effectiveness:***

Is the forum achieving what it wants to? If not, what would help it be more effective?

- Forum would like to have formal structural engagement and the MH/LD Commissioning Board.
- Forum would benefit from resources to provide secretariat and admin support.

7. ***For more information:***

Please give the name and contact details of the chair or secretariat, their email and/or tel

Chair: Amanda Hedley, CEO, Norwich and Central Norfolk Mind, ceo@norwichmind.org.uk
Vice Chair: Pip Coker, CEO, Julian Support, p.coker@juliansupport.org

6. ***Date completed and by whom:***

18 March 2014 claire.collen@voluntarynorfolk.org.uk

Norfolk Community Advice Network (NCAN) Strategic Partnership

1. ***Purpose:***
Who is the forum for? What are its main purposes? (This could be an extract from the terms of reference.)

The NCAN Strategic Partnership sits within the structure of the Norfolk Community Advice Network (NCAN), a network of around 50 advice providers (including public sector and some solicitors).

The overall aim of NCAN is to ensure Norfolk residents have access to good quality social welfare legal information, advice, assistance and representation at a time or place when they need it most.

The NCAN Strategic Partnership drives the strategic lead on advice and advocacy in Norfolk and is drawn partly from network members, but also other key stakeholders from across the voluntary and public sector. Its role is to:

- raise the profile of advice and advocacy in the county
- identify cross-cutting issues and work collaboratively to address them
- exchange information, share knowledge and identify common areas of interest
- promote and advocate good practice in advice and advocacy provision
- seek resources to further the work of the Partnership
- commission pieces of work to deliver advice and advocacy provision in Norfolk
- evaluate provision of advice and advocacy in Norfolk and recommend improvements
- inform the development of NCAN and the work undertaken by the project

Much of the work of the Strategic Partnership is taken forward by the NCAN Co-ordinator (funded through the Big Lottery until Sept 2014.) NCAN is hosted by Norfolk Community Law Service.

2. ***Meetings:*** *Generally how often does the forum meet?*
5-6 times per year

3. ***Membership:*** *Please list current membership (with web address/emails if possible). Include public sector members where relevant.*

Active participants in the Strategic Partnership include:

Voluntary Sector Members	**Public Sector Members**
Advice and Information Specialist Contract Group*	Breckland District Council
Age UK Norfolk	Broadland District Council
Age UK Norwich	Community Relations and Equality Board
Carers Agency Partnership	Norfolk County Council (Community Services/Integrated Commissioning Team)
Equal Lives	Norwich City Council (Financial Inclusion Project)

	KLARS (Kings Lynn Migrant Worker Advice Service)	South Norfolk Council
	Norfolk CAB (King's Lynn; Norwich)	
	Norfolk Community Advice Network	
	Norfolk Community Law Service	
	Mancroft Advice Project	
	Shelter Housing Advice (Eastern Counties)	
	Voluntary Norfolk	

**We work closely with the Advice and Information 'Specialist Contract Group', the delivery partnership of advice providers commissioned by Norfolk County Council, the members of which are:*

- *Age UK Norfolk and Age UK Norwich for older people*
- *Deaf Connexions and West Norfolk Deaf Association for people who are deaf*
- *Alzheimer's Society for people with dementia*
- *Equal Lives for people with disabilities and those with mental health problems*
- *EAST for people living with HIV*
- *Opening Doors for people with learning difficulties*

The SCG is considered a sub-group of NCAN around areas of common interest, such as referrals, outcome measurement and quality of advice.

4. ***Influence:***

Over the last 12 months or so, has the forum been able to influence decision-makers in the public sector e.g. commissioners, or other voluntary or public sector partnerships? Please give examples as appropriate:

- NCAN SP is a member of the Joint Health, Social Care and Voluntary Sector Strategic Forum, and through that, holds the VCS substitute place on Health and Wellbeing Board.
- The SP played a lead role in delivering the Welfare Reform event for the Health and Wellbeing Board (June 2013), the results of which generated an extensive debate at the following HWB – and was covered by the local press. (The SP would like to see that monitoring the cumulative impact of the changes is reflected in the on-going work of the HWB.)
- The Chair of the SP is an active member of the HWB Strategy Group.
- Provides commissioners with a strong and well-evidenced collective voice from frontline advice agencies on current social welfare issues and the impact of policy changes. (For example, played an important role in helping to inform the service specifications for the County Council's advice and information service.)

5. ***Outcomes:***

In last 12 months or so, what difference do you think the forum, as a collective voice, has been able to make that individual members, acting alone, would have found difficult?
Please give examples:

- The NCAN Co-ordinator has worked extensively with key decision-makers in local authorities, CCGs, Health and Wellbeing service providers, police and courts on the implications of welfare reform and advice need.
- Working with the Community Relations and Equality Board to pilot a voluntary sector

	consortium membership of INTRAN to ensure adequate language support for advice services. (This is as a result of our sitting on the Steering Group for the Community Relations and Equality Board representing the advice sector generally.) • Working with Norfolk County Council on the project board developing the Local Assistance Scheme. Through this we were able to provide a voice that represented a diversity of experience from advice agencies, rather than the County Council project team having to consult with individual organisations across the sector. • The referral system, developed and co-ordinated by NCAN, along with other data sources, provides a valuable source of intelligence to inform the Strategic Partnership and wider stakeholders about current social welfare issues.
6.	***Effectiveness:*** *Is the forum achieving what it wants to? If not, what would help it be more effective?* The SP provides a platform on which to build coherence within the sector and to integrate better with public services (operationally and strategically). The SP is recognised by commissioners and others in the public sector as the 'go to' forum to engage with on advice matters. The SP is keen to move towards a genuinely co-ordinated and strategic approach to social welfare advice in Norfolk. Whilst there is active commitment from the cross-sector and multi-agency members, its ability to progress work is due in large measure to the resource afforded it by the wider NCAN project - effectively its delivery mechanism. The Big Lottery funding for the NCAN project ends in September 2014, and its loss is likely to impact on the momentum and effectiveness of the SP.
7.	***For more information:*** *Please give the name and contact details of the chair or secretariat, their email and/or tel* Chair: Dan Mobbs, CEO, Mancroft Advice Project, danmobbs@map.uk.net Secretariat: Adam Clark, NCAN Co-ordinator, 01603 496623 adam@ncls.co.uk
6.	***Date completed and by whom:*** 13/02/2014 Adam Clark

Norfolk Specialist Partnership

1.	**Purpose:** *Who is the forum for? What are its main purposes? (This could be an extract from the terms of reference.)* We are a partnership of specialist Voluntary and Community Sector Organisations each of whom share the founding principle of ensuring that the voice of our service users or members (if a member led organisation) is heard. Empowering users to take control of their own lives is at the heart of what we do. We are committed to developing coproduction with our users and members across all new and existing services as standard practice. We share policy and practice which influences the development of our individual strategies. NSP has been pleased to bring our experience as we work to inform and influence strategy, policy and practice between the voluntary and public and private sectors. The forum also provides a fully confidential peer support forum for the Chief Executives of member organisations. This support enables members to share learning, challenge thinking and provide bespoke support.
2.	**Meetings:** *Generally how often does the forum meet?* Quarterly. We are also in regular electronic contact with each other as we share and discuss strategic developments.
3.	**Membership:** *Please list current membership (with web address/emails if possible). Include public sector members where relevant.* • Age UK Norfolk www.ageuk.org.uk/norfolk/ • Equal Lives www.equallives.org.uk/ • Crossroads Carers East Anglia www.crossroadseastanglia.org.uk/ • Julian Support www.juliansupport.org/ • Big C www.big-c.co.uk/ • Norfolk and Norwich Association for the Blind www.nnab.org.uk/ • Community Connections www.communityconnections.org.uk/ • Momentum (Norfolk) www.momentumnorfolk.org.uk/ • The Benjamin Foundation www.benjaminfoundation.co.uk/home
4.	**Influence:** *Over the last 12 months or so, has the forum been able to influence decision-makers in the public sector e.g. commissioners, or other voluntary or public sector partnerships? Please give examples as appropriate:* • NSP is represented on the Joint Health and Social Care Voluntary Sector Strategic Forum and through that holds one of the 3 VCS reps on the Norfolk Health and Wellbeing Board • NSP made representations to both Norfolk MPs and Norfolk County Council members with regard the proposed cuts in services • NSP is involved in the NCC consultation on Voluntary Sector Infrastructure • NSP was the sole voluntary sector representative on the Norfolk County Council Market Development Board • NSP has engaged with all CCG Chief Executives in understanding their own priorities for service user engagement and has sought to help develop shared practice which will best underpin the emerging model of integrated care across both health and social services.

5.	**Outcomes:** *In last 12 months or so, what difference do you think the forum, as a collective voice, has been able to make that individual members, acting alone, would have found difficult? Please give examples:* The detailed knowledge of the members of the NSP with regard their specialist areas of work provide a unique perspective. Having strong ethos and values with regard the voice and engagement of service user/members ensures we have an agreed value set with regard to our collective voice. Many of our members are raising substantial sums of charitable income across a number of sectors in support of the Norfolk public. As independent, locally based organisations we champion causes which resonate with a Norfolk public which is well motivated to help itself as opposed to waiting for outside help. The collective voice of our supporters has generated substantial additional income across a number of sectors. The Position Statement from a number of our members to Norfolk MPs with regard the proposed NCC cuts led to a meeting with Norman Lamb MP. As a result he has convened a meeting between himself, NSP members and leading NCC members. The inclusion of NSP as part of the consultation on Voluntary Sector Infrastructure is another excellent example, none of the individual members would have been invited to be part of that consultation and on-going discussions. Although not an infrastructure organisation NSP was perceived as a strong and important voice to inform that work-stream.
6.	**Effectiveness:** *Is the forum achieving what it wants to? If not, what would help it be more effective?* The Forum has worked hard over the past few years to ensure it provides essential support to the CEOs of it members and by and large has achieved this. It had secured significant Big Lottery funding (3 years) to provide support and training for the sector as personalisation was developing; this included establishing the Centre for Empowering Practice (project now ended.) It has worked hard to secure a place where it can influence and shape strategy and policy and is now represented on a number of high level Boards and working groups. There is still much more it could achieve. It is entirely a voluntary collective, receiving no core funding, occasionally this can constrain our work as all members are busy CEOs. The NSP is a well-respected, well recognised and fully informed group within Voluntary, Community and Statutory services in Norfolk. Probably the greatest barrier to our being more effective is the lack of well designed voluntary/public sector interfaces.
7.	**For more information:** *Please give the name and contact details of the chair or secretariat, their email and/or tel* **Chair:** Richard Draper, CEO, Benjamin Foundation, richard.draper@benjaminfoundation.co.uk
6.	**Date completed and by whom:** Richard Draper 7th February 2014

Norfolk County Council budget 2014/15 – implications for the Health and Wellbeing Board

Cover Sheet

What is the role of the H&WB in relation to this paper?

The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a

- Duty to prepare a Joint Strategic Needs Assessment and a Joint Health and Wellbeing Strategy

Key questions for discussion

Q1. Is the Board aware of any additional mitigating measures that could be delivered in partnership with the Council that would further reduce the risk of Norfolk people, and in particular protected groups and vulnerable people, from experiencing worse outcomes?

Q2. Does the Board have any further suggestions for additional savings that the Council could make in partnership with others to close the financial gap in 2015 – 17?

Actions/Decisions needed

The Board needs to:

- Consider and comment on the report

Norfolk County Council budget 2014/15 – implications for the Health and Wellbeing Board

Report of the Head of Planning, Performance & Partnerships, Norfolk County Council

Summary

This paper:

- Updates the Board on the outcome of the Putting People First consultation, and budget setting process, undertaken by Norfolk County Council
- Outlines the likely implications of the budget on the Board's overarching goals and priorities
- Describes the changes to proposals and the mitigating actions that will be put in place to help manage some of the identified impacts
- Outlines the ongoing risks for Norfolk people, the Board and the Council
- Describes the further £22 million savings that the Council must identify before 2017

Action

- Consider and comment on the report

1. Background

1.1. At its meeting on Wednesday 23 October 2013 the Health and Wellbeing Board received an update from Debbie Bartlett about Norfolk County Council's Putting People First consultation. The consultation sought views on around 60 proposals developed in response to significant reductions in funding to Norfolk County Council.

1.2. As the minutes of the October 2013 meeting note, the Board:

- Received and noted the report
- Agreed that members would respond directly to the consultation
- Agreed to consider the role the Board would have once the outcome of the consultation was decided

1.3. The consultation closed to the public on the 12 December.

Over 4,400 respondents commented on proposals. This number includes:

- Nearly 1,200 people attending 40 consultation events
- Over 2,400 individual members of the public
- Over 170 voluntary and community groups, statutory organisations or businesses
- Nearly 130 Norfolk County Council staff
- Nearly 500 people who commented without specifying whether they were responding on behalf of themselves or others

In addition petitions were received with a total over 2,100 signatures.

