NHS
South Norfolk
Clinical Commissioning Group

COMMISSIONING PLANS 2015-16

Norfolk Health & Wellbeing Board – 29 April 2015

Ann Donkin, Chief Officer

South Norfolk – Programme Aims

Out of Hospital Care

Better Care Fund*

- Full integration of out of hospital, social and community care service delivery*
- Developing new forms of organisation
- Stimulating the market for providers
- Continuing care
- Integrated services for Primary care , intermediate care (reablement & rehabilitation) and falls prevention*
- Maximising independence*
- End of life delivered at right time, right place*
- Identify and support dementia*
- Primary care mental health focus*

Planned Care

- Reduce variation
- Right setting, right time
- Day case to outpatient shift
- Patient choice
- Pathway review and patient flow
- Reduce length of stay
- Refine prior approval and thresholds

Emergency & Urgent Care

- Reduce A&E attenders and A&E admissions
- Deliver stroke services according to best practice tariff and service specification
- Pre admission services
- Local ambulance KPIs
- Right clinical decisions makers in right place

Child Health & Maternity

- Early health and intervention services
- Accessible, high quality CAMHS pathway
- Children & Families Act 2014
- Healthy weight & obesity prevention (Tier 3)
- High admissions pathway i.e. long term conditions
- Looked after children

Mental Health

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Mental Health

- Implement new Primary Care Mental Health Service, increasing access to psychological therapies (IAPT)
- Drive up quality and performance of secondary care MH provision
- Diagnose and ensure the delivery of effective support for people with dementia
- Address the impact and harms of drug and alcohol

Mental Health - Aims

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- Mental Health provision will be open and accessible to all people who need it regardless of their age and the diagnosis and severity of their Mental Health condition

- No Mental Health service user should need to be returned to their GP for onward referral for another Mental Health service

- Mental Health and Learning Disability services are integrated with the wider health and social system and which support the recognition that people's Mental Health 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

Impact on Strategic Aims

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Promoting the social and emotional wellbeing of pre-school children:

- Supporting Norfolk County Council in the development of a comprehensive work plan in response to the Children and Families Act
- Working with Public Health to promote Health Improvement activities aimed at children and families

Reducing Obesity:

- Development of a South Norfolk-specific Obesity Strategy alongside a range of stakeholders
- Reviewing the CCG's commissioning intentions regarding a Tier 3 Weight Management Service.

Making Norfolk a better place for people with dementia and their carers:

- Development of South Norfolk's Dementia Pathway through 'Better Care for South Norfolk'
- Extension of Admiral Nurse service, and commissioning of information and advice service based within Primary Care

Health Inequalities

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The CCG will tackle inequalities in health by:

- **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.**

- **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**

- **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.**

- **Collaboratively commission and strategically link with Public Health Norfolk to target health improvement programmes to areas of need**

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Thank you.

Contact us:

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NHS
Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

Making a difference for our population – 5 Year Strategy and 2015/16 Operating Plan

Dr John Stammers
Chair, NHS GYW CCG

Better Health, Better Care, Better Value

How have we done so far?

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HealthEast

- Well performing system – addressing national conditions within the BCF:
  - Reduced emergency admissions during 2014/15, which is testament to increasing integration of health and social care
  - Delayed discharges of care reducing – nearly halved since February 2015
  - Early adopter for seven day services

- We operate across Waveney as well as Great Yarmouth – increased opportunities for integration

- Consulted on mental health services in GYW

- Increasing evidence of integration in GYW – for example combined health and social care Out of Hospital teams

- Views of patients, including seldom heard groups, taken into account when deciding which services to be commissioned

Plan Summary (1)

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HealthEast

There is an urgent need to change, in less than five years' time more than 50% of our population will be over the age of 65.

