Future of Health in West Suffolk

Operational Plan
2014/15 to 2015/16

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1. Executive Summary – West Suffolk System Vision

The Suffolk Health and Wellbeing Board vision is that people in Suffolk live healthier, happier lives. We also want to narrow the differences in life expectancy between those living in our most deprived communities and those who are more affluent through achieving greater improvements in more disadvantaged communities. Care of the elderly is a key feature of the vision given the rising age of the local population.

The vehicle for delivering this vision is integrated care. In West Suffolk our system, including all our local health services, care services, district and borough councils, Suffolk County Council, our Clinical Commissioning Group, our local GPs and our voluntary sector and communities are developing a united vision, focused on outcomes for integration.

To deliver this vision we will provide determined leadership to build a system that works for our customers and patients, and is financially sustainable into the longer term.

West Suffolk patients and customers have told us repeatedly through our CCG’s ‘Patient Revolution’ strategy that they want to experience a joined up system.

The National Voices patient-centred coordinated care overarching definition is: “Integrated care means person-centred coordinated care where I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes”. Patients and customers often do not know or necessarily care who the provider is but do ask that it is safe, comprehensive, coordinated and meets their needs.

They want to tell their story only once, have those who need to know hear it and co-produce a shared care plan. Also, the majority of people would prefer to remain independent in their own home environment, and this can be achieved most effectively when information, support and resource is available.

In essence, our patients and customers would like to see the transformation of a fragmented set of health and care services to a co-ordinated service that meets their needs.

This change is also supported by our staff, who want to access a system of care and support that is ‘joined up’, and know and understand that the resources available are safe. Therefore the need for real time communication and information sharing is of paramount importance. A productive culture of trust and respect will be developed through increased knowledge and understanding of roles and responsibilities and clear lines of accountability.

The case for integration is made stronger by the reductions in public sector funding which are placing severe strain on all our organisations, meaning that we need to make a transformational change in how we deliver services, in order to continue to provide high quality and comprehensive services for the people in West Suffolk.

NHS England’s Five Year Forward View sets out how the health service needs to change, arguing for a more engaged relationship with patients, carers and the public to promote health and wellbeing and prevent ill-health.

It sets out the vision for the NHS of the future and the steps that need to be taken to ensure a sustainable health service which continues to provide comprehensive and high quality care for all.

The Forward View outlines how CCGs will be given the ability to influence an increasing proportion of the total local and regional NHS commissioning resources, including primary care and specialised services. This
1. Executive Summary – West Suffolk System Vision

will put them in a much better position to match investment decisions with the needs and aspirations of their local communities, for example to improve primary care and mental health services.

Primary care is central to the new population-based health care models described in the Forward View. The CCG has been approved to jointly commission primary care services, and will be working with NHS England on the local implementation of the new arrangements from April 2015.

The CCG recognises that primary care plays a critical role in the prevention of ill health and the management of people with long term conditions. The CCG places primary care at the heart of its joint plan to support people at home through the implementation of risk stratification, integrated community teams, case management and care coordination.

Linked to this, the CCG will also be enhancing the joint commissioning arrangements with local government.

Organisations in West Suffolk are already committed to creating an integrated health and care system that supports our population to keep well and 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. They agree that the only way to do this effectively is to work together to remove barriers and costs, and ensure that we spend as much as possible of our budgets on the direct provision of care. We believe that a more integrated system will help us to manage demand pressures, as well as give us the ability to use our funding more effectively.

Locally, the model of integrated health and care, and improved access to high quality urgent and emergency care, will be delivered through the Suffolk Health and Care Service model.

Since November 2013, the CCG and Ipswich and East Suffolk CCG have worked closely with partners, in particular Suffolk County Council (SCC) and Healthwatch, to engage the wider Suffolk community on the future of health and social care services in Suffolk. A number of themes have been incorporated into the system design, based on feedback from patients and partners, local experience, national policy and evidence:

- the major building blocks of the new system will be Integrated Neighbourhood Teams. Social care, community health services and some aspects of mental health services will be organised and delivered at neighbourhood level. There will be an increased emphasis on teams managing their populations in a systematic way, to identify the individuals at higher risk, and placing care plans which are joint between all relevant agencies. Some individuals will be sufficiently complex to require a case co-ordinator; the most appropriate person for this role will depend on the team’s view on which professional is most appropriate to that individual’s needs;

- communication between healthcare professionals will be improved. One component of this is commissioning an NHS 111 service with a dedicated line for professionals to allow them to link them to partners; for example, a paramedic attending a patient who needs care will be able to access community alternatives to hospital treatment. For patients calling NHS 111, their service experience will be improved by stronger clinical support;

- services at the acute trust will be strengthened by a significant primary care presence and there will be an increased emphasis on moving patients into the community rather than hospital beds.

During 2015/16, work will continue towards this system reform and redesign of the way the local health and social care systems work. This will be initially in Sudbury as an “Early Adopter’ site where the concepts and practical applications of the model will be tested, and used as an opportunity to further understand the key components of building a more cohesive health and care system with cross-organisational working.

In conclusion, the difference we shall make to the health and social care outcomes for all people in West Suffolk is that local people:

- will not have to navigate around a complex system to find the right information, care or services that meets their needs;
- will have their health and care needs identified early before a crisis occurs;
1. Executive Summary – West Suffolks System Vision

- will have access to a range of local services that focus on supporting people to self-care and supporting primary prevention;
- will have control and choice over their care;
- will have a named coordinator when they need help who will ensure that the system works effectively, with a single care record.

This Operational Plan sets out how the West Suffolk system vision will be delivered. The summary “Plan on a Page” is set out at Appendix ‘A’.
2. National Background and Context

2.1 Introduction

NHS England’s publication “Everyone Counts: Planning for Patients 2014/15 to 2018/19” established 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. “Everyone Counts” emphasises the need for an outcomes focused approach to planning, aligned to the NHS National Outcomes Framework, and for CCG plans to reflect stretching local ambition over the next 5-year period.

The publication sets out the key challenges facing NHS England over the next few years:

- raising the quality of care to best international standards (responding to recommendations of Francis, Keogh and Berwick);
- closing potential funding gap of arrange £30 billion by 2020/21.

In order to achieve this, there are three core areas that will need to be delivered:

- shift of activity and resources to more integrated out-of-hospital services;
- 15% reduction in emergency activity and admissions by 2015;
- 20% productivity increase in elective care over next five years.

In October 2014, NHS England published its “Five Year Forward View” setting out a clear direction for the NHS for the next five years. It articulates a priority focus and radical upgrade in prevention and public health. Furthermore, it is envisaged that when people do need health services, patients will gain far greater control of their own care, and that the NHS will take decisive steps to breakdown the barriers in how care is provided – delivering health and care needs a more joined-up and integrated way.

The CCG has fully embraced the direction of the “Five Year Forward View” and sets out in this Plan how it will be implemented locally.

2.2 Strategic Planning 2014/15-18/19

The CCG is part of a ‘unit of planning’ with Ipswich & East Suffolk CCG. Both CCGs are working jointly with Suffolk County Council, partners, patients and the public to develop a strong, robust and ambitious five year plan to secure the continuity of sustainable high quality care for everyone in West and East Suffolk.

The transformational change to deliver the West Suffolk system vision is taking place at a time when the health and social care system in Suffolk is facing a number of major challenges over the next few years:

- staffing – significant recruitment and retention difficulties in certain key areas and an ageing workforce;
- increased clinical specialisation with centralisation of services potentially leading to reduced local health services;
- seven day working leading to further staffing and resourcing issues;
- significant financial constraints – against a background of an ageing population, an increase in long term conditions, rising costs and increased public expectations.

The current national, regional and local position provides a massive opportunity and responsibility for transformational change in the system, breaking down historic organisational barriers and radically rethinking how care can be provided in Suffolk. To do this, the Suffolk ‘system’, including all our local health and care services, including the voluntary sector and communities have developed a common, united vision that “the people of Suffolk will live healthier, happier lives with reduced inequality of life expectancy”.

This vision will be delivered through the five year Strategy which focuses on three key strategic areas:

- a national drive looking for integrated health and care which saves money and improves outcomes and experiences for customers;
- a wish to work better together locally across the to ensure that we make best use of resources and minimises impacts of savings on customer care;
2. National Background and Context

- to take full advantage of the potential of partnership working to prevent need and an increase in people’s dependence.

The strategic planning will consider all options to ensure resilient, viable, high quality services are available for West and East Suffolk residents. It is 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 and works with our communities to promote independence.

These major transformational changes will be delivered through the ‘Health and Independence’ Programme Board:

The Governance arrangements and details of the work programmes deliverables are set out in Sections 3.5.

The CCG’s 5-year Strategic Plan is aligned to the outcomes established by the Programme Board, and will be informed by the use of the Better Care Fund.

2.3 Better Care Fund

The £3.8 billion national Better Care Fund (formerly the Integrated 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 addition to the Health and Wellbeing Board and individual partner organisations, the process of developing the delivery plan is supported by West Suffolk, Ipswich and East Suffolk, and Great Yarmouth and Waveney CCGs, under the governance of the System Leadership Partnerships that bring together relevant commissioners and providers.

The Better Care Fund provides an opportunity to accelerate progress in delivering the vision of the Suffolk Health and Wellbeing Board. 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, 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 the CCG and Local Authority. Further detail around the use of the Better Care Fund locally, and the 5-year delivery plan that underpins it, is set out at Section 6.4.

2.4 NHS Outcomes Framework

The NHS National Outcomes Framework 2014/15, together with the Adult Social Care and Public Health Outcomes Frameworks together support the Government’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 CCGs should be aiming to improve. They focus on:

- preventing people from dying prematurely;
- enhancing quality of life for people with Long Term Conditions, including mental health illnesses;
- helping people to recover from episodes of ill-health or following injury;
- ensuring that people have a positive experience;
- treating and caring for people in a safe environment.

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.
2. National Background and Context

- 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.

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, NHS England 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:

- new approach to ensuring citizens fully included in all aspects of service design and change, and patients empowered in their own care;
- wider primary care provided at scale;
- modern model of integrated care;
- access to highest quality urgent and emergency care;
- step change in productivity of elective care; and
- specialised services concentrated in centres of excellence.

Section 6 of 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 essential elements are:

- **quality**, focusing on patient safety, patient experience, compassion in practice, staff satisfaction, seven day services, and 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;
- **value for money**: focusing on effectiveness, efficiency and improved procurement.

The CCG will continue to place significant focus on these elements and sets out in Section 7 to 10 of this Plan how they will be implemented to drive improved outcomes for patients and local communities.