Many respondents commented on several of the proposals. Taking this into account, the consultation prompted around 15,700 individual responses.

1.4. Responses were analysed to inform two linked purposes:

- To identify the range of people's views, consistent or repeated themes and alternative suggestions to inform budget decisions
- To identify the impact that people anticipate the proposals would have on them as part of an Equality Impact Assessment (EQIA) of each proposal. EQIAs particularly assessed whether any specific groups or areas might be disproportionately affected by proposals, and identified possible mitigating actions to reduce the impact of proposals on any disproportionately affected groups.

1.5. The impact assessment process confirmed that the Council's proposals are likely to have adverse effects on Norfolk people, including some vulnerable groups. In addition some proposals are likely to have impacts on partner organisations, either by affecting "shared" customers or directly through changing commissioning or partnership working arrangements. Mitigating actions are suggested to minimise adverse impacts where possible and relevant.

1.6. Reports outlining the consultation and EQIA findings were presented to the Council's Overview & Scrutiny panels during January. The consultation findings and panel comments then informed a Cabinet discussion on the 27 January that in turn made recommendations to Full Council on the 17 February. Copies of the reports, which include references to all of the proposals, can be found on the Council web site here: www.norfolk.gov.uk/budgetconsultationfindings.

1.7. Council agreed its budget which included most of the savings outlined in the proposals consulted upon. Notable elements of the agreed budget include:

- A freeze in the Council's share of council tax for the fourth year running
- Some additional funding to mitigate budget reductions including the following:
  - Consolidating the improvement programme for safeguarding children by restoring £3.1m of funding to the Children's Services budget
  - Delaying the introduction of changes to post 16 transport for a year by providing an extra £1m
  - Mitigating the savings required in the wellbeing element of personal budgets by re-profiling the three year saving, reducing the savings amount in the coming year to £3m to give time to ensure those affected are supported with face to face reassessments of their needs

- An additional £123,000 to reduce the impact of spending reductions in Trading Standards
- Some further additional funding for emergency coastal defences (£250,000), support for carers (£127,000).

1.8. This report suggests a way that the Health and Wellbeing Board might address the issues raised by budget reductions. Specifically it looks at each of the Health and Wellbeing Board's overarching goals and priorities and:

- Identifies the agreed proposals relevant to each
- Summarises by goal/priority the findings and impacts identified by the consultations for the relevant proposals

It then asks the Board to:

- Consider any additional mitigating actions that might be delivered through partnership working
- Consider other ideas, suggestions or proposals that might support the Council to meet savings targets in years two and three.

2. The impact of budget reductions on Health and Wellbeing Board overarching goals

2.1. **Over-arching goal – driving integration**

In reviewing the findings in the light of the Board's goal of driving integration the following themes emerge.

2.1.1. **Reduced funding affecting the Council's partners**. There are several proposals that involve funding reductions from partners. Those directly affecting partners include:

- P28 Reduce the amount of funding we contribute to the partnerships that support young people who misuse substances and young people at risk of offending
- P32 Cut the cost of the contract we have with the provider delivering community health support to people with a learning disability.
- P57 Reduce funding to organisations which support and represent the local voluntary sector

In each case the proposals mean that partners will be required to make savings in line with those being made within the Council.

The Impact Assessments of these proposals recognise the affect they are likely to have on partner organisations. Reductions may lead to service rationalisation, redundancies or changes in working practices.

It is clear that partners will largely determine how the proposals are implemented. Nevertheless the mitigating actions identified by the Council commit it to working with Norfolk Community Health & Care (NCH&C) and umbrella voluntary organisations to ensure that reductions affect front line services as little as possible.

2.1.2. **Changes that may increase demands on partners' services**. Impact assessments also identify proposals that may, directly or indirectly, increase demands on other services

including those provided by or with partners. These are:

- P23 Reduce the funding for restorative approaches
- P31 Reduce funding for wellbeing activities for people receiving support from Adult Social Care through a personal budget
- P35 Scale back housing related services and focus on the most vulnerable people

In each instance there is a risk that Council service reductions will mean fewer preventative or remedial interventions, and possibly a greater demand for more intensive and expensive services (including those provided by partners) later on. In each case the mitigating actions identified aim to reduce the impact of such changes on the most vulnerable people. For example P31 'Reduce funding for wellbeing activities…' has the potential to disproportionately affect people with learning disabilities or mental health problems. In addition, if it were applied without discretion, there are clear examples of where a reduced wellbeing allocation would be very likely to prompt a crisis. As a result mitigating actions make provision for personal assessments for everyone affected, and local discretion about exceptions to the policy or alternative arrangements.

Nevertheless there remains a risk that proposals might inadvertently create risks in other organisations, particularly if they are not implemented with care.

2.1.3. **Changes to the context for integrated commissioning and services**. Some of the proposals either change or challenge the context and assumptions upon which integrated services are planned. These include:

- P2 Using newer and cheaper ICT systems
- P6 Changes to the way key social care contracts are monitored
- P11 Using information about Norfolk citizens better to inform service design
- P15 Using Public Health skills and resources to improve the Council's work around improving health and independence
- P34 Working better with the NHS to deliver the Reablement and Swifts Services and look to share costs equitably

In some cases – for example changes to ICT arrangements and contract monitoring – proposals present different challenges for partners that should not pose significant risks. In others – Improving the use of information, using Public Health skills and re-balancing the funding for Reablement and Swifts Services – proposals suggest both risks and opportunities that will require joint planning and management. In particular, for proposals to succeed, it is likely that partners will need to develop shared assumptions, and a shared view of the costs and benefits of specific services.

2.2. **Over-arching goal – reduce inequalities**

One of the most consistent concerns expressed by respondents to the consultation was that vulnerable people would be disproportionately affected by proposals. These concerns are recognised by the Council, and many of the mitigating actions identified for proposals seek to minimise their impact on those with the lowest income, who are most isolated, or who are most at risk of poor outcomes.

The following outline the main areas of risk identified.

2.2.1. **Risk of specific groups of vulnerable people experiencing reduced services**. The Council is clear that some proposals will mean that some groups will receive less support

or fewer services. For example proposals P31 to reduce funding for wellbeing activities through a Personal Budget, P35 to scale back housing related services and P28 to reduce funding to partnerships supporting people who misuse substances or are at risk of offending will affect the level of support provided to respective groups.

2.2.2. **Risks of specific groups of vulnerable people experiencing a cumulative impact from several proposals**. In addition to the 'straightforward' reductions above there are less obvious cumulative impacts from different proposals affecting the same groups. Both the EQIA process and responses to the consultation highlight the risk that people with learning disabilities and people with mental health problems may be affected by several of the proposals. Mitigating actions recognise this, but do not entirely remove the risk. In addition as some of the proposals will be implemented by, or with, partners the risks are complex and will require close monitoring.

2.2.3. **Risk of isolation**. Several proposals may make people more isolated. Those affecting school and student transport, mobile libraries, the Coasthopper service and transport for some social services users may have a particular impact in rural areas. Changes to funding for wellbeing services through a personal budget and changes to home care arrangements also have the potential to increase individuals' isolation by reducing or change access to community-based support. In add cases these risks are clearly acknowledged within the EQIAs, and mitigating actions are identified to reduce these risks to people whose health and wellbeing would be most severely affected by increased isolation.

2.3. **Over-arching goal – promote healthy lifestyles and prevent problems**.

2.3.1. **Focusing services on the most vulnerable groups**. A large number of proposals may have an indirect impact on this goal. Any of the Adult Social Care and Children's Services proposals that involve changes to services that provide advice or preventative interventions could have some kind of impact. It is also possible that changes to the School Wellbeing Service and changes to Libraries may also have an impact. The Council recognises these risks, and is clear that changes to preventative services that would prompt crises, require more expensive interventions later, or be a false economy in the long run would be unacceptable. Equally it recognises that changes to preventative services that might cost other agencies more later on – the issue of "cost shunting" highlighted in many responses to the consultation – would not be right. Accordingly the proposals, and associated mitigating actions, seek to focus remaining services and support on those most vulnerable people. In addition, as discussed in 2.1, where partners' services may be affected the Council has committed to work with them to manage this.

2.3.2. **Making the most of expertise**. 'P15 Use Public Health skills and resources to improve the way the Council promotes people's health, wellbeing and independence' has a more direct, and potentially positive, impact on the over-arching goal of promoting healthy lifestyles and preventing problems. The proposal plans to remove any duplication between other council services promoting better health and wellbeing, and those provided by Public Health, whilst maximising the expertise provided by Public Health.

3. The impact of budget reductions on Health and Wellbeing Board's strategic priorities

3.1. **Priority – Early Life (0-5)**

This priority will be indirectly affected by proposals. P25 'Change how we support childminders, nurseries and other childcare providers in response to the Children and Families Act' will clearly affect this age group, but actually only means that the inspections that we do in childcare placements will be rationalised. Proposals to library services, including reductions in some of the activities and resources available in libraries, will also affect this age group to some extent. However, mitigating actions are in place to ensure that young children from lower income families continue to be supported where possible. Beyond these proposals, others have some implications for children aged 0-5, but these are unlikely to be significant or widely felt.

3.2. **Priority – Obesity**

Again this priority is likely to be indirectly affected by the budget. The effect of changes to activities that generally improve health and wellbeing are described in section 2.3 above. Beyond this obesity may be a contributory factor explaining poor health and wellbeing outcomes for both younger and older people receiving support from Adult Social Care and Children's Services. As such it may be affected by proposals in these services – and in particular where there are risks of people accessing community resources or community-based services less. However it is unlikely that these changes will significantly impact on overall levels of obesity, or that changes to proposals would significantly address the root causes of obesity in these groups.

3.3. **Priority – Dementia**

Three of the proposals are likely to directly affect the delivery of this priority.

3.3.1. 'P30 Change the type of social care support that people receive to help them live at home' is clearly relevant to this priority as a significant proportion of people affected by the proposal are likely to have, or be caring for someone that has, dementia. The changes will mean that home care will increasingly be commissioned by outcome rather than by a set number of hours of care. It will also look at whether people with low numbers of hours of care a week can have their needs met in other ways. In terms of this priority, the proposal is likely to have particular impacts on those living in rural areas, and on those who care for people with dementia. Responses to the proposals highlighted the importance of home care services to those who use them, and a concern that volunteers could not provide the same kinds of services that paid carers could. In considering this feedback and setting out its mitigating actions the council has highlighted that it will look at the appropriateness of more community-delivered home care approaches on a case-by-case basis. Practically, for people with dementia, their safety and capacity to move to new services will be assessed before any changes are made. The Council is also clear that personal care and similar key social care services will always, in line with legislation, be carried out by registered providers following a personal assessment that takes into account their specific circumstances.

3.3.2. 'P31 Reduce funding for wellbeing activities for people receiving support from Adult Social Care through a personal budget' is again relevant to this priority because of the relatively high number of people with dementia that are likely to be affected. As highlighted in section 2.2.1 this proposal will mean that social care funding will increasingly be used to pay for 'core' care services like Personal Care, Respite, Day Care and Residential Care; and less funding will be available to day-to-day wellbeing activities. New resource allocations will be calculated through the Personal Budget process. The proposal is likely

to affect most people with a personal budget, including informal carers. The EQIA process, and responses to the consultation, highlighted the risk that the proposal may reduce people's access to some preventative services, and there is a risk that in some cases there will be a greater demand for more intensive care services. The Council has recognised the risks associated with this proposal in agreeing its budget, along with the practical challenges that services face in delivering it, and decided to reduce the amount of savings required from the budget by £3 million. In deciding how to further mitigate against these risks the Council has committed to a range of actions including providing everyone affected with a face-to-face assessment, ensuring that social work teams can exercise discretion in agreeing personal budget allocations, and monitoring the effect of the proposal on protected groups over the next two years.

3.3.3. 'P35 Scale back housing related services and focus on the most vulnerable people' will mostly affect people who are under 65, but is likely to have an effect on a relatively small number of older people with dementia. The proposal means that there will be fewer hours of housing related support available overall, that there will be fewer specialist and more generic services, and that services will increasingly be providing support in people's homes rather than in housing schemes. As with other proposals, safeguards will be put in place to ensure that people with dementia are not put at risk. Providers of services will also increasingly be required to provide staff with the specialist right skills to support people with particular needs.

4. Key issues for further exploration or for discussion

4.1. Whilst sections 2 and 3 above highlights the measures that the Council have taken to minimise the risks to vulnerable and protected groups, it is clear that the risks remain and require ongoing review.

4.2. In addition, whilst the proposals deliver significant savings over the coming three years, there is still a considerable financial gap in years two and three. Specifically the Council needs to save a further £3.8 million in 2015-16 and £18.2 million in 2016-17 – so a total of £22 million altogether.