- It is our intention to improve both the quality and accessibility of the services we provide **and** deliver better value for money
- Maintain safe and high quality care, within a balanced budget
- Providers and commissioners increasingly pooling budgets and operating combined and co-located teams
- Looking right across the system to integrate, including primary care, acute and community care, mental health and social services
- Innovative out of hospital team model increases access for vulnerable elderly groups

Plan Summary (2)

Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

- Focus on areas needing particular support and development:
  - Primary care
  - Access to responsive mental health services

- Linkages with public health around prevention and inequalities identified in JSNA
- Jointly funded schemes with voluntary sector e.g. Red Cross Home from Hospital
- Progress, with our partners, the agreed Better Care Fund Schemes – finding savings for the system
- Meeting the national conditions within the BCF (reduced emergency admissions, DTOCs, 7 day services etc)

Fairness for all

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Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

JSNA says:
Generally, we have an ageing population and high numbers of patients with multiple long term conditions. Health inequalities include premature mortality for COPD, high levels of admission for people with cancer, circulatory and respiratory disease.

Initiatives include:

- Diabetes intermediate care service – increasing access
- Public health producing a strategy to actively reduce inequalities
- Giving every child best start in life – breast feeding, smoking cessation, childhood obesity
- Decreasing alcohol use – alcohol directed enhanced service and reinvigorated GYW drugs and alcohol multi agency forum
- Working with district councils around housing

Parity of esteem

NHS
Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

- GYW CCG spends more per head on mental health than any other CCG in Norfolk
- Full public consultation around mental health services was completed in 2014
- Implementation plan underway, including allocation of resources for service changes an developments to support parity of esteem
- Clear person centred approach – including physical and mental wellbeing of all patient groups
- We are working on how to improve the transition to adulthood across all our pathways, including children and adolescent mental health services and learning disabilities

In summary:

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Great Yarmouth and Waveney Clinical Commissioning Group

HealthEast

We are pushing on with integration of health and social care

We recognise the challenges around reducing inequalities

We will be consulting over the summer on proposals to bring care closer to home

We are implementing, alongside NSFT, improved service models to ensure parity of esteem

We are also working with NHS England around how we best support primary care

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North Norfolk Clinical Commissioning Group

Health and Wellbeing Board

April 29th 2015

Plan on a page

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Three key areas of focus for the 2015/16 operational plan

1. We will aim to prioritise access to services available 7 days a week across health and social care, building on the current success of the Integrated Care Programme and support for people with complex mental and physical care needs.
2. We will continue to improve the rate of dementia diagnosis and the development of local support services to enable patients and their carers to live well.
3. We will work in conjunction with partner organisations to implement sustainable resilience in the local health system including improved performance in emergency care, improved elective care pathways to meet local need and national targets and a reduction in the rate of avoidable admissions.

Access

Meeting the NHS Constitution standards and Mandate commitments, we will:

- Deliver System Resilience plans, to improve the urgent care system and delivery of national emergency care standards.
- Develop winter resilience and urgent / emergency care schemes including alternatives to admission and improved patient flow.
- As lead commissioner ensure all patients start consultant-led non-emergency treatment within 18 weeks.
- Drive through improvements to achieve earlier diagnosis of cancer to increase the scope for successful treatment.
- Ensure most appropriate usage of diagnostics
- Improve access to Mental Health services and assessments.
- Increase the rate of dementia diagnosis within primary care.
- Build on the success of the Integrated Care programme to reduce the rate of avoidable admissions related to long term conditions.
- Support plans to increase recruitment and retention within Primary Care.

Outcomes

To ensure delivery across the five domains and seven outcome measures, we will:

- Commission according to health need and to promote better health outcomes.
- Provide additional support to vulnerable groups and locate services in the most appropriate setting.
- Ensure health services are equitable.
- Embed the principle of Parity of Esteem into all commissioning activity, to ensure mental and physical health needs are met equally.

Transformation programmes, reconfiguration plans and re-procurement

- Integrated Care Programme – working in conjunction with county and district councils, health & social care providers and the voluntary sector to deliver an effective model of integrated care.
- Central Norfolk System Resilience Group – Accountable Officer representation supported by Project Domino and Capacity Planning Group to drive through system resilience schemes.
- QIPP Programme – delivery of substantial transformational projects to achieve our planned and underlying surplus for 15/16.