The diagram to the right summarises the national framework through which NHS England’s overarching vision and ambitions will be delivered, and against which the CCG will deliver high quality service locally for the people of West Suffolk.

This will support delivery of the NHS Five Year Forward View which was published in October 2014 and articulated the shared vision for the NHS over the next five years.
2. National Background and Context

2.5 NHS Five Year Forward View


The Forward View represents the shared views of the NHS’ national leadership, and reflects the emerging consensus amongst patient groups, clinicians, local communities and frontline NHS leaders.

It sets out the vision for the NHS of the future and the steps that need to be taken to ensure a sustainable health service which continues to provide comprehensive and high quality care for all. This includes the better prevention of ill-health, empowering patients, engaging diverse communities, and stimulating the development of better models of care, supported by innovative use of technology and workforce.

The Forward View articulates the significant move towards “place-based” clinical commissioning that will be seen in 2015/16. The CCG will be given the ability to influence an increasing proportion of the total local and regional NHS commissioning resources, including primary care and specialised services. This will put them in a much better position to match investment decisions with the needs and aspirations of their local communities, for example to improve primary care and mental health services. Linked to this, the CCG will also be enhancing their joint commissioning arrangements with local government (e.g. for the operation of the Better Care Fund – Section 6.4).

In addition, there will be a continued and intense focus on continuing to deliver NHS Constitution (Section 2.6) rights and pledges and NHS Mandate requirements.

The CCG has fully embraced the direction established in the Forward View, and sets out within this Operational Plan how the national strategy will be delivered locally.

2.6 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 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.
2. National Background and Context

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;
- mental Health access waiting times.

The CCG has embraced these rights and pledges within this Operational Plan and sets out (Section 4) its plans to commission sufficient services to ensure it can deliver those rights and pledges for patients on access to treatment. Delivery of the rights and pledges are monitored on a monthly basis through Service Level Agreements (SLA) with providers, and further scrutinised by the CCG’s Executive and Governing Body as part of an Integrated Performance Report.

Contractual sanctions are applied where performance is not at the required standard (and these will be published on the CCG’s website) and significant performance failure is risk-managed through the Governing Body Assurance Framework, detailed at Section 12.

2.7 NHS England Direct Commissioning

NHS England is currently responsible for directly commissioning healthcare services including primary care, specialised services, secondary care dental services, some public health services, offender health and armed forces health. Where commissioned services directly need to join up with locally commissioned services, NHS England co-ordinates with the CCG and other partners, to ensure people experience a seamless and integrated service. Details of those services commissioned by NHS England are set out below:

2.7.1 Primary Care

Primary care has a key role to play in improving health outcomes and reducing health inequalities. Good primary care has a positive impact across the whole of the health and social care system. Evidence shows that strong and effective primary care services are vital for health economies and for delivering high quality, best value health services and healthy populations. Primary care is central to the new population-based health care models described in the Forward View.

Section 6.3.2 sets out the CCG ambition to work with NHS England to co-commission primary care services from 2015/16.

2.7.2 Dental Health

NHS England are responsible for commissioning all NHS dental care; across the hospital (secondary), community (e.g. care for people with special needs), and primary dental care settings, and managing some 10,000 contracts with ‘high-street’ dental practices. Its aim is to deliver excellence in commissioning NHS dental services including improvements in quality and patient satisfaction, and reductions in inequalities of access and outcomes.

2.7.3 Offender Health

With commissioning of offender health services, NHS England is responsible for the planning, securing and monitoring of an agreed set of services for prisons, Young Offenders Institutions (YOIs), immigration removal centres, secure training centres, police custody suites, court liaison and diversion services and sexual assault services.

This entails aligning the justice commissioning intentions with those of the NHS England offender teams and local partnerships, particularly for children and young people and setting commissioning standards that reduce the potential for variation in outcomes and inequalities of access to services that prisoners currently experience across England. This will also include a focus on mental health services in prisons and detainee settings.
2. National Background and Context

2.7.4 Armed Forces Health

NHS England is responsible for commissioning armed forces health care. This includes, for example, increasing and improving access to mental health services for serving personnel and veterans, as well as improving prosthetic care for veterans.
3. Local Background and Content

3.1 Local Demographic Profile

The West Suffolk CCG provides healthcare services for around 240,000 people in West Suffolk. In 2014/15 and 2015/16 it will spend around £280m each year on commissioning healthcare services for these people.

The CCG’s population is registered with 25 West Suffolk practices and is predominantly rural with the population scattered in small towns and villages. Geographically, the area includes the whole of Forest Heath and St. Edmundsbury local authority districts and part of Mid Suffolk and Babergh districts.

The town of Bury St. Edmunds (43,000 residents) is at the centre of the area, which also includes the small towns of Haverhill (27,000), Mildenhall (14,000) and Newmarket (20,000) in the west, Brandon (9,000) in the north and Sudbury (22,000) in the south-east (based on 2011 Census Built Up Area data).

The main roads A14, A11, A134 and A143 cross the area, as does the railway line from Ipswich to Cambridge, with stations at Bury St. Edmunds and Newmarket and villages in between. The United States Air Force (USAF) has large airbases at Lakenheath and Mildenhall.

Geographical area of West Suffolk CCG:

Population profile of West Suffolk CCG:

The graph above shows a population pyramid for the CCG. 16% of the CCG’s registered population are under age 15 (England average 17.2%) and 9.5% are aged 75 or over (England average 7.8%).
The overall population of West Suffolk is projected to increase by over 7% between 2014 and 2024, with nearly a 40% increase in people aged over 70 years old. Between 2001 and 2011 the absolute numbers of children in the 5-7, 8-9 and 10-14 age bands actually fell across Suffolk as a whole. The numbers of older teenagers rose slightly, whilst there was a relatively sharp increase of 9.7% in the number of children aged 0-4.

West Suffolk has similar levels of deprivation to Suffolk overall. The areas of highest deprivation are located in parts of the small towns, including areas within Bury St Edmunds, Brandon, Mildenhall, Newmarket, Haverhill and Sudbury as well as the more rural areas which have relatively poor geographical access to services. 42% of Suffolk residents live in rural areas, and a great proportion of the county population are claiming incapacity or DWP benefits, or living with a limiting long term illness. The State of West Suffolk report is attached at Appendix B.

Overall the population of West Suffolk is generally healthy with high life expectancy. Life expectancy at birth for males was 80.6 years and females 84.1 years in West Suffolk compared with 78.9 and 82.3 years respectively for England. Life expectancy at birth in 2008-2012 for both males and females was higher than in England as a whole by 1.7 and 1.3 years respectively. However, there are significant health inequalities with a 5.5 year gap for men and a 4.3 year gap for women in life expectancy between those living in the most and the least deprived areas.

The following section sets out the health profile for each district (based on Public Health England – Health Profiles 2014). The charts show how the health of people in the district area compares with the rest of England. The district's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that the district is significantly worse than England for that indicator.

Key:

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
3. Local Background and Content

3.1.1 Babergh

The health of people in Babergh is generally better than the England average. Deprivation is lower than average, however about 2,000 children live in poverty.

Life expectancy for both men and women is higher than the England average. Life expectancy is not significantly different for people in the most deprived areas of Babergh than in the least deprived areas.

Over the last 10 years, all-cause mortality rates have fallen. Early death rates from cancer and from heart disease and stroke have fallen and are better than the England average.

In Year 6, 15.4% of children are classified as obese, better than the average for England. The level of teenage conceptions and breast feeding initiation rates are better than the England average.

An estimated 12.5% of adults smoke and 21.7% are obese.
3. Local Background and Content

3.1.2 Forest Heath

The health of people in Forest Heath is varied compared with the England average. Deprivation is lower than average, however about 1,300 children live in poverty.

Life expectancy for women is higher than the England average. Life expectancy is not significantly different for men or women in the most deprived areas of Forest Heath compared to the least deprived areas.

The early death rate from heart disease and stroke has fallen and is similar to the England average.

In Year 6, 17.6% of children are classified as obese.

Levels of teenage conceptions, alcohol-specific hospital stays among those under 18, are similar to the England average. Breastfeeding initiation is better than the England average. Rates of statutory homelessness and new cases of malignant melanoma are worse than average.

An estimated 21.9% of adults smoke and 23.6% are obese.
3. Local Background and Content

3.1.3 St. Edmundsbury

The health of people in St. Edmundsbury is varied compared with the England average. Deprivation is lower than average, however about 12.1% (2,300) children live in poverty.

Life expectancy for both men and women is higher than the England average.

Life expectancy is 4.5 years lower for men in the most deprived areas of St Edmundsbury than in the least deprived areas.

The early death rate from heart disease and stroke has fallen and is better than the England average.

In Year 6, 15.8% of children are classified as obese, better than the England average. Levels of teenage conceptions are similar to the England average and breastfeeding initiation rates are better than the average for England.

An estimated 18.5% of adults smoke and 23.2% are obese.
3. Local Background and Content

3.1.4 Community Modelling and Analysis

The CCG, in conjunction with Public Health colleagues continues to undertake modeling and analysis of the constituent communities in West Suffolk, in respect of their:
- age;
- deprivation;
- mortality and premature mortality;
- marginalised vulnerable adults which are divided into:
  - homeless;
  - refugee and asylum seekers;
  - black and minority ethnic communities (BME);
  - gypsy & Traveller;
  - ex-offenders.

Each year, the CCG publishes equality information about its staff and our local communities. The latest information can be found on our website at:

http://www.westsuffolkccg.nhs.uk/about-us/equality-diversity/

3.2 Joint Strategic Needs Assessment and Suffolk Health & Wellbeing Strategy

Under the Health and Social Act 2012, upper tier local authorities and CCGs have an equal and joint duty to prepare a Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWBS). This duty is delivered through the Health and Wellbeing Board. JSNAs are local assessments of current and future health and social care needs, and are unique to each local area. The aim of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages. It is not an end in itself, but a continuous process of strategic assessment and planning. It is used to help to determine what actions local authorities, the local NHS and other partners need to take to meet health and social care needs and to address the wider determinants that impact on health and wellbeing.

The information within the JSNA was used to inform the development of the West Suffolk CCG’s ambitions, priorities and outcomes. In Suffolk, there are many components of the JSNA; these include:

- Suffolk Observatory: http://www.suffolkobservatory.info/
- Haverhill health needs assessment http://www.westsuffolkccg.nhs.uk/your-health/health-needs-assessments/

The State of Suffolk report is an overarching analysis of health and wellbeing in Suffolk. A first draft of the 2015 State of Suffolk report was produced in January 2015. It has been a statutory duty to produce a Joint Strategic Needs Assessment for upper-tier local authorities and the NHS since 2007. Suffolk’s first JSNA was published in 2008, with the 2011 State of Suffolk report being the first major update. Under the Health and Social Care Act 2012, upper tier local authorities and CCGs have an equal and joint duty to prepare a
3. Local Background and Content

Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWBS). This duty is delivered through the Health and Wellbeing Board.