5. Action

5.1. The Board needs to:

- Consider and comment on the report

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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If you need this Agenda in large print, audio, Braille, alternative format or in a different language please contact Jeremy Bone 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Report to Norfolk Health and Wellbeing Board

6 May 2014

Item 13

Joint Health and Wellbeing Strategy 2013/14 – end of year report

Cover Sheet

What is the role of the H&WB in relation to this paper?

The role of the Health and Wellbeing Board is to note the progress that it and its partners have made in the implementation of the 2013/14 Joint Health and Wellbeing Strategy. The end of year report provides an overview of key achievements. A more detailed description of the work that has been undertaken is appended.

Key question for discussion

Q.1 In implementing the 2013/14 Joint Health and Wellbeing Strategy, what have we learnt about how the Board works and how this learning can these be applied to the implementation of the 2014/17 strategy?

Action required

The Health and Wellbeing Board is asked to:

- Note the progress that has been made with the implementation of the 2013/14 JH&WBS.

Report to Norfolk Health and Wellbeing Board

6 May 2014

Item 13

Joint Health and Wellbeing Strategy 2013/14 – end of year report

Report of the NCC Head of Policy, Performance and Partnerships

Summary

The 2013/14 Joint Health and Wellbeing Strategy (JH&WBS) was developed by the shadow Health and Wellbeing Board (H&WB). The strategy was agreed in principle by the H&WB at the meeting on 24 October 2012 and since then the focus has been on responding to the 11 priorities that were identified. The response has taken a number of forms, been led by different groups and organisations and real progress has been made in a number of areas.

Action required

The Health and Wellbeing Board is asked to:

- Note the progress that has been made with the implementation of the 2013/14 JH&WBS.

1. Background

1.1 The Health and Social Care Act 2012 sets out a number of legal responsibilities for the Health and Wellbeing Board, including a duty to prepare a Joint Health and Wellbeing Strategy.

1.2 The shadow Health and Wellbeing Board agreed in principle the 11 priorities that make up the 2013/14 Norfolk Joint Health and Wellbeing Strategy at the meeting on 24 October 2012. Since that time, work has been underway to respond to the priorities. The progress that has been made is summarised in the following section and outlined in greater depth in Appendix 1 of this report.

1.3 A copy of the 2013/14 Joint Health and Wellbeing Strategy is available on the Norfolk Ambition website, as follows: http://www.norfolk.gov.uk/view/NCC122775.

2. Summary of progress

2.1 Outlined over is a high level summary of some of the key aspects of progress that has been made with the implementation of the 2013/14 Joint Health and Wellbeing Strategy. A fuller description is available in Appendix 1.

Priority	Achievements in 2013/14	Planned activity in 2014/15
Alcohol misuse	• Commissioning of a whole systems approach to drug and alcohol treatment in Norfolk • Increase in service user/recovery community led projects • Provision of free substance misuse training • An Alcohol Diversion scheme (alcohol related disorder). • The 'Reducing the Strength' campaign to remove high strength lagers from sale.	• Review of how older people with alcohol related needs access treatment and what treatments are best suited to their needs • Partnership response to the treatment/enforcement responses to new Psychoactive Substances (Legal Highs).
Smoking	• Local delivery of national media campaigns focusing on smoking, such as 'The toxic cycle' and 'Stoptober' • Seizure of illicit tobacco (2245 cigarettes and 13.3kg of hand rolling tobacco) • Public Health led commissioning of a range of Stop Smoking services.	• Increase and improve access to stop smoking services and review all pathways to quitting • Consider new developments in harm reduction • Complete a Tobacco Control Needs Assessment.
Healthy eating and weight management	• Healthy weight Norfolk Needs Assessment and the Physical Activity Norfolk Needs Assessment are near completion • Slimming World on Referral – 250 vouchers ready to be distributed in West Norfolk. This will be evaluated alongside the Norwich pilot that ran in 2013.	• Investigate options for commissioning a Tier 2 weight management service • Review options for a county-wide strategic obesity co-ordinator post • Encourage sign up to the Public Health Responsibility Deal.
Unplanned care/emergency admissions & preventing re-admission	• Operation Domino II currently has 31 active projects • Less people waiting for more than 4 hours in A&E • December 2013 a multi-agency operations centre was opened to support system wide responses to system pressure.	• Ongoing development of the scope and reach of 'Operation Domino II'.
Supporting frail elderly people living independently	A range of projects and initiatives for the over 65s across integrated health and social care, targeting: • Advice and information • Excess Winter Deaths • Integrated case management • Improved diagnosis of dementia • Carers of people with dementia.	• Ongoing development of integrated, community based responses and the evaluation of pilot projects that started in 2013/14.
Carers of older people and	• Review of numbers of adult carers, their needs and possible responses –	• Development and implementation of 2014-17

people with long term conditions	published on Norfolk Insight, July 2013 • JSNA Briefing session and workshop, November 2013.	Adult Carers Strategy • Explore role of employers in supporting employees with caring responsibilities.
Young carers	• Review of numbers of young carers and young adult carers, their needs and possible responses – published on Norfolk Insight, July 2013 • JSNA Briefing session and workshop, November 2013	• Review and update existing young carer and young adult carers strategy • Identify commissioning and contract-management arrangements for young carers and young adult carers • Encourage schools to recognise their role in supporting young carers • Explore role of employers in supporting employees with caring responsibilities.
Mental wellbeing and resilience to mental illness	• The three priorities of mental health and employment, Improving Access to Psychological Therapies and dual diagnosis were incorporated into a broader priority around wellbeing and resilience • Task and finish group looked at what Board members could do, as policy makers and commissioners, and as employers of over 42,000 people. • JSNA briefing session and workshop on mental wellbeing 18 December 2013	• Explore impact of declining physical activity in schools on children's mental wellbeing • Review whether procurement takes into account social value and measures that would promote good mental wellbeing • Explore role of H&WB as employers in promoting workplace health.
Creating good outcomes for all children and young people	• Workshop on early help, April 2013 • Board discussion on Norfolk Early Help Programme Board and "Raising our Game on Early Help", October 2013 • Building on the local partnerships already established for Norfolk Family Focus, to develop early help • Aligning processes within individual organisations to meet the vision for working with families • Putting in additional resource or reallocating existing resources to support the new approach (such as family support workers).	• Ongoing implementation of the early help strategy • Workshop on related issues around child poverty • Draft reducing child poverty strategy is due to come to the Board in July • Prevention has been agreed as one of the overarching goals in the 2014/17 JH&WBS and early life (0 – 5 years) has been agreed as one of the priorities.

2.2 Significant progress has been made with the implementation of the first Norfolk Joint Health and Wellbeing Strategy. Work on the priority areas will continue over the next

year, much of which will enable the implementation of key aspects of the 2014/17 JH&WBS.

2.3 Three areas in which the Board may be able to assist with have been highlighted by the lead officers for the priorities as part of the preparation of this report, as below:

- Health eating and weight management - as employers, sign up to the central government Public Health Responsibility Deal - https://responsibilitydeal.dh.gov.uk/.
- Carers – as employers, promote HR policies and corporate positions that enable employee Carers to maintain their employment and attract, encourage and support carers into their employment.
- Mental wellbeing and resilience to mental illness – as employers, promote work place health programmes and HR policies that help promote the mental wellbeing of people they employ, keep employees with mental health problems in work and enable people with existing or previous mental health problems to access work.

3. Action required

3.1 The Health and Wellbeing Board is asked to:

- Note the progress that has been made with the implementation of the 2013/14 JH&WBS.

Appendix 1

Responding to the priorities in the 2013/14 JH&WBS

1. Key aspects of the progress made to date with the implementation of the 2013/14 JH&WBS, are outlined below.

Alcohol misuse

2. The lead organisation that was identified for co-ordinating work to respond to this priority was the Norfolk Drug and Alcohol Partnership (NDAP). The NDAP strategy manager brought an initial report to the H&WB on 17 April 2013 that outlined the scale of the issue, existing responses and a number of areas for discussion, as below:

- What more needs to be done in order to make the provision of alcohol brief interventions a reality in a wide range of Norfolk support services?
- How can we ensure that community and family focused approaches to reducing alcohol related harm are developed and supported across Norfolk?
- How can individual agencies help to reduce alcohol related hospital admissions?

3. The discussion points did not result in any specific actions for the Board. NDAP committed to bring a progress report back to the Board.

4. Since April 2013, the NDAP has continued to work with partners on reducing the harms associated with alcohol misuse and key aspects of the progress that has been made are as below:

- The commissioning of a whole systems approach to drug and alcohol treatment in Norfolk came into place in April 2013 with the Norfolk Recovery Partnership (NRP). NRP currently provides a drug and alcohol service to approximately 5,800 people in structured intervention, outreach and low intensity work.
- There has been an increase in service user/recovery community led projects, such as: ReCafe – community café project in Norwich; ACORNS – community support group Norwich; Hands on HeArt – community arts project Great Yarmouth; Road to Recovery group – community collective focusing on developing recovery capital in the local Great Yarmouth Community; Thetford Music group - music/social group for those in recovery; The Overcomers – community support project Hunstanton; The Lighthouse Project – recovery support/social/community action group Cromer.
- In addition there have been 22 community projects across the County that have been funded directly from the NDAP Recovery Community Fund
- The provision of free training places, which were used by a range of professionals, volunteers and services users across a range of sectors.
- The development of a core competency framework for people who work within the area of substance misuse is underway with a view to the competencies being embedded into job descriptions.
- An Alcohol Diversion scheme is now in operation across the County to address alcohol related disorder.
- The ‘Reducing the Strength’ campaign to remove high strength lagers from sale is about to launch and roll out across Norfolk.
- The NDAP strategy has been developed and agreed.
- Commissioning is now taking place for a Children, Families and Friends Service which includes children and young people affected by the substance misuse of others.

5. A number of actions will be taken forward over 2014/15, which will involve Board members through the NDAP partnership, as follows:

- A review of how older people with alcohol related needs access treatment and what treatments are best suited to their needs
- A partnership response to the growing concerns about the health impacts of and treatment/enforcement responses to new Psychoactive Substances (Legal Highs)
- Development of 'Recovery Champions' within key organisations across the County to enable reduction of barriers and stigma associated with substance misuse recovery.

6. There are known links between parental alcohol misuse and the developmental milestones achieved by children. As such, the work that is co-ordinated by NDAP, with the Drug and Alcohol Action Team now part of NCC Public Health, will support the achievement of the 2014/17 JH&WBS priority 'Giving Every Child the Best Start in Life'.

Smoking

7. The lead organisation that was identified for co-ordinating work to respond to this priority was NCC Public Health. The lead Public Health consultant for tobacco control, Augustine Pereira, brought an initial report to the HWB on 17 April 2013 that outlined the scale of the issue, the work of the Tobacco Control Alliance and highlighted a number of areas for discussion, as below:

- Note the progress in setting up the Norfolk Tobacco Control Alliance and agree the reporting arrangements suggested by the Alliance
- Note the appointment of Chair, leads of Workstreams and coordinator of the Norfolk Tobacco Control Alliance
- Make a recommendation on Health and Wellbeing Board Champion for the Norfolk Tobacco Control Alliance
- Discuss the role of various partners to improve the health and reduce health inequalities by each partner contributing to the smoking cessation and tobacco control agenda.

8. The discussion points did not result in any specific actions for the Board.

9. Since April 2013, Public Health as continued to work, through the Norfolk Tobacco Control Alliance, to reduce smoking prevalence and the harms associated with smoking. Some of the key aspects of the progress that has been made are as below:

- Local support for and delivery of national media campaigns focusing on smoking, such as 'The toxic cycle' and 'Stoptober'
- NCC Trading Standards media campaign highlighting illicit tobacco and related issues in Norfolk, which led to the seizure of 2,245 cigarettes and 13.3kg of hand rolling tobacco
- Ongoing commissioning by Public Health of a range of Stop Smoking services and co-ordination of activity through the Tobacco Control Alliance.

10. Some key aspects of Public Health led activity and interventions planned for 2014/15, are summarised as below:

- Re-energise the commissioned stop smoking services and make them more attractive to new providers
- Increase and improve access to stop smoking treatments/services
- Consider new developments in harm reduction following anticipated EU tobacco directive and Medicines and Healthcare Products Regulatory Agency (MHRA) guidance
- Review all pathways of quitting
- Work with strategic partners and Health Watch to improve provision in Norfolk.
- Complete a Tobacco Control Needs Assessment and following this a workshop will be held to present the findings and recruit new members to attend the Alliance.

11. As the Tobacco Control Alliance is working towards recruiting new members and develop a strategy, continued support from the Health and Wellbeing Board would add value to this development.