Planned Procurement Activity

- 111/ Out of Hours mobilisation
- IAPT mobilisation

Quality

- Continue to incentivise the uptake of patient Friends & Family Test through the national CQUIN.
- Ensure local provider plans are delivered against the six action areas of the Compassion in Practice implementation plan.
- Ensure that our commissioning activity and collaboration with county and district councils reflects the needs of the most vulnerable within our community
- Improve communication, consultation and culture across staff groups, ensuring clarity of roles, working arrangements and co-location.
- Increase the numbers of Integrated Care Coordinators available out of hours, to support access to services 7 days a week.
- Embed lessons learned from the Francis, Berwick and Winterbourne View whilst adopting a “zero tolerance” approach to breaches of fundamental standards.
- Embed patient experience in the Quality Schedule of the NNUH contract.

Delivering value

Financial resilience; delivering Value for Money for taxpayers and patients and procurement

- Deficit 15/16 (£1.9m)
- Drawdown (£2.2m)
- Investments – incl BCF (£12.2m)
- Underlying deficit (£0.5m)
- Contingency (£1.1m)

Link to BCF Plans

2015/16 levels of emergency admissions to be reduced by 3.5%

Activity assumptions

- Elective activity (3%)
- Non-elective activity (3.5%)
- Outpatient activity (1.3%)

Financial Challenges

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- £14m gap for 2015/16
- Plan to address over 2 years by:
  - Transformational change
  - Remodelling the system
  - Community based local care models
- £224,000,000 total allocation 2014/15
  - £ per person in North Norfolk - £1,333
  - £ per household in North Norfolk - £3,010
- £225,923,000 total allocation for 2015/16 (1.9 % uplift from 14/15)
- Amount being pooled between LA and CCG in the BCF £11,553,000

Health & Wellbeing Priorities

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- ✓ **Reducing Obesity**
  - Newly commissioned Tier 3 weight management service Fakenham Medical Practice
  - Exercise Referral (NNDC 'Well Active' & BDC Broadly Active)
- ✓ **Making Norfolk a better place for people with dementia and their carers**
  - Living Well with Dementia project:
    - Increased Diagnosis rate
    - Better support for patients and their families & carers
    - Dementia Information Pack Pilot – NN CCG leading for Norfolk

Health & Wellbeing Priorities

NHS
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Clinical Commissioning Group

✓Promoting the social and emotional wellbeing of pre-school children

- CCG involved in NN Health Improvement Forum supporting projects that encourage children to be more active
- CCG working with PHE to co-produce the transition of current service delivery to the Healthy Child Pathway, in line with national guidance/best practice, and where possible accessible from the acute setting closest to home.

North Norfolk's 'Golden Threads'

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- **New Primary Care Mental Health Service**
  - Improving access to MH support in rural areas and for older people
  - Improving integration between primary care and MH service
  - Embed the principle of *Parity of Esteem: Transformative Ideas for Commissioners* into all commissioning activity
- **Looking after people closer to home**
  - Better use of beds
  - Community contract wrapped around GPs
  - Falls pathway
  - More development of Integrated Care Hubs

West Norfolk Clinical Commissioning Group

2015/16 Operational Plan

Health and Wellbeing Board: April 2015

West Norfolk CCG priorities (1)

- Three key areas of focus for the 15/16 operational plan:
  - To deliver operational resilience throughout the year, ensuring sustainable compliance with NHS Constitution standards and Mandate commitments
  - To ensure financial sustainability via robust financial planning and management, and QIPP delivery
  - To maintain progress on integration and transformation of service delivery with West Norfolk 'Alliance' partners across health, social care, borough council and third sector

West Norfolk CCG priorities (2)

- Frail and elderly
- Urgent care
- Mental Health; parity of esteem
- Elective care
- Women and Children's
- Primary Care development
- Targeting health inequalities

A patient's experience now . . .

Too many of our most frail and elderly patients receive sub-standard care now, due to fragmentation of services, duplication of effort, 'gaps' in provision, lack of continuity of care and unnecessary, untimely intervention. Here is one example…

CARE PLANNING
Lack of timely, proactive care planning, leading to un-coordinated care

STAFF
Multiple visits from several staff from different organisations

PATIENT
Elderly patient with multiple co-morbidities (Diabetes, COPD) living with husband of similar ill-health living in rural West Norfolk. Patient has had a recent hospital admission for treatment of COPD exacerbation. In hospital the patient became disorientated and was assessed and diagnosed with dementia. Discharge from hospital was complicated by an infected leg ulcer with a need for daily dressings. At home the patient had 9 different people visiting for health and social care. The patient and her husband feel anxious and unsupported.