The information from the JSNA was used by the Health and Wellbeing Board to agree four priority areas for Suffolk:

**Priority one: Every child in Suffolk has the best start in life**

**Why?**

Giving every child the best start in life is crucial to reducing health inequalities across the whole life course and establishing a good foundation for future development. Early intervention not only improves the life chances for our children, but is essential in reducing costs to the system. There is a strong link between poverty and poor health, educational and social outcomes.

In Suffolk children achieve less than the national average in educational attainment, and those in more deprived areas have worse outcomes than those in affluent areas.

**Priority two: Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing**

**Why?**

A healthy lifestyle will improve the health and wellbeing of the population and that the environment people live in can facilitate this. If green spaces are available and people feel safe they are more likely to take exercise, which will improve their health and wellbeing.

Tobacco is still the greatest behavioural risk factor and accounts for up to half of the life expectancy gap between deprived communities and the rest of the population. Increasing levels of obesity and excessive alcohol consumption affect quality of life and are increasing rates of long term conditions and hospital admissions. Alcohol and drug abuse also detrimentally affect communities; increasing high risk behaviour which can lead to more sexually transmitted infections and unplanned pregnancies, and also increasing levels of antisocial behaviour and crime.

**Priority three: Older people in Suffolk have a good quality of life**

**Why?**

As the population of older people in Suffolk increases, the Health and Wellbeing Board want to create a county in which older people can enjoy a good quality of life. Ensuring the environment enables them to be active, engaged and independent in safe, supportive communities that value their experience and contribution, remains a challenge.

People who enter old age healthily have a longer healthy life expectancy. It is widely recognised that the current provision of health and social care services is unlikely to be sustainable in the face of anticipated future need and most of the disease burden is attributable to long term conditions.

**Priority four: People in Suffolk have the opportunity to improve their Mental Health and wellbeing**

**Why?**

Good Mental Health is crucial to our overall health and wellbeing.

Yet almost half of all adults will experience at least one episode of depression during their lifetime, self-harming in young people is not uncommon and 60% of older adults in acute hospitals have a co-morbid mental health condition.

These four priorities are reflected in the CCG’s mission, set out below, and the clinical priorities that underpin it. The Health and Wellbeing Board priorities one and two are reflected in the CCGs priority to improve health and wellbeing through partnership working. Priority three is reflected in the CCG’s priority to improve the
3. Local Background and Content

health and care of older people. Priority four is reflected in our priority to improve access to mental health services.

3.3 CCG Clinical Priorities

The CCG has developed its own distinctive ambition and underpinning priorities for 2014/15 to 2015/16 to accelerate the delivery of QIPP and provide a local approach for delivery of the Health and Wellbeing Strategy. At the heart of this ambition is the view that greater integrated working is the primary vehicle to improve the quality of those services locally. The CCG, therefore, has the following ambition – “to deliver the highest quality health service in West Suffolk through integrated working”.

Supporting the delivery of the CCG’s ambition are six clinical priorities, which are aligned to both national and local frameworks:

- develop clinical leadership;
- demonstrate excellence in patient experience and patient engagement;
- improve the health and care of older people;
- improve access to mental health services;
- improve health and wellbeing through partnership working;
- deliver financial sustainability through quality improvement.

The CCG’s priorities are delivered through the CCG’s clinical workstreams which drive the local system changes within the overall strategic framework.

3.4 Local System Leadership

The Suffolk Health and Wellbeing Board is the strategic forum where the CCG, together with Suffolk County Council, District Councils and other key stakeholders from the local health economy agree and address strategic priorities. Under this strategic umbrella, the CCG and local authority colleagues are actively engaged on a number of fronts (as well as developing the visions and ambitions that underpin this Plan):

A key part of the programme of work is aimed at narrowing the differences in healthy life expectancy between those living in the most deprived communities and those who are more affluent through achieving greater improvements in more disadvantaged communities.

Health and wellbeing encompasses a person’s life experience and includes a sense of physical, mental and social wellbeing. Many factors contribute to a person’s wellbeing for example how safe they feel in their community and whether they are able to find a job. Through working jointly across health, local government and wider communities, the Board can make a real difference in improving the health and wellbeing opportunities for those in Suffolk.

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. The Board believes that through our shared vision, shared principles and priorities we can achieve so much more than we are able to on our own.

The Board is committed to remove organisational barriers and to having relentless focus on improving the health and care outcomes for people in Suffolk, with seamless services and support to promote independence, and preventing further dependency on long term and emergency health and care services.

Supporting the Health and Wellbeing Board is the System Leaders Partnership Board which exists to provide system leadership for delivery of elements of the joint Health and Wellbeing Strategy and other areas of agreed joint working as appropriate. The key functions of the group are to:

- identify and agree on areas of beneficial joint working priorities identified through the Health and Wellbeing Board;
- agree plans to deliver the joint strategic aims where cross organisational co-operation is required;
- scrutinise progress of the joint delivery workstreams and remove blockages to progress;
3. Local Background and Content

- deliver system leadership in the optimum use of resources to deliver the best overall outcomes for Suffolk residents.

The Suffolk System Leaders Partnership Board exists to provide a joined-up approach to commissioning Suffolk services to delivering the elements of the Health and Wellbeing Strategy and other areas of agreed joint working as appropriate. The key functions of the group are to:

- identify and agree of areas of beneficial joint commissioning for priorities identified through the Health and Wellbeing Board;
- agree plans to deliver the joint strategic aims where cross-organisational commissioning is required;
- scrutinise progress of joint commissioning workstreams and remove blockages to progress;
- deliver system leadership in the optimum use of resources to deliver the best overall outcomes for Suffolk residents.

**Linkage between Health and Wellbeing Strategy and CCG Clinical Priorities**

<table>
<thead>
<tr>
<th>Health and Wellbeing Strategy</th>
<th>CCG Clinical Priorities</th>
</tr>
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<tbody>
<tr>
<td>Vision; People in Suffolk live healthier, happier lives. We also want to narrow the differences in healthy life expectancy between those living in our most deprived communities and those who are more affluent through greater improvements in more disadvantaged communities.</td>
<td>The CCG, with strong clinical leadership, will continue to work closely in partnership with other stakeholders, to ensure that the significant changes to the way that services are delivered continue to provide value for money and meet the needs of the local population.</td>
</tr>
<tr>
<td>Priorities:</td>
<td>Priorities:</td>
</tr>
<tr>
<td>- Every child in Suffolk has the best start in life</td>
<td>- To develop clinical leadership</td>
</tr>
<tr>
<td>- Suffolk residents have access to a health environment and take responsibility for their own health and wellbeing</td>
<td>- To demonstrate excellence in patient experience and patient engagement</td>
</tr>
<tr>
<td>- Older people in Suffolk have a good quality of life</td>
<td>- To improve the health and care of older people</td>
</tr>
<tr>
<td>- People in Suffolk have opportunities to improve their mental health and wellbeing</td>
<td>- To improve access to mental health services</td>
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<td></td>
<td>- To improve health and wellbeing through partnership working</td>
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<td>- To deliver financial sustainability through quality improvement</td>
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3.5 Health & Care Review

The CCG, working with Ipswich & East Suffolk CCG, have formed a ‘Unit of Planning’ and together have developed a joint Health and Care Strategic Plan that will deliver the Health and Wellbeing Board vision and create a health and care system that delivers excellent services for people in Suffolk which is effective and sustainable.

The CCG is 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.

Working as part of the Suffolk ‘system’, including all our local health services, care services, district and borough councils, Suffolk County Council, our local GPs and our voluntary sector and communities, the CCG will provide determined leadership to create a different system - one that works for our customers and patients, but is financially sustainable into the longer term.

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. The CCG believes that if the system as a whole can create a shared vision, with shared principles and priorities so much more can be achieved than the CCG
3. Local Background and Content

is able to do on its own. The CCG is committed to remove organisational barriers and to having relentless focus on improving the health and care outcomes for people in west Suffolk. The CCG 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 patients and service users.

This shared vision presents huge opportunities – to deliver excellent care within local 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.

Reductions in public sector funding are placing a severe strain on all our organisations. This, coupled with rising demand, means that we need to make a transformational change in how we deliver services, in order to continue to provide high quality and comprehensive services for the people in Suffolk. In order to meet these challenges and ensure that high quality local services are available where possible the Suffolk CCGs, Suffolk County Council and Suffolk’s district and borough councils are proposing to work together to commission integrated services in their area of Suffolk.

The Health & Wellbeing Board will retain oversight of delivery.

The System Leaders Partnership Board (SLPB) will be accountable to the Health & Wellbeing Board. The SLPB is already established with very senior membership from the major public sector organisations in Suffolk and its purpose with respect to the Review is to:

- identify and agree on areas of beneficial joint working priorities identified through the Health & Wellbeing Board;
- oversee the delivery of joint strategic aims where cross organisational co-operation is required;
- scrutinise progress of the joint delivery workstreams and remove blockages to progress;
- deliver system leadership in the optimum use of resources to deliver the best overall outcomes for Suffolk residents.

The strategic planning will consider all options to ensure resilient, viable, high quality services are available for West and East Suffolk residents. It is 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 and works with our communities to promote independence. It will also develop thinking for the use of the Better Care Fund.

The strategic planning will not be considering changes in organisational form at this stage.

3.5.1 Health and Independence Programme Board

The Health and Independence Programme Board will design an integrated health and care system for supporting the health and independence of all people in Ipswich, East and West Suffolk: adults, children and families. Because of the impact that an integrated system will have on their lives, the Board will have a particular focus on the frail, elderly, people with a learning disability or those living complex needs (including mental health conditions).

Terms of Reference

The Health and Independence Programme forms part of the integrated health and social care governance structure, answerable to the Systems Leaders Partnership and ultimately to the Health and Wellbeing Board.

The Programme Board will involve membership from the health and care commissioning organisations, provider organisations, the voluntary sector and organisations that represent the voice of people in Suffolk.

The ambition of the Board is to demonstrate and lead behaviours required within an integrated system, and be thinking “whole system approach” at all times. It is recognised that this is a change of culture for organisations but believe that this will help us to deliver the vision for integrated care for the people of Suffolk.