12. There are known links between smoking prevalence and one of the three overarching goals in the 2014/17 JH&WBS of 'Reducing Inequalities in health and wellbeing outcomes'. As such, work that is co-ordinated by Public Health through the Norfolk Tobacco Control Alliance will help support the achievement of the strategy.

Healthy eating and weight management

13. The lead organisation that was identified for co-ordinating the work to promote healthy eating and healthy weight management was NCC Public Health. Dr Jenny Harries, as Director of Public Health, brought a report to the HWB on 9 January 2013 that outlined the scale of the issue, the work of Public Health and highlighted a number of areas for discussion, as below:

- The direct links with other priorities adopted by the Board, such as mental health and wellbeing and alcohol misuse
- The opportunities for a number of local government regulatory bodies and Public Health to work together to create healthy environments
- The Healthy Towns programme may offer a good vehicle for an holistic approach to healthy weight management
- Workplace health can play an important role and the Board members may wish to consider their own role as large employers in Norfolk
- The work that is done in Norfolk's 437 schools can introduce positive influences in the family home.

14. The discussion points prompted the Board to identify a specific action looking at the role that preventative programmes in schools, like Norfolk Healthy Schools, had in promoting health eating and weight management. Changes in the senior management team in NCC Children's Services and the strong focus on work to support an OFSTED improvement plan has meant that this work has not progressed.

15. Since January 2013, Public Health has continued to work to promote healthy eating and weight management and some key aspects of the progress that has been made to date are outlined below:

- Healthy weight Norfolk Needs Assessment and the Physical Activity Norfolk Needs Assessment are near completion

- Options for commissioning a Tier 2 weight management service in 2014/15 are being investigated
- British Heart Foundation funded Hearty Lives project is just about to commence in West Norfolk. This will look at issues around healthy diet and weight management in men
- Slimming World on Referral – 250 vouchers ready to be distributed in West Norfolk. This will be evaluated alongside the Norwich pilot that ran in 2013
- Reviewing options for a county-wide strategic obesity co-ordinator post.

16. Based upon a follow up meeting, the lead officer for this area of work in Public Health felt that the inclusion of this as a priority in the JH&WBS 2013/14 had: raised awareness of the issue; given it renewed focus; and enabled conversations to take place that otherwise would not have done. From 2015/16 onwards there will be a greater focus upon prevention and a move away from the treatment of people who are already obese.

17. A key role that members of the H&WB could consider to help with this priority is, as employers, signing up to the central government Public Health Responsibility Deal - https://responsibilitydeal.dh.gov.uk/.

18. There are clear links between healthy eating and weight management and the developmental outcomes achieved by children. As such, the work that is co-ordinated by Public Health, will support the achievement of the 2014/17 JH&WBS priorities 'Giving Every Child the Best Start in Life' and 'Reducing the Prevalence of Obesity'.

Unplanned care/emergency admissions & preventing re-admission

19. The lead organisations that were identified with responsibility to drive this area of work forward were integrated health and social care and NCC Public Health. At the H&WB meeting on 9 January 2013, a presentation was given by Dr Jenny Harries, which highlighted the key role that 'Project Domino' had to play.

20. The discussions at the H&WB meeting focused on the separate and distinct roles and responsibilities of the H&WB and Health Overview and Scrutiny (HOSC) as well as the NHS Commissioning Board's Quality Premium. No specific actions related to Project Domino or the priority.

21. Since January 2013, work has continued and Project Domino has evolved into 'Operation Domino II', with a wider scope and reach than was originally specified. The Head of System Transformation (Unplanned Care) for Norwich Clinical Commissioning Group (CCG) has summarised progress as follows:

- Operation Domino II currently has 31 active projects working across the Urgent and Emergency Care System, involving 3 CCGs, 4 NHS Trusts, the County Council and other independent organisations and charities.
- System performance has improved over the past month with less people waiting for more than 4 hours in A&E and attendance has reduced since its peak in July but remains higher than previous years.
- In October 2013 a Community IV (Central Norfolk), Rapid Response (Alternative Care Pathway for Ambulance Crews) and Case Manager Pull Out Service (Supporting the discharge of patients known to case managers and community matrons) became operational as small scale pilots and are already reporting positive benefits, preventing ambulance conveyances, admissions and reducing length of stay in the acute hospital, on the system with plans to extend during 2014/15.

- In December 2013 a system wide operations centre was opened to support system wide responses to system pressure, the Community IV service extended to include an additional clinical pathway (Osteomyelitis), assessors to support Norfolk First Support were made available at the weekends.
- The programme recently benefited from additional investment from NHS England to support winter pressures. This money was deployed to 16 projects which spanned the Urgent and Emergency Care System including an Urgent Care Unit, additional community beds, Placement without Prejudice, Hospital & Ambulance Liaison Officer (HALO), an addition 3 Immediate Assessment Unit cubicles, GP Support to Care Homes (North Norfolk) and additional resources for Norfolk First Support.

22. No specific actions have been identified for the H&WB to consider.

23. There are clear links between unplanned care/emergency admissions and preventing re-admission and the effective management of dementia from the first signs of onset. As such, this work will support the achievement of the 2014/17 JH&WBS priority 'Improved Quality of Life for People with Dementia and their Carers'.

Supporting frail elderly people living independently

24. Summaries of the work to date have been received from the heads of integrated commissioning for the five CCG/adult social care areas in the county, as below.

25. No specific actions have been identified for the H&WB to consider.

West Norfolk Integrated Community Health and Social Care

26. The overall aim of the West Norfolk Prevention First Project are to co-ordinate access to and provision of services for older people in West Norfolk who are in need of low level preventative support and help to remain independent in their local community.

27. The project has achieved the following in the year 2013/14 to date:

- Establishment of a Steering Group with representation from West Norfolk Alliance organisations, West Norfolk Older People's Forum and Public Health
- ˜ 4 public consultation and engagement events focused on local asset mapping, gap identification and prioritisation
- ˜ Preparation and soft launch of LILY (Living Independently in Later Years), an advice and information service for older people in West Norfolk. Planned to go live in March 2014 with interactive web-site and telephone advice line
- ˜ Planning and preparation of community network and activity event for voluntary sector providers and stakeholders in spring 2014.

28. A series of public engagement events have been held in the west as part of the development of the project. One issue that have arisen that the HWB may be able to assist with is the access to local, affordable transport for health and social care service users and their carers.

Norwich Integrated Community Health and Social Care

29. Norwich Integrated Community Health and Social Care has worked on three projects to support frail elderly people living independently: falls and injuries prevention in over 65's; reduction in the numbers of excess winter deaths; and integrated case management with the intended aim of reducing emergency admissions to hospital.

30. Falls and injuries in the over 65's - NCCG has established a multi-agency Falls Reference Group, led by the Integrated Commissioning Team, to review the local falls pathways and prevention/management services. The group feeds into the countywide Falls Steering Group, which is led by Public Health. The Group has mapped the local pathway/services and is identifying areas for improvement for implementation now and in 2014/15.

31. Excess winter deaths (EWD) – NCCG has established a multi-agency Working Group, led by the Integrated Commissioning Team, to reduce the number of EWD. The group identified the need for a more coordinated approach to local service delivery in the Norwich locality. In October 2013, it launched the 'stay warm this winter' campaign to raise public awareness locally of how to stay warm this winter. A business case is also being developed for a referral scheme for professionals to refer vulnerable people for a seasonal health assessment (using Home Shield Norfolk).

32. Integrated case management - NCCG works with stakeholders to encourage integrated case management with the intended aim of reducing emergency admissions to hospital, reducing length of stay if admitted to hospital and also importantly, improving care outcomes for the patient and enhancing the patient experience.

33. <u>South Norfolk Integrated Community Health and Social Care</u>
South Norfolk Integrated Community Health and Social Care have three key projects to support frail elderly people living independently, as follows:

- A frail older person's pilot service has been established in the Ketts Oak locality. The team supporting the pilot includes: a discharge support worker, to facilitate timely discharges from hospital; and community nurses.
- The mid-Norfolk locality has an integrated multi-disciplinary team supporting frail older people which includes: social work; nursing; dementia support; and a community geriatrician.
- There is a dementia support worker in the Breckland locality and they have piloted the use of risk screening tools with frail older people.

34. Following positive initial evaluation, all of these initiatives are continuing and will form part of the proposed approach to developing integrated services in all localities which is envisaged for the South Norfolk CCG area as part of our proposals for the transformation of services required under the Better Care Fund initiative.

35. The other areas of focus for our draft Better Care Fund plan include: developing more integrated approaches to intermediate care to support discharge and re-ablement; preventative services to support independence; end of life care; mental health; and falls prevention.

36. On a countywide basis, SNCCG integrated team leads on the commissioning of information and advice services. The re-commissioned services include specialist information and advice for older people and for people with dementia. We are working with providers to regularly evidence the outcomes from the specialist information and advice services.

37. <u>North Norfolk Integrated Community Health and Social Care</u>
North Norfolk's Integrated Care Programme is the key conduit in 'Supporting frail elderly people living independently'. A broad base partnership has been built that includes:

North Norfolk Clinical Commissioning Group (NNCCG); Norfolk County Council – Community Services (NCC); Norfolk Community Care & Health Trust (NCHC); Norfolk and Suffolk Foundation Trust; and North Norfolk and Rural Broadland Strategic Partnership.

38. The approaches and interventions that we have been developing that will deliver against the integrated care programme are:

- Risk Stratification – identifying those people at highest health risk or those who will benefit most from proactive support to enable patient centred community service interventions.
- Integrated Community Care Teams –the development of integrated Primary & Community/Mental Health, social care, acute, district council, ambulance, reablement and voluntary/3rd Sector teams aligned our 4 community hubs, delivering timely, joined up quality care.
- Integrated Care Approach to Falls Management Programme – as a key indicator for avoidable hospital admissions integrated solutions to falls management are being developed, including Home hazard assessments and interventions and a comprehensive integrated Falls Prevention Programme.
- Living Well With Dementia Programme – the delivery of improved diagnosis of dementia across our integrated teams.by improving access to memory assessments, diagnosis education programmes, targeted screening, assessments and referrals and integrated community support developments.
- Urgent Care Programme –the delivery of improved pathways in and out of the acute hospital settings including improved, appropriate access to A&E, improved community care solutions to expedite faster, appropriate discharges and reduce any delayed transfers of care, including improved use of integrated community bed provision to support this.

39. <u>Great Yarmouth and Waveney Integrated Community Health and Social Care</u>
Great Yarmouth and Waveney Integrated Community Health and Social Care have a number of key projects to support frail elderly people living independently through an integrated approach to health and social care interventions, as follows:

- A 6 month pilot started in February 2014 of the Flexible Dementia Service pilot, which is a home care service providing support to people with dementia at time of crisis, such as carer breakdown. The service provides short term intensive support to enable people to remain in their own home. The service may just provide support until the crisis is resolved, or there may be an element of reablement in order to get the person back to the level of independence they were before the crisis. During this period the carers are also helping to assess the persons longer term care needs.
- At a county level the Council and Health now procure an Integrated Equipment Service that provides equipment to help people remain at home. Equipment has been provided previously but was sourced separately by health and social care so is an example of integrated provision.
- As part of the drive for integrating services, there are now social workers attached to each GP Practice in the Great Yarmouth area and some Practices now also hold Multi-Disciplinary Team meetings which helps identify those people most in need and thereby ensures they receive appropriate services.
- All of the above is in the context of the overarching work towards an Integrated Care System in Great Yarmouth and Waveney.

40. **Carers of older people and people with long term conditions & Young carers**
The lead organisations that were identified for the co-ordination of support to carers of older people, young carers and young adult carers were NCC Children's Services, integrated health and social care, the Carers Council for Norfolk and the Young Carers Project Advisory Group. Two reports were posted on the Norfolk Ambition website, ahead of 10 July 2013 H&WB meeting, with the intention that Board members would respond to the discussion points raised and undertake activity outside of a formal Board meeting.

41. The role that Norfolk's estimated 94,700 carers have to play in supporting people both in contact with and outside of the health and social care system is well documented. Supporting unpaid carers in their role is something that cuts across all the priorities and goals in the 2014/17 JH&WBS.

42. Working with the NCC Planning, Performance and Partnerships team, those people with a lead responsibility for carers hosted a Joint Strategic Needs Assessment (JSNA) briefing session on 19 November 2013.

43. An area in which members of the H&WB could consider to help with this priority is below:

- What joined up actions, initiatives or policies and procedures could the Health and Wellbeing Board and its member organisations, as employers of over 42,000 people in Norfolk, help to shape, influence and agree which would: 1) Enable employee Carers to maintain their employment; and 2) Attract, encourage and support carers into their employment.