RESOURCES
Duplication of resources via organisational and care replication

COMMUNICATION
Lack of communication and coordination between health and care professionals

ASSESSMENT
Multiple assessments, duplicating information requested

TIMELINESS
Lack of timely, proactive care to meet individual need and support health and wellbeing

A patient's experience in the future . . .

Our aspiration is for all of our patients, and their carers to be in control of their healthcare. It is to provide them with all of the support they wish to access regarding planning of their care, the timeliness and type of interventions they receive, the services they choose to access. It may include control of the budget for their care, but will always mean that their needs are put first by all…

PATIENT
Elderly patient, with multiple co-morbidities (Diabetes, COPD) living with husband of similar ill-health living in rural West Norfolk. Patient is well supported in the community by her GP and community matron. During an unavoidable admission to hospital the patient received care and support from a community key worker to arrange timely discharge from hospital, with the right support at home. Throughout their care the patient and her husband remain involved, well supported and feel safe.

CARE PLANNING
Proactive care planning, with full engagement of the patient and her husband

STAFF
Named key worker responsible for coordinating care

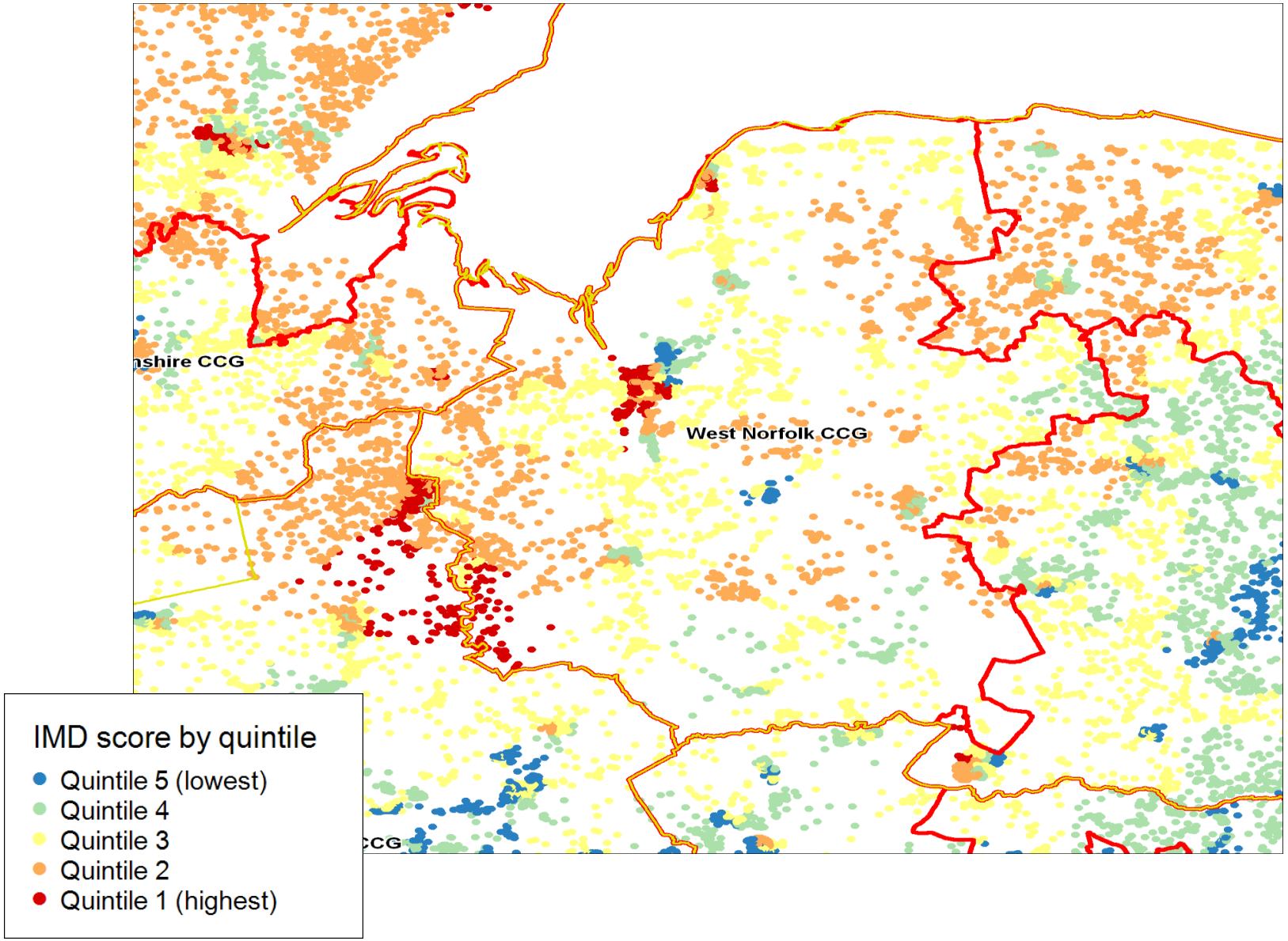
RESOURCES
Remove perverse incentives, resources aligned to person's needs