Subgroups of the Board will develop the detailed design proposals against the objectives listed below. Board meetings discuss the outputs from these subgroups and test and challenge the proposals to ensure that they will meet the vision for integrated care. This work will look at preventative actions for Suffolk across the work of the partners of the Health and Wellbeing Board.
3. Local Background and Content

Subgroups

- living well;
- returning to independence;
- ongoing support for self-management;

These subgroups will be working across the following domains:

- health and care services;
- other publicly funded service;
- healthy communities.

The key outcomes of the Board are set out below:

**Living well**

- people and communities know who their local primary care and support staff are, and are able to contact them;
- people have good information;
- all people have opportunities for physical activity;
- all people have opportunities for social interaction;
- housing provision supports people living independent, active lives even when they have a limiting long term condition;
- people have the opportunities to gain skills and to get paid employment when this is appropriate for them;
- people’s environment supports them to live independently;
- transport solutions support people to live active lives;
- we know who is at risk of deteriorating physical and mental health, and ensure that we support them to prevent this;
- the whole system will work together to deliver creative and pragmatic solutions to support people to remain living independently without support from health and social care services;
- we will work with people in ways that encourage them to manage their own conditions.

**Returning to independence**

- our response provides integrated mobilisation of health, social care, district councils, Voluntary and Community Sector (VCS) and other resources to maximise the possibility of people continuing to live independent lives home;
- where people are looking to recover there is one plan: short term, outcome focused, coordinated which has:
  - One set of agreed outcomes built on an understanding of a ‘good life’ for the person and their family;
  - One lead co-ordinator, accountable for maximising the chance of success of the plan;
- shared priorities for action are in place including work around pathways: stroke, falls, dementia and around priority inputs: reablement/rehabilitation, disabled facilities grants/housing options;
- our response when someone has had an urgent health and care response makes sure that they get the follow through they need to return to being as well and independent as possible;
- the system is clear and understands when short term interventions are going to be beneficial in the long term, and is prepared to invest so that people get the benefit of this;
- Occupational Therapists (OTs) and Physiotherapists and other practitioners work across the system seamlessly.

**Ongoing support for self-management**

- when people, including young people moving into adulthood have ongoing support needs and/or a long term condition there is a joint commitment that we work with them to:
  - promote choice and design services that enable people to exercise choice where possible;
3. Local Background and Content

- have one plan, and where possible one budget;
- plan is co-ordinated where people have multiple long term conditions;
- we argue for an investment in managing conditions rather than treating complications;
- feel confident that they have the support they need to help them manage their lives;
- when people transition across different service areas, e.g. from children’s to adults services there is a seamless plan and delivery which provide the continuity across any service changes;
- every contact with a person with ongoing support needs will always be used to work with people to increase independence, where this is possible.

The Health and Independence service model is being implemented in Sudbury as an “Early Adopter” site. This will test out the concepts and practical applications of the model, as well as provide an understanding of how to build a more cohesive health and care system with cross-organisational working.

Further detail on the service model and the programme of work in Sudbury is reported in Section 6.4.1

3.5.2 West Suffolk Health & Care “forerunner site” bid

NHS England’s “Five Year Forward View” sets out a number of options for local and national organisations to work together to accelerate the design and implementation of new models of care which will underpin a sustainable NHS going forwards. NHS England will work with a small cohort of sites to start prototyping the new models of care, and co-design a programme of support to accelerate change, assess progress and demonstrate proof of concept.

The CCG submitted an Expression of Interest to introduce a local ‘Health & Care’ strategy and the primary and acute care system (PACS) model for delivery in West Suffolk. It has been created by a wide range of partners as part of the ‘Suffolk Health & Care Review’, including service users, health and care providers and commissioners, voluntary and community partners, district and borough councils. The application was approved by the West Suffolk System Forum on the Suffolk System Leaders Partnership in February 2015.

Further detail on the “forerunner site” application and the primary and acute care system (PACS) model of care is shown at Section 6.4.2

3.6 Provider Landscape

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 long term 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.

The CCG is committed to ensuring a clinically and financially sustainable future for the local acute hospitals, and to ensuring that primary, community, mental health, 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.
3. Local Background and Content

The local provider landscape is going through a period of significant change as part of the wider health and care review. The CCG will continue to actively develop the provider landscape, and to work with providers and stakeholders to support improved health outcomes and reduced health inequality, ensuring clinical sustainability in West Suffolk.

Within the local healthcare system, the transformation of an integrated model of care continues, and aligns with the overarching strategy of providing care in the right place, at the right time and by the most appropriate person. All providers are integral to this strategic direction and successful implementation of the system-wide transformation programme.
4. Commissioning and Planning

4.1 Commissioning and Planning Cycle

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. The CCG adopts the planning model cycle set out opposite.

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

We will set up two designated periods each year to run organised engagement in planning with the involvement of Suffolk Healthwatch. The two periods that best fit with our annual planning cycle are:

May – July  
Publication of refreshed strategic plans and annual commissioning plan. Engagement in specific projects and implementation plans. Early engagement to inform plans for the subsequent year, Joint Strategic Needs Assessment and Health and Wellbeing Strategy.

Sept – Jan  
Report back on previous year’s outcomes. Engagement in proposals for the next annual commissioning plan and review of longer term strategy.

Following the success of the last ‘Patient Revolution’ event in June 2014, we will be holding other events on 15 July 2015. This ensures stakeholder input into our commissioning cycle and that the CCG has opportunity to feedback on how previous input was used.

The CCG will maintain open channels for service user and carer feedback on service quality and the patient experience. These include a range of routes, such as:

- service user and carer surveys and feedback questionnaires;
- informal and ad hoc reports from practices and local patient groups;
- reports from complaints, patient advisory and liaison services and information requests;

This type of feedback will link to the CCGs Clinical Quality monitoring function. Where possible, the CCG would aim to address issues and resolve problems as quickly as possible as part of our day to day work, as well as considering an analysis of feedback in regular performance and quality reports.

4.1.1 Introduction

The following section sets out the CCG’s commissioning intentions for 2015/16 and beyond. The detailed projects which support these intentions and which will continue to provide high quality, sustainable and efficient services to the local population are set out in Section 6. Whilst the Commissioning Intentions are
4. Commissioning and Planning

focussed on the radical pathway redesign in 2015/16, these have been developed with due consideration of the substantial efficiencies that will also need to be realised in 2016/17 and beyond.

The Commissioning Intentions letter sent to providers signals the start of the contracting process and is designed to:

- outline the CCGs strategic direction;
- give advance warning of changes, opportunities and threats to Providers.

It should be noted that there are existing projects and programmes of work that the CCG will continue to implement and develop with providers. The letter does not include on-going review of existing contracts for services which are a recurring requirement. The focus of the letter is to signal either a new or extension of existing developments that will be a priority in 2015/16.

These intentions have been developed by the Chief Contracts Office (CCO) with lead GPs working on the Clinical Executive of the CCG. The GPs leading the clinical workstreams will be steering the development and implementation of these intentions in 2015/16.

The CCG and the west Suffolk healthcare system are facing significant financial challenge over the next few years. This is due to a real term reduction in funding allocation coupled with an increase in demand for both elective and non-elective activity. This financial pressure will result in an increased level of scrutiny that will be applied to spend, activity and commissioned pathways going forwards.

4.1.2 Strategic Vision

The CCG is working with NHS Ipswich & East Suffolk CCG to develop a joint health and care model that will deliver the Health and Wellbeing Board vision and create a health and care system that delivers excellent services for people in Suffolk which is effective and sustainable.

Through its six clinical priorities (set out below), the CCG is 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.

The CCG has developed six clinical priorities as set out below which will help deliver its ambition:

- develop clinical leadership;
- demonstrate excellence in patient experience and patient engagement;
- improve the health and care of older people;
- improve access to mental health services;
- improve health and wellbeing through partnership working;
- deliver financial sustainability through quality improvement.

Working as part of the Suffolk 'system', including all our local health services, care services, district and borough councils, Suffolk County Council (SCC), our local GPs and our voluntary sector and communities, the CCG will provide determined leadership to create a different system - one that works for our customers and patients, and that is financially sustainable.

The CCG has worked hard to engage with our local patients and stakeholders and their feedback has influenced our strategic and operational planning, of which these commissioning intentions are part.

1. Health and Care Service Model

Since November 2013, the CCG and Ipswich and East Suffolk CCG have worked closely with partners, in particular Suffolk County Council (SCC) and Healthwatch, to engage the wider Suffolk community on the future of health and social care services in west Suffolk and east Suffolk.

A review of the above feedback, local experience, national policy and evidence has identified a number of key themes which have been progressed in the service redesign:
4. Commissioning and Planning

- the health and care system should empower individuals to take a more proactive role in managing their care, including the prevention of ill-health;

- from the individual’s perspective, the system’s response must be more integrated. Many patients have complex needs which require close operational co-operation between professionals from different backgrounds, organisations and the wider community.

This includes improving the access routes into the system, such that the professionals in first contact with patients have the necessary knowledge of both the individual’s history and how to work closely with other professionals and organisations to provide the most integrated and efficient response leading to best outcomes.

- the emergency departments of both hospitals are under severe pressure, and the system needs to ensure that their expertise is focused on genuine emergencies. This is especially important given the national shortage of emergency medicine consultants acknowledged by Health Education England in their December 2013 report.

These themes have been incorporated into the system design, and included the following features:

- the major building blocks of the new system will be Integrated Neighbourhood Teams. Social care, community health services and some aspects of mental health services will be organised and delivered at neighbourhood level, serving the population of an average of four general practices and mindful of natural geographic factors. In particular, there will an increased emphasis on the teams managing their populations in a systematic way, using risk stratification tools to identify the individuals at higher risk, and placing care plans which are joint between all relevant agencies. Some individuals will be sufficiently complex to require a case co-ordinator; the most appropriate person for this role will depend on the team’s view on which professional is most appropriate to that individual’s needs;

- communication between healthcare professionals will be improved. One component of this is commissioning an NHS 111 service that goes beyond the national minimum requirements. In particular, there will be a dedicated line for professionals to access a strengthened Directory of Services (DoS) that will allow them to link them to partners; for example, a paramedic attending a patient who needs care will be able to access community alternatives to hospital treatment. For patients calling NHS111, their service experience will be improved by stronger clinical support;

- services at the acute trust will be strengthened by a significant primary care presence. The Primary Care Foundation, College of Emergency Medicine and Royal College of General Practitioners all agree that a significant proportion of patients present to Accident and Emergency with a primary care problem, in good faith that they consider themselves to have an urgent or emergency problem. The national term for this element is an Urgent Care Centre, and it will help to protect scarce emergency centre expertise and there will be an increased emphasis on moving patients into the community rather than hospital beds.