44. **Mental wellbeing and resilience to mental illness** (incorporating the three priorities of mental health and employment, Improving Access to Psychological Therapies and dual diagnosis)
The Head of Planning, Performance and Partnerships brought an initial report to the H&WB on 9 January 2013 on the priority 'mental health and employment' that outlined the scale of the issue, existing responses and a number of areas for discussion, as below:

- Broker a discussion with Job Centre Plus about their patterns of engagement with individual CCGs in relation to getting people back into work
- Convene a one-off task and finish group under the auspices of the Health and Wellbeing Board which looks at the wider determinants of good mental health and wellbeing. This could include a discussion around:
    - The steps Health and Wellbeing Board members, as employers, of over 42,000 people are collectively taking to build a resilient workforce in Norfolk
    - Health and Wellbeing Board members as policy makers and commissioners to consider the impact and effectiveness of what we do and spend on non-NHS services to promote and foster positive mental health.

45. The Board agreed to convene the suggested one-off task and finish group to look at the wider determinants of good mental health and wellbeing from the perspective of what Board members could do, as policy makers and commissioners, and as employers of over 42,000 people.

46. A task and finish group was formed of lead officers for the commissioning and provision of mental health services. They met to work out a way forward and in doing so decided to focus in on the promotion of mental wellbeing and resilience to mental illness, as opposed to the three very specific and technical priorities that had been identified (mental health and employment, Improving Access to Psychological Therapies (IAPT), Dual diagnosis). This was done in consultation with the leads for those areas.

47. The task and finish group then delivered a JSNA briefing session and workshop on mental wellbeing 18 December 2013, the key findings of which were:

- Stable employment has a key role to play in promoting good mental health and wellbeing
- Principle that exercise is good for mental wellbeing. Concern over the long term impact of declining exercise and activity in schools.
- HWB members collectively employ about 42,000 people. Able to reach dependent others and so about 100,000. What more could they do as employers?
- Commissioners of services could ensure that their procurement takes into account social value and measures (HR) that would promote good mental wellbeing. Norwich City Council has experience of this and the HWB members could also adopt it.
- A golden thread runs through the three priorities being developed in the 2014/17 Joint Health and Wellbeing Strategy (Early Years, Obesity, Dementia), that of exercise.

48. An area or work that the H&WB could consider to help with this priority is to promote work place health programmes and HR policies that help promote the mental wellbeing of people they employ, keep employees with mental health problems in work and enable people with existing or previous mental health problems to access work.

49. **Creating good outcomes for all children and young people**
The lead organisation for this priority was identified as NCC Children's Services working with the Norfolk Early Help Programme Board. An initial workshop on early help was held on 17 April 2013, followed up by a presentation from the Chair of the Norfolk Early Help Programme Board at the Health and Wellbeing Board meeting on 23 October 2013. The presentation detailed the strategy for "Raising our Game on Early Help", identifying the following next steps for the Norfolk Early Help Programme Board, as follows:

- Building on the local partnerships already established for Norfolk Family Focus, to develop early help.
- Aligning processes within individual organisations to meet the vision for working with families.
- Putting in additional resource or reallocating existing resources to support the new approach (such as family support workers).

50. The H&WB has maintained a high level of interest in the work of the Norfolk Early Help Programme Board and prevention and early intervention with children and families in need. A follow up workshop on related issues round child poverty has been delivered and the draft reducing child poverty strategy is due to come to the Board in July, prevention has been agreed as one of the overarching goals in the 2014/17 JH&WBS and early life (0 – 5 years) has been agreed as one of the priorities.

Norfolk's Health & Wellbeing Board – Annual Review of Membership, Terms of Reference and Forward Plan

Cover Sheet

What is the role of the H&WB in relation to this paper?

The Health and Social Care Act 2012 requires that every upper-tier local authority establishes a health and wellbeing board from April 2013. Norfolk County Council established the Norfolk Health & Wellbeing Board on 25 March 2013.

The Act also sets out a number of legal responsibilities for the Health and Wellbeing Board, as below:

- Duty to prepare a Joint Strategic Needs Assessment (including a Pharmaceutical Needs Assessment) and a Joint Health and Wellbeing Strategy
- Duty to encourage integrated working between commissioners of health and social care services
- Duty to provide an opinion as to whether the CCG commissioning plan has taken proper account of the Health and Wellbeing Strategy and what contribution has been made to the achievement of it
- Duty to assess how well the CCG has discharged its duties to have regard to the JSNA and JH&WBS

The Health & Wellbeing Board has been operational, with statutory responsibilities for one year and this is an opportunity to review the current arrangements and forward plan.

Key questions for discussion

Q1. How well has the Board's membership & ToR supported it in carrying out its functions in the past year?

Q2. Will the draft forward plan bring the right matters before the Board - and at a time that is appropriate and practical?

Actions/Decisions needed

The Board needs to:

- Consider and comment on the report
- Agree the forward plan for the year ahead

Norfolk's Health & Wellbeing Board – Annual Review of Membership, Terms of Reference and Forward Plan

Report of Head of Planning, Performance and Partnerships

Summary
The Norfolk Health & Wellbeing Board has been established and operational for one year. This paper sets out the Health & Wellbeing Board's current membership, terms of reference and forward plan. It provides an opportunity for the Board to review the existing arrangements and for its comments to be taken into account by the County Council at the next appropriate stage. It also enables to Board to review and comment on its forward programme of work for the coming year.

Action
The Board is asked to:
- Consider and comment on the report
- Agree the forward plan for the year ahead

1. Background

1.1 The Health and Social Care Act 2012 (the Act) requires that every upper-tier local authority establishes a health and wellbeing board from April 2013. Although the Act provides that H&WBs are a committee of the local authority, H&WBs are very different to other local authority committees and so regulations give local authorities certain flexibility in relation to the governance of their H&WBs.

1.2 Health & Wellbeing Boards (H&WBs) are intended to be a forum for collaborative local leadership in an area and as such they have the following main functions:

- To assess the needs of their local population through the joint strategic needs assessment process (and a pharmaceutical needs assessment)
- To produce a local health and wellbeing strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health, and other services which the board agrees are relevant
- To promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.

1.3 On 25 March 2013, Norfolk County Council established the Norfolk Health & Wellbeing Board as a committee of the Council and the relevant section of the report to Council is available at the following link.

2 The development of a H&WB in Norfolk

2.1 Although the Health and Wellbeing Board has been established and operational with statutory responsibilities for one year, its development has been built on discussions and debate involving a wide range of partners going back to the end of 2010.This inclusive process provided an opportunity for a range of stakeholders to debate health issues in Norfolk and, using a workshop-style, to identify how a Health & Wellbeing board might address them.

2.2 Building on this, and on the experiences of working in shadow form from 2012 to 2013, the Norfolk Health & Wellbeing Board was established from April 2013. The Board's Terms of Reference and membership were agreed by Norfolk County Council's Cabinet in March 2013 and these are provided in Appendix A and Appendix B respectively.

2.3 The Health & Wellbeing Board has an Operating Framework which describes its intentions going forward. This Framework confirms the aim in Norfolk to work towards achieving a 'systems leadership' approach and also outlines what the H&WB it will do - at a strategic level, how it will go about it, and the potential challenges faced. The report on the H&WB's Operating Framework, which was agreed by the Shadow Board in July 2012, is available at the following link.

2.4 Now that the Board has been operational for one year it is appropriate to reflect on the membership and terms of reference as they currently stand and provide any comments to be taken into account by the County Council going forward. It is also an opportunity for members to consider and agree the work programme for the Board for the coming year.

3. Key points

3.1 In considering this report, Board members may wish to be aware of the following points:

Membership

- The Board is a relatively large group and, on agreeing its initial membership, the County Council sought to achieve a balance between establishing a manageable sized committee whilst maintaining the strength of broad engagement, in order for the Board to be effective for such a diverse and large county.

- In January 2013, when the Shadow H&WB considered membership going forward, it agreed that the organisations currently involved brought a breadth and richness to the discussion, which was important to maintain, and provided the Board with the necessary influence and collective 'reach', for example, to be effective in unblocking or problem-solving system-wide.

- The County Council is changing its form of overall governance with effect from May 2014, and is establishing a committee system, which will replace the current 'Cabinet –style' system. The new constitution includes a Children's Services Committee and an Adult Social Care Committee. It is envisaged that the Chairmen of these two Committees will replace the positions on the H&WB held by the NCC Cabinet Member for Children's Services (Safeguarding) and the NCC Cabinet Member for Community Services, as these Cabinet positions

will no longer exist. At its meeting on 27 May the County Council will finalise membership of its committees for 2014/15.

Terms of Reference

- The Shadow H&WB reviewed its Terms of Reference in January 2013 and at that time considered that they should be strengthened to reflect the clear intent of the Board in terms of integration. The statement at point 6 of the Board's current Terms of Reference (Appendix A) reflects this.

Forward Plan

- The H&WB's agreed last April that it was useful to have an outline framework from which to plan its work to help ensure that it met its statutory responsibilities. The Board agreed a forward plan for 2013/14.

- Whilst it is useful to have an agreement in outline, the forward plan remains flexible and responsive and it is open to any member of the Board to request that an item be included on the agenda of a formal Board meeting. Such requests are at the discretion of the Chairman.

- A draft forward plan for 2014/15 is at Appendix C. It is based on the Board's statutory responsibilities and from learning from the Board's first year in operation.

4. Action

4.1 The Board is asked to:

- Consider and comment on the report
- Agree the forward plan for the year ahead

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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Appendix A

Health and Wellbeing Board – current Terms of Reference

Aim

The Norfolk Health and Wellbeing Board will lead and advise on work to improve the health and wellbeing of the population of Norfolk by providing strategic leadership of, and oversight for, the commissioning across the NHS, social care and public health.

Purpose is to:

1. Lead the development, with Norfolk County Council and Norfolk's Clinical Commissioning Groups, of the Joint Strategic Needs Assessment (JSNA)

2. Lead the development, with Norfolk County Council and Norfolk's Clinical Commissioning Groups, of the Joint Health and Wellbeing Strategy (JH&WBS)

3. Speak up for Norfolk, championing the health and wellbeing needs of the people of Norfolk at a local, sub-regional, regional and national level and challenging central government policy where it conflicts with locally identified priorities

4. Lead and encourage a broad base of partners outside of formal health, public health and social care settings to tackle the wider determinants of health and wellbeing

5. Influence and support commissioners of health and wellbeing services to act in line with the evidence-based findings of the JSNA, and to highlight where commissioning is out of step with best evidence

6. Drive the further integration of health services and social care services, and other public services and hold each other/the Board to account for it

7. Promote the sharing of good practice and learning across the Norfolk health system.

Appendix B

Norfolk's Health & Wellbeing Board – Current Membership

Name	Position
Dan Roper (Chair)	Cabinet Member, Public Protection, Public Health, Trading Standards, Fire & Rescue, Norfolk County Council * (Nominated representative in place of the Leader of NCC)
James Joyce	Cabinet Member, Safeguarding Children, Children's Services
Sue Whittaker	Cabinet Member, Adult Social Care
Lucy Macleod	(Acting) Director of Public Health *
Anne Gibson	Acting Managing Director, Norfolk County Council
Sheila Lock	Interim Director Children's Services *
Harold Bodmer	Director Community Services *
William Armstrong	Chairman, Healthwatch Norfolk Board*
Clinical Commissioning Groups x 5	Representatives agreed with each of the 5 CCGs*
District Council leaders (or their nominated substitutes)	Representatives agreed with all 7 District/City/Borough Councils
Tracey Dowling	Director of Operations & Delivery, NHS England, East Anglia Area Team
Voluntary sector representatives	Three representatives from the voluntary sector, as agreed through Norfolk's Health, Social Care and Voluntary Sector Strategic Forum
Chief Constable	Norfolk Constabulary **Note -** Transitional arrangements are currently in place in the light of the new role of the Police and Crime Commissioner (PCC)
Stephen Betts	Norfolk's Police and Crime Commissioner

* Denotes statutory member

Note – Board members have been asked to provide the details of **one named substitute** who would deputise for them should they be unable to attend a formal meeting of the Board, and in most cases this has been provided.