COMMUNICATION
Safe sharing of relevant information between agencies

ASSESSMENT
Tell the story once, leading to a single, holistic assessment

TIMELINESS
Timely care, supporting the patient to remain healthy and safe, preventing avoidable crises

Deprivation Map



Primary Care Development & Localities

- Establishment of 4 localities
- Care / Nursing Home LCS – aligning GP Practice to improve continuity of care
- Risk Stratification Toolkit – identify patients at high risk of admission
- Tackling variation in Primary Care – initial focus Atrial Fibrillation (AF)
- Programme to review opportunities across General Practices in Norwich to address capacity & workforce issues
- Electronic Prescription Service – move away from paper based system

Healthy Norwich
Core Work Programme

- Healthy eating and physical activity
- Smoking cessation, early intervention and prevention
- Affordable warmth
- Improving mental wellbeing and reducing health inequalities amongst vulnerable groups and deprived communities

Healthy Norwich continued

Cycling:

- Skyride - provision of weekly bike rides across Norwich
- Push the Pedal ways - improvements to 8 miles of pedal ways
- Funded projects to support individuals and families most likely to experience health inequalities to access and maintain bicycles

Health Promotion and Workforce Development:

- Workshops provided by Enable East to target vulnerable groups
- RSPH accredited Health Improvement Training available from early summer onwards to multidisciplinary staff to make every contact count

Healthy Norwich Funding Grants:

- Provision of funds to 23 organisations to deliver projects which target individuals and communities experiencing the greatest health inequalities

Your Norwich - Integration with Community, Social, MH and Voluntary Sector Services

- Community based rapid response service - to support diagnosis which will inform required health & care package
- HomeWard (Virtual Ward) including Community IV service
- Procured Beds pilot with in-reach therapy and clinical tracker nurse
- Age UK Promoting Independence pilot
- Admiral Nurse Consultant - to support the Norwich Dementia programme
- Enhanced Community Heart Failure service
- Review of Integrated Case Management including Integrated Care Coordinator role
- Review of the falls pathway in Norwich
- Review of community palliative care provision - to enable people to die well in their preferred place of care
- Action plan to implement the Norfolk Carer's Strategy

Urgent Care

- Working in partnership
- System Resilience Group
- Capacity Planning Group
- Domino – Demand / Flow / Discharge -eg
  - GP Enhanced Clinical Triage
  - Emergency Dept redesign including Urgent Care Centre

Mental Health, Drugs and Alcohol

- Norwich MH Locality Group –membership to be widened; themed meetings planned
- Norwich CCG Mental Health / Dual Diagnosis strategic statement and local action plan to be produced
- Eating Disorders Medical Monitoring LCS commissioned

Children

- Joint commissioning with Norfolk County Council – in line with the Children & Families Act 2014
  - Paediatric Speech & Language Therapy
  - Compass Centre
  - Short Breaks