2015/16 will be about working towards this system reform and redesigning the way health and social care systems work

ii. Clinical Strategy and Priorities

In order to achieve its key priorities, the CCG has organised the workload into four key workstreams:

- Integrated Care (incorporating unplanned, emergency, continuing health care, and ‘end of life’ care);
- Planned Care (incorporating elective and cancer care);
- Mental Health, Children and Young People (incorporating maternity care);
- Medicines Management
4. Commissioning and Planning

These are supported and facilitated by strategies focusing on prevention (with Public Health and SCC), Primary Care, information technology and workforce planning. The key focus for the workstreams is set out below. Details of the specific schemes are shown in Section 10.

4.1.3 Clinical Workstreams

Integrated Care

This CCG workstream focusses on partnership working to support the shift from a reactive fragmented model of health and care delivery towards one that is more proactive, holistic and preventive. The workstream has prioritised the following strands of work:

- managing emergency admissions with a focus on developing and improving access to a wider range of alternatives to A&E including ambulatory care, sub-acute care models and admission avoidance services;
- integrating health and care services on a locality basis with a focus on proactive care through implementing risk stratification, multidisciplinary teams, joint care planning and care coordination;
- implementing an integrated approach to care delivery through the pooling of health and care budgets;
- supporting more people to die with dignity at their preferred place of death;
- supporting people to self-care including increasing use of assistive technology.

Planned Care

The overarching aims of the workstream are to provide local integrated services through shared decision making, support and access to patient centred and holistic services. To achieve these aims, the Planned Care workstream will take forward three strands of work:

- **strand one**: GP Practice support and referral refinement - focus will be on education and guidance across the health system and in a multi-faceted approach that recognises clinical and patient choice;
- **strand two**: Optimisation of current services – ensuring that current services are achieving maximum outcomes and seek further opportunities;
- **strand three**: Transformation of services into the community – continued roll out of community services and exploration of further opportunities.

Planned Care (High Cost Drugs and Devices)

The CCG will ensure that there is a consistent, evidenced-based, cost-effective commissioning programme for the implementation of all tariff excluded high cost drugs and devices. This will mean that only the excluded drugs and devices commissioned are those where a consistent body of evidence exists for a specific indication and will require collaboratively working with Providers to identify and implement changes which provide more cost effective pathways for the local health economy.

Planned Care (Cancer)

Cancer sits within the Planned Care workstream and will build on the work programmes in 2014/15 and develop further areas in 2015/16. This will be done by ensuring that cancer care provision is open and accessible to all within the west Suffolk locality.

Focus will be on supporting cancer survivors and improving cancer survivorship, providing care closer to home and providing up-to-date, quality and personalised cancer information – linking with the Shared Decision Making process (SDM).

Mental Health

The overarching aims of this workstream are:
4. Commissioning and Planning

- to ensure that 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;
- to improve access to mental health services for all, simplifying entry and reducing incidents of patients being ‘bounced’ around the system and promoting parity of esteem with patients with physical health needs;
- greater integration of specialist mental health services and learning disability services with the wider health and social care system, specifically in the area of urgent and crisis care;
- to ensure we embed the principle of co-production and working closely with users;
- redesigning and promotion of community based services and supported accommodation to reduce the levels of dependency on bed based care within the system;
- reviewing and improving wellbeing services specifications with a view to re-commissioning the service which is currently due to expire in July 2016;
- evaluating the psychiatric liaison services in West Suffolk NHS Hospital Foundation Trust (WSFT) and take a view jointly with WSFT on the re-commissioning or de-commissioning of this Commissioning for Quality and Innovation (CQUIN) pilot as a recurrent service.
- supporting recovery and rehabilitation through a joint review with SCC of mental health interaction with rehabilitation, employment and housing services;
- responding to the Suffolk Joint Mental Health and Learning disability Commissioning Strategies expected to be completed by March 2015);
- reviewing and potential commencement of re-commissioning of the specialist marginalised and vulnerable adults service to commence in March 2016:

The CCG will continue to engage and liaise with local clinical networks and the managed Clinical Networks organised by NHS England in order to identify best practice and share learning with our peer group in Suffolk across the East of England.

Children and Young People and Maternity

- the focus of the Children and Young People’s and Maternity workstream will be in the following areas:
  - promoting early intervention and prevention approaches;
  - improving multi-agency/ professional working based around the child and family;
  - re-commissioning of specialist community paediatric medical, nursing and therapy services and improved integration of those with the wider health, social care and education system;
  - improved outcomes for vulnerable groups such as Looked After Children (LAC);
  - reviewing emotional health and wellbeing services including the newly commissioned primary mental health workers and autism services;
  - exploring opportunities for better integration of tier 3 and 4 CAMHS services;
  - development of personal health budgets in accordance with national guidelines;
  - work with the commissioned Young Persons Ambassador and CCG Community Engagement Group (CEG) to identify and respond to issues arising and ensure principles of user co-production are followed in service development and redesign;
  - continued management of paediatric asthma, epilepsy and diabetes, specifically community pathways and non-elective activity.

The above priorities will be achieved through working closely with our partners, in particular with SCC, Norfolk and Suffolk Foundation Trust (NSFT) and the members of the West Suffolk CCG Paediatric Strategy Group and Regional Children, the Young People and Maternity clinical Network and the voluntary sector.

We will:

- work with NHS England to ensure criminal justice and offender health services are integrated with CCG commissioned services;
- continue the development of mental health payment mechanisms including the definition of care packages with NSFT and partnering commissioners;
- develop personal health budgets in accordance with national guidelines.
- these key priorities will be delivered with partners particularly WSCCG, SCC and through the establishment of local networks.
4. Commissioning and Planning

Medicines Management

The Medicines Management workstream will focus on:

- completing work commenced in 2014/15 on improving the communication around and monitoring of Shared Care Agreements (SCA);
- working with primary care providers to improve the quality and safety of prescribing;
- promoting adherence to the Traffic Light System (TLS), as developed by the Suffolk CCGs’ Drug and Therapeutics Committee and Clinical Priorities Group (CPG);
- aligning actual prescribing spends with practice prescribing budgets.

Primary Care

The CCG will work with NHS England as the main commissioner of primary care to ensure primary care contracting is joined up. The overarching intention is to ensure that there is access to high quality, sustainable, primary care services which work as part of an integrated system helping people stay healthy and providing proactive, coordinated support particularly for people with long term conditions.

Focus will be on the following areas:

- implementing Reporting Analysis and Intelligence Delivering Results (RAIDR) which is a system that enables practices to review data relating to their patients and in particular to identify those most at risk of admission. This will be fully rolled out by the end of 2015/16;
- implementing ‘Map of Medicine’ to facilitate GPs making referrals consistently in line with local guidelines;
- increased the new e-referral process;
- developing an approach to co-commissioning that will facilitate the delivery of high quality care, more flexible provision and enhanced joint working with partner organisations in neighbourhood teams.
- ensuring flexibility and resilience through winter to cope with surges in demand;
- reviewing and revising the existing list of contract enhancements - The GP practices will be commissioned to provide funded, targeted interventions previously called Local Enhanced Schemes (LES); These incentive schemes are reviewed annually and subject to the outcome will either be terminated or developed further in 2015/16.

4.1.4 Public and Patient Involvement

This year we will continue to offer opportunities for patients and the public to have their say in how we plan our work. This year we have:

- further developed members of the Community Engagement Group, which is a sub-committee of the CCG Governing Body;
- worked with partners to go out to the six market towns to hear people’s views – firstly in autumn to discuss general items and secondly in spring to focus on young people and mental health;
- hosted the third Patient Revolution event, at which 170 people from the community came to share their views on services;
- grown our Health Forum membership by another 200 so that we have 500 people we are in contact with, sharing information and encouraging involvement.

In the future we will:

- continue to aim to ensure all service areas have patient and public representation to meaningfully affect commissioning intentions in the future;
- improve our social media use, to share information and encourage debate;
- work on our voluntary sector strategy to improve on our partnership workings
4. Commissioning and Planning

4.1.5 Patient Safety and Quality

Patient Safety

The CCG commits to work as part of the local Patient Safety Collaborative which is being established as a further response to the report, A Promise to Learn – a commitment to act, which made a series of recommendations to improve patient safety; and called for the NHS "to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end."

The CCG further endorses the aim of the ‘Sign up to Safety’ campaign to make the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement.

Quality and Patient Experience

Valuing mental health equally with physical health is a theme of NHS England’s Call to Action. Achieving ‘parity of esteem’ will require a fundamental change in the way services are commissioned. Consideration will need to be given to equitable distribution of resources and supporting the commissioning of services which tackle the association between physical and mental disorders. The CCG is working on the key priorities of services for Improving Access to Psychological Services (IAPT), dementia and the application of the mental capacity act to address parity of esteem objectives.

4.1.6 Promoting Healthy Outcomes

In partnership with Public Health and Suffolk County Council, the programme aims to improve population health by focusing on prevention to limit the onset, or reduce complications of conditions such as diabetes, cardiovascular disease, other long term conditions and some cancers which are associated with lifestyle. It aims to provide an evidence based approach to deliver health improvement and reduce health inequalities by decreasing the gap in life expectancy and adding life to years. It will:

- ensure that the alcohol services commissioned by the CCG work seamlessly with the new integrated services commissioned by Public Health expected to start in April 2015;
- review the obesity pathway and weight management treatment services ensuring all patients flow through a tiered programme of care to improve the quality of interventions for those requiring bariatric care;
- work with Public Health and others in SCC to ensure that prevention is embedded into our integrated care approach. We will look at co-commissioning opportunities as Public Health re-procures the current lifestyle service;
- ensure that maternity services increase the mothers and babies benefitting from breast feeding and also supporting mothers to start.

4.1.7 Market Reviews

A number of procurements have been undertaken by the WSCCG during 2014/15 and there continues to be a flow of tenders to be released. Services for procurement include

<table>
<thead>
<tr>
<th>Service</th>
<th>Likely tender start*</th>
<th>Service Implementation Date*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homecare–joint procurement with SCC</td>
<td>Autumn 2014</td>
<td>Summer 2015</td>
</tr>
<tr>
<td>Out of Hours</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td>111</td>
<td>tbc</td>
<td>tbc</td>
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<tr>
<td>Urgent Care Integration</td>
<td>tbc</td>
<td>tbc</td>
</tr>
<tr>
<td>Musculoskeletal Services, including Physiotherapy</td>
<td>Autumn 2014</td>
<td>Early 2015</td>
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</tbody>
</table>
4. Commissioning and Planning

<table>
<thead>
<tr>
<th>Telederm services</th>
<th>August 2014</th>
<th>Autumn 2015</th>
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</thead>
<tbody>
<tr>
<td>Community Services</td>
<td>tbc</td>
<td>tbc</td>
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</tbody>
</table>

*These dates are subject to Governing Body approval*

There are further services with market review planned and/or specifications in development, these include:

- care homes;
- Myalgic Encephalomyelitis and Chronic Fatigue Syndrome;
- autism services;
- child and adolescent mental health services;
- improving access to psychology therapies/ Suffolk Wellbeing Service;
- marginalised and Vulnerable Adults Service

4.1.8 Notice Periods and Contract Renewal

The CCG will apply reasonable notice periods in line with contractual requirements where significant change is anticipated. The CCG has in the region of 200 health service contracts. Each of these has an expiry date and the CCGs’ constitutions and the emerging changes to procurement law mean all renewals should be scrutinised by the CCG in order to make decisions about whether contracts are to be decommissioned, tendered or extended. In 2014/15 a number of key contracts will require renewal. Many of the contracts are Suffolk wide. Should the CCG decide on a different direction of travel there will need to be a mutually agreeable solution or whether there will be a divergence and contracts split.