Appendix C

Forward Plan, Health and Wellbeing Board – July 2014/April 2015

Meeting	Title and content	Lead
July 2014		
	Election of Chair and Vice Chairs (annual event following May 2014 NCC AGM))	Clerk to the Committee
	Director of Public Health - Annual Report • Consider the DPH's Annual Report and implications for the work of the H&WB	Director of Public Health
	Annual Joint Strategic Needs Assessment (JSNA) Report • Consider the first Annual JSNA Report - which is produced to assist in monitoring needs and to support future planning	Director of Public Health
	Monitoring health & wellbeing in Norfolk and the JH&WBS 2014-17 • Update on progress	Director of Public Health
	Integration and Better Care Fund • Update on progress on integration in Norfolk & the BCF	Director of Community Services
	Children's Services Improvement - Update • Update on Children's Services improvement planning	Director of Children's Services
	Norfolk Reducing Child Poverty Strategy • Consider the draft Norfolk Strategy and the actions arising, both collectively and individually, for the Board	Director of Children's Services
	Healthy Child Programme • To consider the national Healthy Child Programme and the implications for Norfolk and for the H&WB	Director of Operations & Delivery, East Anglia Area, NHS England
	Locally-led Health Improvement • Report back from each of the City/District/Borough Councils on the outcome of their projects/use of the H&WB 2013/14 funds	Representatives from the 7 x district/city/borough

Meeting	Title and content	Lead
		councils
	Services for Adults with a Learning Disability: Outcomes of the Winterbourne View Enquiry • Consider the draft Joint Strategic Plan for Norfolk	Director of Community Services
October 2014		
	Monitoring health & wellbeing in Norfolk and the JH&WBS 2014-17 • Update on progress	Director of Public Health
	Integration and Better Care Fund • Update on progress on integration in Norfolk & the BCF	Director of Community Services
	Healthwatch Norfolk - Annual Report • Consider the first HWN Annual Report	Chairman Healthwatch Norfolk
	The H&WB's Community-led health Improvement Programme • Final report – outcomes achieved, legacies, etc	Director of Public Health
	Children's Services Improvement - Update • Update on Children's Services improvement planning	Director of Children's Services
January 2015		
	Monitoring health & wellbeing in Norfolk and the JH&WBS 2014-17 • Update on progress	Director of Public Health
	Integration and Better Care Fund • Update on progress on integration in Norfolk & the BCF	Director of Community Services
	Clinical Commissioning Groups - Commissioning intentions • Consider the CCGs commissioning intentions and how well they align with the H&WB's strategic priorities	Representatives of the 5 x CCGs

Meeting	Title and content	Lead
	Children's Services Improvement - Update • Update on Children's Services improvement planning	Director of Children's Services
	PNA 2015 • To approve the PNA ready for publication in 2015	Director of Public Health
April 2015		
	Annual Review of the JH&WBS 2014-17 • Consider progress, impact of the strategy, review any emerging priorities, etc	Director Of Public Health
	CCGs Operational Plans • To consider the operational plans for each of the CCGs	Representatives of the 5 x CCGs
	Integration and Better Care Fund • Update on progress on integration in Norfolk & the BCF	Director of Community Services
	Children's Services Improvement - Update • Update on Children's Services improvement planning	Director of Children's Services
	H&WB Budget Report • Review 2014-15 spend • Decide use of any allocation for 2015-16	Head of Corporate Planning & Partnerships
	Forward Plan, Membership and terms of Reference • Annual review of the H&WB's membership and ToR • Review forward plan for 2015/16	Head of Corporate Planning & Partnerships

Standing items

- **Norfolk Health Overview and Scrutiny minutes** - this will ensure that the Board picks up and considers any appropriate issues raised by scrutiny
- **Healthwatch Norfolk minutes** - this will ensure the Board is able to pick up and consider any appropriate issues arising from local Healthwatch
- **NHS England** - verbal update to include feedback from local Quality Surveillance Group (QSG). This will ensure the Board is able to pick up and consider any appropriate issues from NHS England and/or arising from the Local QSG.
- **Children's Services improvement update** – this will ensure the Board consider any appropriate issues arising from the improvement agenda

Annual items

- Director of Public Health Annual Report (July each year)
- Annual JSNA Report (July each year)
- Annual Report of Healthwatch Norfolk (Oct each year)
- Annual review of Membership, ToR and Forward Plan (April each year)

Draft minutes of Board Meeting

Monday 11 November 2013

	Attendees: William Armstrong (WA) – Chair Nick Baker (NB) – Co-opted member Jon Clemo (JC) – Provider member Diane DeBell (DD) – Community member Graham Dunhill (GD) – Community member Moira Goodey (MGo) – Provider member Mary Ledgard (ML) – Community member Fiona Poland (FP) – Co-opted member Julia Redgrave (JR) – Co-opted member **Officers in attendance:** Alex Stewart (AS) – Chief Executive Chris Knighton (CK) – Communications Manager Chris MacDonald (CM) – Operations Manager Sam Revill (SR) – Research Manager Andy Magem (AM) – Information Officer **Guests:** Louise Cumberland (LC) – Norfolk county council Emma Ratzer (ER) – Access Community Trust
1.	**Apologies for absence and introductions**
	Apologies: Roan Dyson (RD) – Provider member Pa Musa Jobarteh (PJ) – Co-opted member Mark Ganderton (MGa) – Community member Debbie Bartlett (DB) – Norfolk County Council
2.	**Declarations of Interest**
	ML has been elected as a patient governor of Norfolk Community Health and Care NHS Trust. WA is a trustee of Voluntary Norfolk.
3.	**Presentations**
	ER presented a report by Access Community Trust on Access to Services by Homeless People. The board praised the quality of the work, thanking ER and Access Community Trust for producing a valuable and detailed report. **Resolved:** The board resolved that the recommendations contained in the report required further consideration. The board asked that AS work with Access Community Trust and Healthwatch Norfolk (HWN) staff to develop the recommendations further and present a set of formal proposals to the board in January. An interim report from POhWER on NHS complaints handling in Norfolk was tabled. The Board expressed concern that POhWER were not present to present the report and to that end, the report was not discussed. In addition, The Board expressed severe concerns that the report was currently 3 months overdue. AS to follow up with CEO of POhWER.

	The board noted that the final report would be completed in December.
4.	**Minutes of the meeting held on 16 September 2013**
	The minutes of the HWN board meeting held on Monday 16 September 2013 were confirmed as a correct record of the meeting.
5.	**Matters arising**
5.1	**Update on TUPE claims (verbal)** The board discussed the pending TUPE claims following a verbal update from AS **Resolved:** The board requested that a written report from the solicitor be circulated in one week.
5.2	**Sign off board resolution re provider representative** **Resolved :** The board agreed to approve the resolution. WA will contact the CAB chair to discuss future working.
5.3	**Qtr 2 Finance Report** The board noted the report and requested that there is a column inserted which denotes committed spend.
5.4	**Key Performance Indicators Report** The board reviewed the contents of the report and noted the positive activities completed to date. The board strongly noted the danger of 'drift' and the importance of a clear plan setting strategic priorities.
5.5	**Norfolk County Council Budget Consultation** The board agreed that HWN must draft a public response to the consultation document. The board discussed the importance of identifying clear, fundamental messages that would make up this response. It was also agreed that a HWN response would be people focused and emphasise joined-up thinking. A request for further detail would also be included. **Resolved:** The board resolved to submit a response to the consultation before Thursday 12 December 2013. It was agreed that a response would be drafted by AS and circulated to board members by Thursday 28 November for comment and analysis.
6.	**Items for decision**
6.1	**Options Appraisal – Research Intern** The board urged that the admission avoidance project not only compliment the Prevention in West Norfolk project, but also contributes to the body of work already produced in this area across the county. **Resolved:** The board approved option 2 as set out in the paper, to tender for an internal (i.e. consortium) provider to host the intern.
6.2	**Options Appraisal – Children and Young People Work Programme**

	Resolved: The board welcomed the paper and approved option 1, to undertake a full CYP work programme with four phases from Q4 2013 – Q4 2014.
6.3	**Options Appraisal – Children and Young People Intelligence Gathering** **Resolved:** The board welcomed the paper and approved option 2, to tender for an internal (i.e. consortium) provider to undertake the project activity on HWN's behalf.
6.4	**Insight Partners Proposal** **Resolved:** The board approved the proposal as set out in the paper for HWN to develop a support programme for Insight Partners from the voluntary and community sector to promote and facilitate information sharing of *individual* experiences of health and social care. The board also highlighted the importance of learning from the year one pilot and feeding into a sustainable model for the long term future of HWN.
6.5	**Board Visibility Paper** **Resolved:** The board accepted the paper's recommendation to approve the following options: - To revisit the decision not to hold HWN board meetings in public - To expand board profiles on the HWN website - To include board content in the HWN prospectus - To produce board member video profiles - To produce individual features for the HWN newsletter and website The board resolved to meet in public following the publication of the 2014 Prospectus. The board agreed that it was important to wrap further engagement opportunities around public board meetings in order to encourage participation and add value to the practice. It was suggested that this might include moving board meetings around the county to community venues. The board agreed to consider protocols, venues and opportunities in more detail and feed back at the next board meeting on Monday 20 January 2014.
7.	**Items for information and discussion**
7.1	**Board feedback from attended events** WA and AS had met with the Chairs of the 3 Scrutiny Committees – the meeting was informative and enables the Scrutiny Chairs to have a greater understanding of the work HWN was involved in. In addition, the 3 Chairs considered that HWN was working well and being very proactive in its approach to partnership working.
7.2	**Feedback from consortium event** WA reported positively on the consortium event. AS added that the consortium's role in establishing HWN had now been fulfilled and without explicit reference to the consortium in the Articles of Association to guide working practice, it was now time to revisit the idea of a consortium and consider how HWN works with the local voluntary and community sector.

	Resolved: The board agreed to establish a Task and Finish group led by WA, to consider the future of the consortium. ML and GD volunteered to participate and it was agreed that the group would report back at the next board meeting on Monday 20 January 2014. The board also asked that WA call on other board members if required.
7.3	**Updated Risk Log** The paper was noted by the board.
7.4	**General Correspondence** AS informed the board that he believes mental health is a key area for HWN and that they should expect to hear more on this issue in future meetings.
8.	**Staff Reports**
8.1	**Communications Manager** CK presented a scoping document to the board for a HWN Prospectus (programme of work) for 2014. It was confirmed that the prospectus would be funded from the approved communications budget and that the final draft would be presented to the board at the next board meeting on Monday 20 January 2014. **Resolved:** The board agreed to establish a Task and Finish group led by WA, to review the scoping document in greater detail and support the development of the prospectus. JR and FP volunteered to participate.
8.2	**Research Manager** The paper was noted by the board.
8.3	**Operations Manager** The paper was noted by the board.
8.4	**Information Officer** The paper was noted by the board.
9.	**Dates of future board meetings – discussion as to frequency and venue**
	The board noted the dates of future meetings
10.	**Any Other Business**
	JR suggested the idea of using headlines on officer reports to outline one or two key messages.

Minutes of Board Meeting

Monday 20 January 2014

	Attendees: William Armstrong (WA) – Chair Nick Baker (NB) – Co-opted member Jon Clemo (JC) – Provider member Diane DeBell (DD) – Community member Graham Dunhill (GD) – Community member Moira Goodey (MGo) – Provider member Mary Ledgard (ML) – Community member Fiona Poland (FP) – Co-opted member Julia Redgrave (JR) – Co-opted member Mark Ganderton (MGa) – Community member **Officers in attendance:** Alex Stewart (AS) – Chief Executive Chris Knighton (CK) – Communications Manager Chris MacDonald (CM) – Operations Manager Sam Revill (SR) – Research Manager Andy Magem (AM) – Information Officer **Guests:** Louise Cumberland (LC) – Norfolk County Council Christine Lawson – University of East Anglia (UEA) Dr Richard Sly – UEA Prof Francine Cheater - UEA
	Presentation
	Representatives from the UEA presented an update report on Young Persons' Perspectives and Experiences of Specialist Tier 4 In-patient Mental Health Services in Norfolk. The UEA team outlined the project brief, methodology and key findings so far, confirming that project was on-schedule and the full report would be completed as planned. The board were invited to comment and make suggestions that could contribute to the project. WA thanked the UEA team, praising the quality of the presentation and in anticipation of receiving the full report.
1.	**Apologies for absence and introductions**
	Apologies: Roan Dyson (RD) – Provider member Pa Musa Jobarteh (PJ) – Co-opted member
2.	**Declarations of Interest**
	ML is a patient governor of Norfolk Community Health and Care NHS Trust. WA is a trustee of Voluntary Norfolk.
3.	**Minutes of the meeting held on 11 November 2013**
	The minutes of the HWN board meeting held on Monday 11 November 2013 were confirmed as a correct record of the meeting.

4.	**Matters Arising**
4.1	**Update on TUPE claims (verbal)** The board discussed the recent TUPE claims following a verbal update from AS. The board emphasised the importance of learning from the claims. **Resolved:** That the Board await the final response from the Solicitor's before considering any further action and that a brief report be provided outlining what lessons had been learnt as a result of the experience.
4.2	**Board Meetings in Public (verbal)** The board discussed public meetings and how the board should engage with the public in this forum. In the discussion the following points were made: • Local people are Healthwatch Norfolk's (HWN) eyes and ears • The importance of transparency for a publically funded organisation • Other opportunities may provide for more effective engagement beyond Question and Answer (Q&A) sessions. **Resolved :** The board agreed that public meetings would open with a 10 minute Q&A session to be chaired by WA; questions must be sent to the Chair 7 days prior to the meeting. WA confirmed that this process would be kept under continual review and that the board must always be mindful of how best to engage members of the public at meetings. The board also agreed that protocol would be amended to include a Part 2 session at the end of meetings for sensitive information that could not be publically disclosed.
4.3	**Feedback from Task and Finish Groups – Consortium & Prospectus (verbal)** The Consortium Task & Finish Group proposed that eligibility for membership is widened to include all organisations whose aims and objectives met the necessary criteria. It was also proposed that the tendering process should be shortened, giving consortium members 5 days to register their interest and 2 weeks to submit a formal tender before the contract is opened to other bidders. The Prospectus Task & Finish Group reported on a productive session and confirmed that the document was on schedule to be launched prior to the start of the next board meeting on 17 March 2014. The board meeting will be preceded by a 45 minute launch event presenting the document and setting out HWN's work plan for 2014/15.
4.4	**Update on Access to Services by Homeless People report (verbal)** AS confirmed that HWN would now focus on disseminating the findings of the report and developing its recommendations pointing to the second, wider circulation of the survey and the HWN Homelessness Summit on 11 March 2014 as significant areas of work in this area. Invitations have been sent out to a wide range of stakeholders who are able to influence and act upon the findings outlines in the report's recommendations.
5.	**Items for Decision**
5.1	**Recruitment of Business Support Assistant (board paper)** Items 5.1 and 5.2 were taken together by the board. See item 5.2 for further detail.

5.2	**Healthwatch Norfolk Engagement Capacity (board paper)** The board acknowledged the pressing need for an increase in capacity and supported the case as set out in papers 5.1 and 5.2. Before resolving to approve any proposals the board agreed that it is necessary to set the required resources against HWN strategy. In the discussion the following points were made: • Failure to increase capacity would pose a reputational risk • Engagement capacity is required to support a shift in the communications strategy towards content development • Any change in the delivery model must be approved by the full board • Strategy must provide monitoring and reporting tools to support performance management • Recommendations agreed in principal pending strategic corroboration **Resolved:** The board resolved that a strategy document would be drafted by AS and circulated not later than 24 January 2014. The board will then have one week to submit comments in writing before 17:00 on 31 January. WA will then review the comments and decide either to approve the Strategy on behalf of the board if members are in broad agreement or to call a special meeting and address any differences.
6.	**Items for Information and Discussion**
6.1	**Board feedback from attended events (verbal)** WA reported on useful and helpful events attended in his capacity as Chair of HWN – these included visits to Great Yarmouth and to City Reach in Norwich.
6.2	**Updated Risk Register (board paper)** The paper was noted by the board.
6.3	**General Correspondence (verbal)** AS informed the board that he had sent a letter to the CEO expressing concern over the way in which the Complaints Tender had been managed and reported back on the letter from POhWER's CEO
6.4	**Mental Health (board paper)** The board welcomed the paper and warned that cuts to preventative services will continue to have a knock-on effect on provision whilst environmental factors post-recession will in turn drive demand. The board criticised an apparent disparity in the quality of services available to mental health patients in comparison to health patients pointing to varied intelligence from public and professional sources. AS confirmed that the task & finish group would co-opt local experts in mental health. **Resolved:** The board resolved that a) A Task and Finish Group be established b) An indicative budget of £30,000 be set aside to help deliver on the project c) The Task and Finish Group make recommendations for consideration to the QC1 Panel and that this panel be given delegated authority to authorise an agreed approach and report back at a later date.
6.5	**Duty of Candour (board paper)**

	The paper was noted by the board. **Resolved:** The board advised its view as to the most appropriate sanctions to be adopted in failure to meet 'duty of candour' making it clear that punitive sanctions should not be endorsed. The board agreed that such punitive sanctions would create a climate of fear around the duty, potentially leading to less openness overall.
6.6	**Qtr. 3 Finance Report (board paper)** The paper was noted by the board.
7.	**Staff Reports**
7.1	**Communications Manager** The paper was noted by the board.
7.2	**Operations Manager** The paper was noted by the board.
7.3	**Research Manager** The paper was noted by the board.
7.4	**Information Officer** The paper was noted by the board.
8.	**Dates of future board meetings – discussion as to frequency and venue**
	The board noted the dates of future meetings
10.	**Any Other Business**
	No further business was brought to the attention of the board.

Norfolk County Council
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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
ON 16 January 2014

Present:

Mr C Aldred	Norfolk County Council
Mr J Bracey	Broadland District Council
Mr D Bradford	Norwich City Council
Mr M Carttiss	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mrs M Fairhead	Great Yarmouth Borough Council
Mr E Seward	Norfolk County Council
Mrs M Somerville	Norfolk County Council
Miss A Kemp	Norfolk County Council
Mr A Wright	King's Lynn and West Norfolk Borough Council

Substitute Members Present:

No substitute Members attended the meeting in this role.

Also Present:

Dr Sue Crossman	Chief Officer, West Norfolk Clinical Commissioning Group
Mark Taylor	Chief Officer, North Norfolk Clinical Commissioning Group
Dr Anoop Dhesi	Chairman, North Norfolk Clinical Commissioning Group
Andrew Hopkins	Acting Chief Executive, Norfolk and Suffolk NHS Foundation Trust (NSFT)
Dr Julian Beezhold	Lead and Clinician and Chair of the Medical Advisory Committee, Norfolk and Suffolk NHS Foundation Trust
Dr Neil Ashford	Lead Clinician, Norfolk and Suffolk NHS Foundation Trust
Jane Marshall-Rob	Director of Workforce and Organisational Development, Norfolk and Suffolk NHS Foundation Trust
Terry Skyrme	Campaign to Save Mental Health Services in Norfolk and Suffolk
Euan Williamson	NHS Integrated Mental Health and Learning Disabilities Commissioning Manager, North Norfolk Clinical Commissioning Group
Rebecca Champion	Engagement Manager, North Norfolk Clinical Commissioning Group
Peter Balcombe	Broadland District Council
Emma Corlett	County Councillor and Member Champion for Mental Health
Chris MacDonald	Healthwatch Norfolk
Jean Thirtle	North Norfolk Trade Union Council
Trevor Wright	UNISON
Carol Briggs	UNISON
A Evans	Unite (Norwich Medical) Branch
Ann Baker	Norfolk Older People's Strategic Partnership
Hazel Fredericks	West Norfolk Older People's Forum

Christine Mawson	Anglia Commissioning Support Unit
Fiona Devine	NNUH
Kevin James	NSFT
Jane Marshall-Robb	NSFT
Andrea Goldsmith	The Eastern Academic Health Science Network
	There were also several members of the public from the Campaign to Save Mental Health Services in Norfolk and Suffolk present in the meeting for item 7 (Changes to Mental Health Services in Central Norfolk).

Apologies for Absence

Apologies for absence were received from Mr R Kybird, Dr N Legg, Michael Chenery of Horsbrugh and Mr T Jermy.

1. Minutes

The minutes of the previous meeting held on 28 November 2013 were confirmed by the Committee and signed by the Chairman.

2. **A minute's silence in tribute to Mr Garry Sandell and Dr Jim Norris**

The Chairman reported the sad news of the death of a serving member of the Committee, Mr Garry Sandell, and of a former Chairman of the Committee, Dr Jim Norris.

Dr Norris was the first Chairman of Norfolk Health Overview and Scrutiny Committee. He was instrumental in establishing the Committee in September 2002 and his guidance in the early years set the tone for health scrutiny in Norfolk in the years that followed.

Mr Sandell joined the Committee in 2005 and attended its meetings until June 2013, after which time illness prevented him from attending. Garry made a significant contribution to the work of the Committee over the years, including his service as Vice Chairman in 2006-07.

Members of the Committee stood in silence for one minute in tribute to Garry Sandell and to Dr Jim Norris who would be sadly missed by all those who knew them.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. System-wide review of health services in west Norfolk

The Committee received a suggested approach from the Scrutiny Support Manager (Health) to a report from NHS West Norfolk Clinical Commissioning Group on the review of health and social care systems in West Norfolk in response to financial pressures, demographic trends and rising demand for healthcare.

The Committee received evidence from Dr Sue Crossman, Chief Officer, West Norfolk Clinical Commissioning Group.

In the course of discussion, the following key points were made:

- Dr Crossman said that the way in which health and social care were currently configured in West Norfolk was unsustainable.
- Phase 1 of a system wide review of the financial, clinical and operational sustainability of health services in the West Norfolk CCG area had shown that the long term sustainability of the area's health services could only be achieved through system reconfiguration and enhancing integrated care with adult social services.
- Phase 2 of the review involved working jointly with health and social care partners to design a plan for future service configuration.
- Patients and carers would be involved in the work associated with Phase 2 of the review, as would the West Norfolk Older People's Forum and Healthwatch.
- Healthwatch was represented on the project review steering group.
- The CCG had recently secured £200,000 of transitional funding from NHS England which would be used in the west Norfolk health system in the period up to April 2014. After this time, transitional funding would become available for the period until the recommendations of the system wide review were made known at the end of July 2014.
- Members spoke about what more could and should be done locally in the west Norfolk area to better meet the needs of patients, carers and social workers and prevent costly out of area placements. In reply, Dr Crossman said that out of area placements only took place where there were clear medical reasons for doing so and not for purely financial or other reasons. The West Norfolk CCG had not lost sight of the needs of carers who had to travel long distances to visit loved ones who had been placed outside of the area. Dr Crossman said that limited support with travel costs was available for carers in financial hardship who visited patients placed at Blickling Hospital and at the Julian Hospital in Norwich. The details of the support with travel that was available from the west Norfolk CCG would be forwarded to the scrutiny support manager to be included in the next Members Newsletter.
- Dr Crossman said that the QEH had a defined geographical boundary and an established identity within the local community.
- The QEH was undertaking a monthly review of its staffing requirements
- There was in West Norfolk what was described by Dr Crossman as a system of "virtual beds in the community" whereby some 14 patients currently received rehabilitation services in their own homes. Dr Crossman added that there were plans to issue patients living in the community with a voluntary, encrypted smartcard that stored information concerning their personal health needs.

It was agreed that the Committee should receive a further report from Dr Crossman on progress or as a formal consultation with the Committee as appropriate and at the same time receive a report from the County Council on the integration of health and social care in the West Norfolk area at a future meeting.

6 Report of Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on the Proposals for Liver Resection Services

The Committee received a suggested approach from the Scrutiny Support Manager (Health) to a report of Cambridgeshire, Norfolk and Suffolk Joint Health Scrutiny Committee on proposals for centralisation of liver resection services at Addenbrooke's Hospital, Cambridge, which was presented to Norfolk Health Overview and Scrutiny Committee for information and discussion.

Margaret Somerville, Vice Chairman of the Joint Committee, introduced the report.

Members' attention was drawn to recommendation 2 in the joint committee's report which asked NHS England to report to this Committee on the rates of referrals, resections, mortality and re-admissions for liver metastases one year after the implementation of any new system across the three counties.

The Committee noted the report and the recommendations and that these had already been reported to the Norfolk Health and Well Being Board.

7 Changes to Mental Health Services in Central Norfolk

The Committee received a suggested approach from the Scrutiny Support Manager (Health), to an update report from NHS North Norfolk Clinical Commissioning Group (currently the lead commissioner for mental health services in Norfolk) and Norfolk and Suffolk NHS Foundation Trust (NSFT) regarding implementation of the changes to mental health services in the central Norfolk Area (i.e. Norwich, North Norfolk and South Norfolk).The report also provided results on safety and quality indicators since April 2013.

The Committee received evidence from Mark Taylor, Chief Officer, North Norfolk Clinical Commissioning Group; Dr Anoop Dhesi, Chairman, North Norfolk Clinical Commissioning Group; Andrew Hopkins, Acting Chief Executive, Norfolk and Suffolk NHS Foundation Trust; Dr Julian Beezhold, Lead and Clinician and Chair of the Medical Advisory Committee, Norfolk and Suffolk NHS Foundation Trust; Dr Neil Ashford,Lead Clinician, Norfolk and Suffolk NHS Foundation Trust and Jane Marshall-Robb, Director of Workforce and Organisational Development, Norfolk and Suffolk NHS Foundation Trust.

The Committee also heard from Terry Skyrme of the Campaign to Save Mental Health Services in Norfolk and Suffolk.

In the course of discussion, the following key points were noted:

- The NSFT was working to reduce delayed discharges and to improve the speed at which it responded to referrals made to the new access and assessment service.
- GPs welcomed the single point of access to mental health services that the new access and assessment service provided.
- It was pointed out that the introduction of the new access and assessment service had involved moving away from a link worker model of service delivery which had worked well for some GP practices but not well for others.
- Under the new system there were two teams of case workers in the central area.
- There were, however, considered to be many cases under the new system where patients had had to make repeated requests to access the service, and an estimated 200 patients were said to continue to have no access to a

care co-ordinator.