4.1.9 Lead Commissioning Arrangements

The CCG anticipates working closely with Ipswich and East Suffolk CCG in particular to ensure a coherent approach to commissioning is maintained. The CCG intends to continue with the lead commissioning arrangements agreed in 2014/15. As with current multilateral contracts there may be variations to the schedules within those contracts to reflect the differing priorities of each group and a separation of the budget elements to each CCG.

In most cases the CCG will seek to enter into associate agreements with other CCGs outside of Suffolk where other CCGs geographically host the service in question.

The CCG is a member of the Suffolk Commissioner’s Group. This forum works collectively to deliver a joined up approach to commissioning Suffolk services for delivery of elements of the joint Health and Wellbeing Strategy and other areas of agreed joint working as appropriate. The Group will work in 2015/16 to agree plans to deliver the joint strategic aims where cross organisational commissioning is required and to deliver system leadership in the optimum use of resources to deliver the best overall outcomes for Suffolk residents. This approach allows strategic alignment with SCC in particular the Section 256 for reablement.

The CCG is also a member of the Suffolk Leaders Partnership (SLP) which exists to provide system leadership for delivery of elements of the joint Health and Wellbeing Strategy. The SLP will be a key system enabler to drive the delivery of programmes for 2014/15.

4.1.10 Other national and local initiatives

The CCG will implement the National Operating Framework requirements when issued by NHS England. The Operating Plan identifies what CCGs must deliver on a number of key outcomes, including commissioning for local need, demonstrating clear alignment with national requirements and to provide evidence that major strategic change programmes will be delivered. The Operating Plan is underpinned by the national allocations and provides a clear framework for the negotiation of all provider contracts.

4.1.11 Activity Levels

The CCG will undertake the following, dependent of type of Provider and contract type:
4. Commissioning and Planning

- review of local tariffs (incl. introduction of a short stay tariff for patients with mental health diagnoses);
- evaluation of the Clinical Decision Unit (CDU) at WSFT;
- evaluation of funding streams outside of contract;
- evaluation of virtual clinics;
- review the non-mandatory funding of Outpatient Procedures;
- review day case procedures expected to be undertaken as outpatient procedures by specialty and specify commissioning levels and require compliance with national guidance over recording of day cases versus outpatient procedures and recording of short stay non elective admissions versus outpatient or appropriate ambulatory care tariff.
- review of block contract and possible moves to cost & volume (incl. service specs for all services);
- review of short stay admissions and whether any should be ward attenders (recorded and paid as an outpatient attendance)

Where appropriate, the Provider will be required to be compliant with 2015/16 National Tariff guidance and national data definitions, and:

- develop pathways for outpatient services to achieve maximum efficiency and quality of care, e.g. one-stop clinics, multidisciplinary clinic, parallel clinics and triage to most appropriate clinics;
- identify potential services eligible for Best Practice tariffs and agree plans/timetable for introduction (must have adequate supporting information);
- review of tariffs for emergency care which may require local tariffs to be developed and agreed

4.1.12 Performance Data / Information

For all contracts the CCG intends the following:

- continued on-going compliance with the reporting requirements of UNIFY2 and SUS, which includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre Guidance and All Information Standards Notices (ISNs), where applicable to the service being provided;
- where the provider is part of a multi provider pathway then the provider will be expected to proactively participate in the development of integrated information flows that are consistent, complete and timely and compliant with all mandatory data items;
- any accountable provider who sub contracts out to other providers should provide evidence and assurance to the CCG that their contracts and schedules with the sub contracted provider are consistent with their contract with the CCG, so that all providers can be held accountable on the same basis;
- proactive participation in the provision of daily information to support the system wide urgent care dashboard;
- submission of any patient confidential data to the DSCRO (Data Service for Commissioners Regional Offices) Timetable

For any new Community Contract the CCG requires the following:

- completion, as a minimum, of the Community Information Dataset and on-going development to ensure that the provider is able to submit the Community Information Dataset to SUS and as an interim measure will be able to submit it locally to WSCTG through the DSCRO;
- where statutory reporting is required to UNIFY2, Choose & Book, Omnibus, Open Exeter and other statutory reporting for a then the Provider should ensure that they are N3 compliant.
- compliance with ISN 0149- where completion of NHS Numbers is a mandatory requirement.
4. Commissioning and Planning

4.1.13 Informatics Strategy

Healthcare can be delivered more efficiently and seamlessly for patients when shared electronic health records, infrastructure and information are deployed widely across care settings, and this is the best way to provide integrated care, particularly for the most complex or vulnerable patients. We will support this whole systems approach by leading the Suffolk Informatics Partnership, which, in the interests of patient care and effective, efficient integrated working, commits to:

- promoting and advancing integration and interoperable information sharing capability;
- ensuring security and information governance is central to this programme, and overcoming obstacles that prevent progress;
- developing a network of integrated and accessible public services infrastructure.

In particular we will be working will all providers to progress the Suffolk Shared Care Record, ensuring that agreed plans for shared records to be available at the point of care are delivered.

Underpinning our Informatics Strategy is the need for fit for purpose IT Service Management. We intend to undertake procurement of redesigned IT services, and transition to a new way of working in 15/16.

4.1.14 Workforce

The commissioning of local services will need a workforce fit for purpose, as we change the shape and delivery of services moving them closer to patients’ homes where necessary.

The workforce will need to be highly flexible to respond to changes in how healthcare is delivered in Suffolk. As services across health and social care become integrated and delivered in a more flexible way in the community, providers and commissioners need to work together and, as appropriate 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 where the provider can demonstrate that they have a robust workforce plan, education and training strategy that delivers an appropriately skilled and competent workforce that provides high quality and safe services for patients, carers and families.

The CCG’s workforce plans will be triangulated with providers on receipt of Health Education England’s guidance, and will be submitted for national aggregation in accordance with national timescales.

Locally, Health Education East of England (HEEoE) - the Local Education and Training Board (LETB) was formally established in April 2013 as a subcommittee of Health Education England. HEEoE’s aim is to ensure the security of workforce supply and to continuously improve the quality of education, training and development in the east of England. It also aims to enable the health and care workforce to respond effectively to the needs of patients, carers and families.

Currently, there are nine priority areas which will deliver staffing and workforce plans that are affordable and aligned to local strategies for transformation:

- developing a health and social care workforce profile for Suffolk;
- integrated health & social care leadership;
- integrated Neighbourhood Teams – linking in with the workforce profiling and developing shared learning opportunities;
- integrated Re-enablement, Rehabilitation, Recovery;
- care Homes/Support to Live at Home Provider Training;
- apprenticeships / Rotational Apprenticeships / Worker Shadowing;
- multi-Disciplinary First Year Academy;
- shared Curriculum for health & social care linking with University Campus Suffolk (UCS);

The Suffolk Health and Social Care Workforce Planning and Development Forum are implementing a system to ensure that intelligence on existing or proposed service changes and related workforce activity are brought into one space in order to support and learn from good practice. It is through this mechanism that great ideas with the potential for adoption and spread will be identified, developed and shared.
4. Commissioning and Planning

Through the identification of ‘what works’, promotion of collaborative working, there will be a reduced demand on the health and social care workforce. The project will identify shared workforce development needs, jointly commission and evaluate opportunities for shared learning and this will create economies of scale and minimise duplication. This reduction in costs and non-productive travelling time will increase productivity and enable the professional to spend more quality time with the patient and would lead to corresponding reductions in avoidable admissions and appropriate safe early discharges from acute hospitals.
5. Improving Outcomes for Local People

5.1 Introduction

NHS England’s publication “Everyone Counts: Planning for Patients 2014/15 to 2018/19” sets out the scope of better outcomes for patients and the public (as set out in the NHS Operating Framework - Section 2.4 refers).

This section sets out the current position in relation to the measurable ambitions, or critical indicators of success, against which the CCG will aim to achieve significant improvement, and the actions the CCG will be undertaking to improve outcomes for local people.

5.2 Delivering the NHS Outcomes Framework

The CCG’s current position across the domains of the NHS Outcomes Framework is summarised below. The chart shows the distribution of CCGs on each indicator in terms of ranks. West Suffolk CCG is shown as a red diamond. The yellow box shows the interquartile range and median of CCGs in the same ONS cluster. The dotted blue line is the England median. Each indicator has been orientated so that better outcomes are towards the right (light blue).

The CCG performs better than the national average in all but five of the measures across the scope of the Outcomes Framework.
5. Improving Outcomes for Local People

5.2.1 Securing additional years of life for people with treatable mental and physical health conditions:

Reducing premature mortality is one of the overarching aims of the NHS. The CCG will have the most significant impact in reducing premature mortality by determining which contributing factors are of greatest impact to the local population. This analysis will continue to be undertaken jointly with Public Health.

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).

National comparison - Potential years of life lost (per 100,000 population)

![National comparison graph]

East Anglia comparison - Potential years of life lost (per 100,000 population)

![East Anglia comparison graph]

The CCG has the best performance in East Anglia and is in the lowest quintile nationally (Year: 2013). The CCG has set an improving trajectory through to 2018/19:
5.2.2 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 priority within the Health and Wellbeing Board strategy, and reflected in the CCG’s clinical priorities. Performance is measured through the national GP Patient Survey, based on the numbers of patients reporting they have a long term condition, together with indicators around the quality of life for such patients.

The CCG’s performance (shown in orange) is in fourth quintile nationally (2013/14) and one of the best against CCGs within East Anglia.