- The witnesses said that the NSFT provided effective and efficient services that compared well with mental health services elsewhere in the country.
- The number of out of area placements was said to show significant fluctuations from one week to the next.
- The NSFT was said to make use of out of area nursing home beds in West Norfolk and in Great Yarmouth and Waverley. The NSFT recognised that pressures on bed places in the central Norfolk area were leading to too many out of area placements and more bed spaces were needed locally.
- In reply to questions, the witnesses said that they considered out of area treatment to be necessary for those small number of cases that would continue to require specialist mental health services that could not be provided in the central area.
- Mr Taylor said that he was working closely with the NSFT on ways to prevent out of area placements and that he was confident that by the end of April 2014 bed capacity in the central area would be what he described as "about right."
- It was pointed out that no single agency had responsibility for patients with mental health needs at the time they were discharged from hospital. This issue was being addressed as part of the review.
- The NSFT was looking to increase the number of people who could gain access to its services and to put in place a more robust system for the recording of patient data which was considered to be somewhat lacking at present.
- Terry Skyrme of the Campaign to Save Mental Health Services in Norfolk and Suffolk said that he worked as a crisis resolution team member at the NSFT. He described the NSFT as being in "dire crisis" at the present time and said that 19 patients were recently placed outside of the area with 8 of these placed in private hospitals at considerable cost.

The Chairman ruled that having allowed significantly in excess of the allotted time for this matter, he had to close the discussion and to move the Committee on to the next agenda item.

It was agreed that the Norfolk and Suffolk NHS Foundation Trust and North Norfolk CCG (lead commissioner for mental health) should report on progress in the central Norfolk area to a future meeting.

8 Mental Wellbeing in Norfolk and Waveney – Shaping the Future

The Committee received a report from the Scrutiny Support Manager (Health) to a report from North Norfolk CCG (on behalf of all the Norfolk CCGs) on plans for the re-commissioning of the 'Improving Access To Psychological Therapies' service.

The Committee received evidence from Euan Williamson, NHS Integrated Mental Health and Learning Disabilities Commissioning Manager, North Norfolk Clinical Commissioning Group and Rebecca Champion, Engagement Manager, North Norfolk Clinical Commissioning Group.

In the course of discussion, the following key points were noted:

- The public consultation exercise ran until the end of January 2014 and was being coordinated by North Norfolk CCG.

- The public consultation documents were available on each of the CCG web sites.
- Patient groups and MIND had helped to design and support the completion of the public consultation exercise.
- The results of the exercise were expected to be made known by the start of March 2014 and work was expected to start on the implementation of the recommendations by April 2014.
- The CCGs wanted to increase the number of people who used the mental well being service and to make the service available to those with more severe common health disorders who could not access the present service.

The Committee noted the consultation on re-commissioning of the "Improving Access to Psychological Therapies Service" (mental wellbeing service) and agreed that the subject would not require further consideration by this Committee.

9 Delayed discharge from hospital in Norfolk

The Committee received a report that asked Members to consider terms of reference for a joint scrutiny task and finish group of members from this Committee and Community Services Overview and Scrutiny Panel on 'Delayed discharge from hospital in Norfolk'.

The Committee agreed to:

(a) establish a joint task and finish group with Community Services Overview and Scrutiny Panel (CSOSP);
(b) approve the draft terms of reference (attached at Appendix A to the report) subject to the proviso suggested by CSOSP that the task and finish group could report back within the new Committee governance arrangements after April 2014, if necessary.
(c) appoint Michael Chenery of Horsbrugh, Alexandra Kemp and Dr Nigel Legg and Mr A Wright to serve on the task and finish group.

10. Forward Work Programme

The Committee agreed the list of items on the current Forward Work Programme with the addition of the issue of Ambulance Turnaround at the Norfolk and Norwich University Hospitals Foundation Trust being added to the agenda for April 2014.

The meeting concluded at 1.20pm

Chairman

Norfolk County Council
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NORFOLK HEALTH OVERVIEW AND SCRUTINY COMMITTEE
MINUTES OF THE MEETING HELD AT COUNTY HALL, NORWICH
ON 27 February 2014

Present:

Mr C Aldred	Norfolk County Council
Mr J Bracey	Broadland District Council
Mr D Bradford	Norwich City Council
Mr M Carttiss (Chairman)	Norfolk County Council
Mrs J Chamberlin	Norfolk County Council
Michael Chenery of Horsbrugh	Norfolk County Council
Mrs A Claussen-Reynolds	North Norfolk District Council
Mrs M Fairhead	Great Yarmouth Borough Council
Mr R Kybird	Breckland District Council
Dr N Legg	South Norfolk District Council
Mr E Seward	Norfolk County Council
Mrs M Somerville	Norfolk County Council
Mr A Wright	King's Lynn and West Norfolk Borough Council

Substitute Members Present:

Ms D Gihawi for Mr T Jermy.

Also Present:

Judith Virgo	Norfolk County Councillor
Andrea Goldsmith	Member of the Public
Esther Aldred	Member of the Public
Alex Stewart	Chief Executive Officer, Healthwatch Norfolk
Richard Smith	Norse Care, Marketing Manager
Lucy MacLeod	Interim Director of Public Health, Norfolk County Council
Maureen Orr	Scrutiny Support Manager (Health)
Chris Walton	Head of Democratic Services
Tim Shaw	Committee Officer

1 Apologies for Absence

Apologies for absence were received from Miss A Kemp and Mr T Jermy.

2. Minutes

The minutes of the previous meeting held on 16 January 2014 were confirmed by the Committee and signed by the Chairman.

3. Declarations of Interest

There were no declarations of interest.

4. Urgent Business

There were no items of urgent business.

5. Chairman's Announcements

5.1 The Chairman tabled proposed revisions to the terms of reference for Great Yarmouth and Waveney Joint Health Scrutiny Committee to be discussed with Cllr Tony Goldson, Suffolk County Council, who chaired the joint committee, and with officers from Norfolk and Suffolk County Councils on 27 April 2014. He said that the proposed revisions to the terms of reference were not for discussion at today's meeting; if Members wished to make comments they should send them to Maureen Orr, Scrutiny Support Manager for Health, by 16 April 2014.It was pointed out that any proposed changes to the current terms of reference would be presented to both the Norfolk and Suffolk Health Overview and Scrutiny Committees for agreement. The NHOSC would receive any such proposals on 29 May 2014 after they had been considered by the Great Yarmouth and Waveney Joint Health Scrutiny Committee.

6. Norfolk Health and Wellbeing Strategy 2014-17

6.1 The Committee received a suggested approach from the Scrutiny Support Manager (Health) to consultation on the content of the draft Health and Wellbeing Strategy 2014-17, which was due to be finalised by Norfolk Health and Wellbeing Board on 16 April 2014.

6.2 It was noted that Mr Daniel Roper, Chairman of the Health and Wellbeing Board, had given his apologies for the meeting because of work commitments.

6.3 The Committee received evidence from Mrs Lucy MacLeod, Interim Director of Public Health, Norfolk County Council.

6.4 In the course of discussion, the following key points were made:

- Mrs Lucy MacLeod said the Health and Wellbeing Board was responsible for developing and delivering the actions that underpinned the health and wellbeing strategy and for making sure that its objectives were met. The Board brought together individuals from the key organisations that delivered health and care services as well as representation from the County and District Councils, the NHS and the county's voluntary and community sector. The perspective of the general public and of patients and carers was provided by Healthwatch Norfolk.

- The draft health and wellbeing strategy was not meant to cover everything that impacted on health and wellbeing.

- The draft strategy was not a final list of everything the Board would do, but a set of the most pressing health and wellbeing priorities.

- In developing the draft strategy, work had focused on identifying where the biggest difference could be made to the health and wellbeing of Norfolk's residents and on achieving goals that would have positive effects on all parts of the health and care system.

- It was acknowledged that much of this work meant working alongside

existing strategies, plans and work programmes. It was suggested that the draft health and wellbeing strategy should not lose sight of the wider determinants of good health, such as: quality housing, local access to a wide range of cultural and leisure activities, and the availability of public transport, all of which contributed in a positive way to the overall health of those living in Norfolk. It was pointed out that the draft health and wellbeing strategy would seek to add weight and influence to these areas of work. This was intended to bring public health issues into sharper focus or to take action to improve coordination.

- Mrs MacLeod said that to avoid duplication, the Health and Wellbeing Board would look to cross reference its work to that of other organisations. The Board would lead the development of integrated approaches to public health to achieve benefits that could not be achieved by any single organisation alone.

- When it had been finalised the health and wellbeing strategy would require health, social care, housing, planning and other partners to work together and behave differently; building positive outcomes that further developed trust and confidence within partnerships.

- Mrs MacLeod said that she was already arranging meetings with all the District Council Chief Executives to discuss the Health and Wellbeing Strategy 2014-17 and how best to work with the District Councils.

- Members stressed the importance of also keeping Parish and Town Councils informed of developments on public health related issues and of making better use of data held by organisations other than Local Authorities and the NHS, where this could be done without incurring data protection difficulties.

- It was suggested that the District Councils would welcome regular briefing notes on the activities of the Health and Wellbeing Board and that the draft strategy should make specific references to what was expected of them. It was noted that the finalised version of the health and wellbeing strategy would include hyper-links to strategic policy documents of County and District Councils and of the NHS.

- Mrs MacLeod said that she had aligned three exiting posts within her team to work on achieving the aims set out in the draft strategy. The draft strategy was based on where it was felt that Norfolk was adrift from the public health position in England as a whole. It was based on the best national data that was available, but not on information obtained from GP practices.

- Achieving a healthy weight was identified as a particular priority because the prevalence of adult obesity in Norfolk was higher than the national average. A member of Mrs MacLeod's staff had been appointed as an obesity co-ordinator, to work with GPs and others on this issue.

- It was pointed out that those born into disadvantaged groups and those who had subjected themselves to alcohol and substance misuse were likely to die at a younger age and live more of their lives in ill health than was the average. The health and wellbeing strategy would attempt to address these issues.

- It was also suggested that the draft strategy should raise awareness of Looked After Children, for whom the County Council was a corporate parent, and to put emphasis on their wellbeing as part of the strategy.

- It was important to look at those areas of service delivery where the draft strategy was collectively able to make the biggest difference to health and wellbeing, at all levels of the health and social care system, and where there would be the greatest benefit from engaging with service users and carers, such as for people with dementia.

- The draft strategy identified where the Health and Wellbeing Board could add the most value through partnership working. It did not override the delivery plans of partners but aimed to focus the efforts of the Board

6.5 The Committee agreed to make the following comments to the Health and Wellbeing Board regarding the draft strategy:-

(a) Integration, making services more joined up for those receiving them, was one of the overarching goals of the Health and Wellbeing Strategy 2014-17 but the County Council had recently taken the decision to end a contract with Norfolk and Suffolk NHS Foundation Trust (NSFT) for integrated mental health and social care for around 1,600 people per year. In view of this, the Health and Wellbeing Board was asked to report back to the NHOSC on the plans for integrated mental health and social care services in the Health and Wellbeing Strategy 2014-17.

(b) Data protection issues could be an obstacle to integrated services. It was very important for the strategy to address these issues.

(c) The strategy needed to be clear on how outcomes would be measured and to start with adequate baseline data.

(d) There needed to be clarity on how the priorities and overarching goals of the strategy and the action plans associated with it would be communicated from Board level to 'floor' level.

(e) It was important for the Health and Wellbeing Board to be particularly aware of the interests of "Looked After Children", for whom the County Council was a corporate parent, and to put emphasis on their wellbeing as part of the strategy.

6.6 It was further agreed that a copy of Mrs MacLeod's presentation should be emailed to Members of the Committee and that when it had been finalised Mrs MacLeod should send a briefing note to the District Councils setting out the broad priorities and goals in the Health and Wellbeing Strategy.

6.7 The Committee asked for the Health and Wellbeing Board to update it on progress with the 2014-17 Strategy on 4 September 2014. The Committee would like the Chairman, or another elected Member of the Board, to accompany the Director of Public Health on that occasion.

7. Forward Work Programme

7.1 The Committee agreed the list of items on the current Forward Work Programme

subject to the following changes:

Delayed Discharge from Hospital in Norfolk – the report of the joint task & finish group to be received at a later meeting (i.e. May or July 2014).

Use of the Liverpool Care Pathway in Norfolk's hospitals – an update on practices regarding end of life care in hospital to be received later in the year (i.e. after 17 April 2014)

Wheelchair provision by the NHS – to be brought forward to 17 April 2014 meeting.

Hospital complaints processing and reporting – added to the forward work programme for 29 May 2014.

Health and Wellbeing Strategy 2014-17 – a progress update report to be received on 4 September 2014.

The meeting concluded at 11.45 am

Chairman

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