As part of the CCG’s strategy to integrate health and social care, there will be a focus on supporting the health and independence of individuals. This will focus on care for frail, elderly, people and those living with chronic long term conditions (including mental health) to ensure care and support is driven towards improving the quality of life for such people. The CCG has set the following trajectory through to 2018/19:

National comparison - Average health score (out of 100) for people with long term conditions

East Anglia comparison - Average health score (out of 100) for people with long term conditions
5. Improving Outcomes for Local People

5.2.3 Reducing the amount of time people spend in hospital by having better more integrated care in community;

Reducing the amount of time people spend in hospital relies on good management of long-term conditions across the health and care system to support people in managing long term conditions and to promote swift recovery and reablement after acute illness.

The CCG’s performance (shown in orange) for the number of avoidable emergency admissions is around the national average (2013/14), but is higher than many other CCGs within East Anglia for emergency admissions that should not usually require hospital admission (adults);

The CCG has set the following improving trajectory through to 2018/19:

National comparison - Avoidable emergency admissions (per 100,000 population)

East Anglia comparison - Avoidable emergency admissions (per 100,000 population)

Based on a composite measure of emergency admissions for acute conditions that should not usually require hospital admission (adults); unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults); unplanned hospitalisation for asthma, diabetes and epilepsy in children; emergency admissions for children with lower respiratory tract infection.
5. Improving Outcomes for Local People

5.2.4 Increasing proportion of older people living at home independently following discharge from hospital;

This is measured through the GP Patient Survey (Q32), which was published in January 2015. Data has been collected on two specific questions.

Do you have confidence in managing your own health?

<table>
<thead>
<tr>
<th>CCGs within East Anglia</th>
<th>% of Yes definitely &amp; Yes to some effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ipswich &amp; East Suffolk CCG</td>
<td>67</td>
</tr>
<tr>
<td>West Suffolk CCG</td>
<td>66</td>
</tr>
<tr>
<td>Norwich CCG</td>
<td>66</td>
</tr>
<tr>
<td>North Norfolk CCG</td>
<td>66</td>
</tr>
<tr>
<td>West Norfolk CCG</td>
<td>66</td>
</tr>
<tr>
<td>Great Yarmouth and Waveney CCG</td>
<td>65</td>
</tr>
<tr>
<td><strong>NHS England average</strong></td>
<td><strong>64</strong></td>
</tr>
<tr>
<td>South Norfolk CCG</td>
<td>64</td>
</tr>
<tr>
<td>Cambridgeshire and Peterborough CCG</td>
<td>64</td>
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</tbody>
</table>

In the last 6 months, have you had enough support from local services or organisations to help manage long-term condition

<table>
<thead>
<tr>
<th>CCGs within East Anglia</th>
<th>% of Yes very confident &amp; Yes fairly confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Norfolk CCG</td>
<td>95</td>
</tr>
<tr>
<td>West Suffolk CCG</td>
<td>94</td>
</tr>
<tr>
<td>South Norfolk CCG</td>
<td>94</td>
</tr>
<tr>
<td>Cambridgeshire and Peterborough CCG</td>
<td>94</td>
</tr>
<tr>
<td>Ipswich &amp; East Suffolk CCG</td>
<td>93</td>
</tr>
<tr>
<td><strong>NHS England average</strong></td>
<td><strong>93</strong></td>
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<tr>
<td>West Norfolk CCG</td>
<td>93</td>
</tr>
<tr>
<td>Great Yarmouth and Waveney CCG</td>
<td>93</td>
</tr>
<tr>
<td>Norwich CCG</td>
<td>92</td>
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</tbody>
</table>

5.2.5 Increasing the number of people with physical and Mental Health conditions who have a positive experience of hospital care; and, positive experience of care outside of hospital, in General Practice and in the community

The CCG’s performance for the proportion of patients reporting a ‘poor’ experience of hospital care is one of the lowest in England (2013)
5. Improving Outcomes for Local People

Comparative performance for the proportion of patients reporting a ‘poor’ experience of care in General Practice

The CCG has set the following trajectory - ‘poor’ experience of hospital care:

The CCG has set the following trajectory - ‘poor’ experience of care in General Practice

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

Patient Safety Incidents

Research shows that organisations which regularly report more Patient Safety Incidents (PSI) usually have a stronger learning culture where patient safety is a high priority. Patient safety incidents are any unintended or unexpected incidents that could have, or did, lead to harm for one or more persons.

West Suffolk hospital sits in the middle 50% of reporters when compared to similar small acute organisations, with 7.28 incidents reported per 100 admissions, in line with the median rate.

An analysis of the types of incidents reported during the period October 2013 to March 2014 is shown on the graph below.
5. Improving Outcomes for Local People

This shows that West Suffolk hospital has broadly the same reporting profile of similar small acute organisations. However, reporting of incidents relating to:

- ‘implementation of care and ongoing monitoring/review;’
- ‘treatment, procedure;’ and
- ‘medication’

are above average.

Comparative reporting per 100 admissions for small acute organisations

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 1 October 2013 and 31 March 2014. Your organisation reported 2,008 incidents (rate of 7.28) during this period.

Figure 1: Comparative reporting rate, per 100 admissions, for 28 small acute organisations.

The median reporting rate for this cluster is 8.77 incidents per 100 admissions.
Incidents reported by degree of harm

The graph above shows the profile of incidents reported and by their degree of harm. At West Suffolk hospital, 85.8% of incidents resulted in no harm to the patients (against a national average of 69.3%), with less than 1% per cent resulting in severe harm or death.

The CCG routinely scrutinises information and metrics relating to patient safety, including the Safety Thermometer, never event and serious incident data and the other quality metrics. This will aid the identification and consideration of emerging themes and trends in patient safety and harm. The CCG will cooperate with, and participate 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 be actively promoted by the CCG through contractual and quality improvement discussions with providers and stakeholders. Monitoring of the levels of reporting through the NRLS system and through Serious Incident reporting routes will support the NHS Outcomes framework aim of ‘higher reporting and the emergence of diminishing levels of harm…through the application of best practice and innovative approaches to service delivery. e.g. pressure ulcer prevalence.

The acute contract with WSFT will place a responsibility on the provider to report all patient safety incidents on a monthly basis. This will be reviewed and monitored at monthly Quality Monitoring meetings, with contractual levers applied where appropriate.

Medication-related safety incidents

Medication incidents are PSIs which actually caused harm or had the potential to cause harm involving an error in the process of prescribing, dispensing, preparing, administering, monitoring or providing medicines advice.

For the period, October 2010 to March 2013, West Suffolk NHS Foundation Trust reported 197 medication-related errors, slightly above the average for similar small acute trusts (194). For the last reporting period October 2013 to March 2014 West Suffolk NHS Foundation Trust reported 261 medication related safety incidents compared to the average of its peer group small acute trusts of 213.
5. Improving Outcomes for Local People

National guidance requires commissioners to agree a specified increase in the level of reporting with providers. By improving reporting in the short term, providers and commissioners can build the foundations for driving improvement in the safety of care received by patients.

The contracts with main local providers will set out the requirement for the reporting of every medication errors each month via the Clinical Quality Performance Report (CQPR). The CQPR report will include details of the level of harm associated with all incidents of medication errors.

**Number of medication-related errors reported (Oct 12 to Mar 13).**

The CCG has agreed a 2% increase in reporting of medications across providers in 2014/15, based on a review of the current National Reporting and Learning System (NRLS) data and in discussion with the CCG Medicines Management team.

**C.difficile and MRSA**

NHS England has published Clostridium difficile infection objectives for acute trusts and CCGs for the financial year 2015/16. These objectives have been calculated on the basis of requiring continuous improvement from all trusts and CCGs, but also reflect a need for organisations with higher rates of infections to do more than those organisations with lower rates.

C.difficile objectives for the CCG in 2015/16 is set at a ceiling of 45 cases. There is a ‘zero-tolerance’ approach to MRSA cases.

The trajectory to achieve this, together with historic performance is set out below:

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<th>E.A.S.5</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
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<th>Feb</th>
<th>Mar</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-16 Plan- CCG</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>4</td>
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<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>45</td>
</tr>
</tbody>
</table>

The CCG is currently undertaking an option appraisal on the best model for the CCG to progress the reduction of C. difficile and MRSA through the infection control processes that are in place. The main points are:

- a new process for following up specific cases in primary care was developed in 2014 and aims to increase the local ownership by GPs;
- there is a lead GP for Ipswich and East and West Suffolk CCG who will champion the Infection Prevention and Control agenda in GP services;
5. Improving Outcomes for Local People

- the CCG will develop proactive and innovative changes aimed at joining up infection prevention expertise to support improvement in patient outcomes for all Suffolk stakeholders in healthcare. The CCG will work with Suffolk County Council in the oversight of safe healthcare services for the Suffolk population;
- the CCG will have a high level Care Home network which will include a link to residential care services. These groups will encompass infection prevention within the broader remit of the CCGs quality and safety agenda for commissioned continuing care and OOHs services. The lead for Infection Prevention & Control in Suffolk County Council will take responsibility for residential care infection prevention issues in conjunction with Public Health England and supported by the CCG on relevant areas.

The CCG will continue to optimise the use of root cause analysis of all incidents relating to MRSA and C difficile to identify lessons learned and action required to prevent recurrence. This includes the monitoring of the C.difficile action plans from provider organisations through the quality and contractual monitoring routes. The CCG also participates in quality surveillance groups to identify early warnings of service and quality failings in order to address the risks to patient that could potentially arise.

The CCG are also exploring models of screening with other CCGs who have adopted specific approaches to the detection of C.difficile cases and this has been discussed by the CCG’s Executive and will be considered further with providers in developing their current plans.

5.3 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 over the medium term, and sets out a five-step framework intended to support CCGs in commissioning for effective prevention:

![Five-step prevention framework](image-url)

The CCG will proactively work with Health and Wellbeing Board partners, utilising the principles outlined in the above framework, to deliver the Health and Wellbeing Strategy (http://www.transformingsuffolk.co.uk/partnerships/suffolk-health-a-wellbeing-board), including those areas of the strategy focusing on health improvement and prevention. The CCG will actively contribute to the work to:
5. Improving Outcomes for Local People

Decrease the harm caused by alcohol to individuals and communities by:

- ensuring that acute trusts assess alcohol intake and provide brief interventions to their patients where appropriate. We will expect at least one member of staff per ward to be trained in assessment and brief intervention;
- working jointly with NHS England to ensure that those GPs signed up to the alcohol DES offer appropriate brief intervention and referral where the alcohol tool assesses the need;
- working with Suffolk County Council to ensure comprehensive treatment services are available to the population and are aligned to services commissioned by the CCG in particular mental health, where there is significant overlap of client groups.

Decrease the prevalence of smoking by:

- ensuring acute trusts identify smoking status and refer smokers to stop smoking services;
- working jointly with NHS England to encourage GPs to actively take up the Suffolk County Council contract for level 2 stop smoking services.

Increase the prevalence of breastfeeding by:

- ensuring the CCGs commissioned services and primary care work in partnership with the PH funded home visiting support

5.4 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 independent Acheson inquiry (1999) into inequalities in health highlighted the main determinants and how to address them. The CCG, working closely with Health and Wellbeing partners, including Public Health, have built on these findings to support the groups of people in west Suffolk that have worse outcomes and experience of care (identified in Section 3 (pg. 16-20)). This focused piece of work is aimed at closing the gap in inequalities by targeting initiatives to groups with lower life expectancies.

With our partners, the CCG is working on the implementation of the three most cost effective high impact interventions recommended by the National Audit Office report on health inequalities:

- increase the prescribing of drugs to control blood pressure by 40 per cent;
- increase the prescribing of drugs to reduce cholesterol by 40 per cent:
  - Medicines management is promoting NICE guidance on the treatment of high blood pressure and cholesterol;
  - The control of blood pressure and cholesterol levels are included in QOF;
  - Complex medication reviews identify patients who are not treated optimally in their treatment of blood pressure and cholesterol;
  - Anomalies in the treatment of blood pressure and raised cholesterol are flagged by medicines management technicians to GPs.
- double the capacity of smoking cessation services:
  - reduce Health inequalities through working with NHS England and Suffolk County council to address the major factors contributing to increased risk of vascular disease by encouraging practices with low levels of level 2 smoking services to increase their activity. However it is recognised that the historical model of delivering stop smoking service and “quit measurement” has become less effective as the smoking population and environment has changed.

Smoking prevalence has decreased dramatically over the past decades but has stagnated recently. The numbers successfully quitting by using NHS services has
5. Improving Outcomes for Local People

decreased national, many current smokers have tried and failed to quit through current services on more than one occasion and the availability of e-cigarettes has influenced smoking behaviour in some people. The CCG will support the new approach to smoking agreed by the HWB focusing on prevention, protection and cessation.

The CCG is also 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 West Suffolk’s diverse population and communities to inform its work;
- the CCG will improve the way that the Governing Body and Executive 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.

5.5 System-wide Prevention Strategy

In addition the CCG will support the development of a system wide prevention strategy led by Public Health and overseen by the system leaders partnership and Health and Wellbeing Board. This work aims to reduce demand through reducing need and in the first instance will focus on ensuring good uptake of Making Every Contact Count (MECC) and workplace health. During 2015/16 a comprehensive strategy aimed at improving health and decreasing health inequalities will be agreed.

5.6 Implementing EDS2

The Equality Delivery System (EDS) was originally rolled out to the NHS in July 2011 and has now been refreshed as EDS2. The main purpose of the EDS is to help local NHS organisations, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the Public Sector Equality Duty (PSED).

The CCG has committed to using EDS2. It has used the EDS to refresh its equality objectives in September 2013 with the help of members of staff and communities representing diverse groups. The CCG’s Equality and Diversity Strategy 2012–2015 details how we will work to ensure we meet and exceed our requirements under the Equality Act 2010. This strategy will continue to be developed. For example, in April 2015, the
5. Improving Outcomes for Local People

CCG expects the national NHS Workforce Race Equality Standard (see below) and will review inclusion of its principles against our EDS2 work. The CCG’s equality objectives are:

- 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 west Suffolk’s diverse population and communities to inform its work;
- the CCG will improve the way that the Governing Body and Executive 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.

The CCG engaged with individuals and organisations representing diverse groups during the EDS grading exercise and during the development of our equality objectives and the associated action plan. Groups included: Healthwatch Suffolk’s Black and Minority Ethnic (BME) and diversity subgroup; the Suffolk lesbian, gay, bisexual and transgender (LGB&T) advisory group; the Suffolk Joint Diversity Working Group; the Gypsy and Traveller Health Subgroup; and, the Suffolk Disability and Health Action Group. The CCG also involved its Community Engagement Group, which includes members from a diverse age range. Dialogue with these groups is ongoing, with meetings every few months to ensure we continue to feed their voices into the CCG’s work.

The CCG also engage with the wider diverse community by having a presence at events such as the Indian Mela, Suffolk Pride and student events at West Suffolk College. Working with Suffolk’s Young People’s Health Ambassador, we plan to hold a series of youth engagement events during the Easter holidays to raise awareness about the services on offer to young people in the area.

Working with our main healthcare providers on their EDS work, the CCG will be an important part of ensuring access for minority groups is improved. This will include, for example; reviewing our process for equality analysis, to ensure any access issues are picked up at the earliest stage and, ensuring our providers have suitable systems in place such as interpreting and translation services. One example of some recent work done to make services more accessible to our migrant communities has included producing basic information about how to access local health services available in ten different languages. This information has been distributed through local Eastern European and Portuguese shops and cafes, as well as to places such as libraries and employment agencies across west Suffolk.

The CCG is currently implementing the action plan for its four equality objectives and has reviewed progress against these in December 2014. Since the introduction of the EDS2, the CCG has been working with local NHS partners to determine if future joint-working will be beneficial.

This year also sees the rollout of the Marginalised and Vulnerable Adults (MVA) Service into West Suffolk. This service helps facilitate access to primary care for six identified communities:

- homeless people;
- refugees and asylum seekers;
- migrant workers;
- ex-offenders;
- gypsies and travellers;
- other black and minority ethnic communities.

As well as helping these groups into the health system by registering with a GP, the service also provides some outreach healthcare to some of the groups listed above. The MVA service makes use of a telephone interpreting service as well as face-to-face interpreters to ensure it is accessible for people who do not speak English as a first language.

5.7 NHS Workforce Race Equality Standard

The Equality and Diversity Council (EDC) have agreed that a Workforce Race Equality Standard (WRES) be consulted on, with a view to it being included in the NHS standard contract 2015/16.
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The WRES will, for the first time, require organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation. All providers, as holders of the NHS Standard Contract 2015/16, will be expected to implement the WRES from April 2015.

There are nine metrics. Three of the metrics are specifically on workforce data and five of the metrics are based on data from the national staff survey indicators. The latter will highlight any differences between the experience and treatment of white staff, and BME staff in the NHS with a view to close those metrics. The final metric requires provider organisations to ensure that their Boards are broadly representative of the communities they serve.

Further detailed guidance is due to be published in 2015. The CCG will respond in accordance to that guidance.

5.8 Mental Health Parity of Esteem

The CCG is fully committed to ensuring an equal focus on improving mental health as physical health and that patients with mental health problems do not suffer inequalities as a result.

The CCG’s overarching aims for mental health services are that:
- 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;
- commission 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.

5.8.1 The resources we are allocating to mental health to achieve parity of esteem

The CCG’s approach to embedding parity of esteem incorporates the following:
- understanding the needs and barriers for people with MH to access health care and developing our plans accordingly. These include:
  - learning from the Suffolk Mental Health Joint Strategic Needs Assessment
  - development of our Mental Health Strategy. This will be taken to the Suffolk Health and Wellbeing Board in May 2015.
  - co-production with Service Users:

The Mental Health Strategy has been co-produced through a series of eight service user led workshops which have developed the key themes of
  a. prevention and living well;
  b. crisis;
  c. recovery.

The CCG has also worked with the Suffolk Youth Ambassador commissioned by Health and Social Care to actively seek the views of children and young people particularly about stress experienced by young people.

We are embarking on a series of targeted consultation with children and young people in schools and local colleges about their health needs and concerns and this will include specific sessions on mental health. This work is part of our ambition to keep service user involvement in the centre of our future planning and help to reduce the stigma surrounding mental health.

- Ensuring equality of access to health and social care:
  - we are working together with Social Care and wider system providers through the shared agenda of the Mental Health and Learning Disability Joint Commissioning Board and agreeing common principles of investment through the Better Care Fund;
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- We continue to review the current joint commissioning arrangements with SCC including review of our mental health pooled fund between health and social care. This fund jointly commissions community based support services for people with mental health needs including accommodation, advocacy, carer support service user groups, information services and community resource services. We have agreed to extend our mental health pooled fund service contracts which were due to end in March 2015 until March 2017 in order to align contracts and ensure continuity of care and support to service users. During this time we will work with our third sector providers to review the specifications and make any updates which will support a better co-ordinated pathway of care for people in the community. We have also agreed to jointly appoint a dedicated pooled fund manager to help support the management of the contracts.

- The CCG are signatories to the Suffolk Crisis Concordat and are partners in developing the action plan for improving care for people in MH crisis. In response to priorities identified in our MH conversation events we have drawn down funding to:
  - Pilot an out of hours crisis support line provided by Suffolk MIND
  - Commission a crisis respite bed in Bury St Edmunds provided by Julian Support

These services will be evaluated with a view to mainstreaming them from 2016/17.

- The CCG’s main local mental health provider has undertaken a programme of radical service redesign in order to respond to the national requirements to achieve financial savings and we will continue to monitor the impact closely through our contracting arrangements including access and waiting time standards. This redesign has afforded the opportunity to modernise service delivery and we have been reviewing and updating the service pathway specifications. Where the CCG has identified areas of need, it has increased investment in 2014/15 including into memory assessment services, children and young people’s eating disorder services and children’s primary mental health workers.

We are currently reviewing commissioning priorities for 2015/16 and beyond to identify those areas into which we would like to make increased investment in line with the mandate from the NHS 5 Year Forward Plan. Priority considerations include:

- Mainstreaming and aligning our autism pilots for both adults and CYP to commission a single dedicated pathway.
- Mainstreaming our psychiatric liaison service.
- Rolling out the MH worker in police cars project which was piloted in Ipswich and East Suffolk in 2014/15.
- Developing a dedicated perinatal MH pathway responding to recommendations made by the review of provision by Sustain.
- Review and update our approach to suicide prevention
- Supporting the modernisation of LD services into a community based model

- The CCG are working with social care to review the current services for people with dementia and their carers and to propose a plan for aligning our commissioning to improve the pathway of dementia care particularly post diagnosis. This will include future commissioning arrangements from 2015 onwards to eliminate gaps, fragmentation and short term funding. Our plan is to have a new specification completed by July 2015. For 2015/16 we continue to re-commissioned community post diagnostic support from third sector providers in order to avoid service gaps whilst this review is under way. We are also engaged in a programme of work with primary care to encourage and support the identification and referral of people with diagnosis so that 67% of those people with dementia are identified and able to access post diagnostic support.

- The CCG has reviewed and evaluated the Psychiatric Liaison service in West Suffolk NHS Foundation Trust during 2014/15 to inform our future commissioning plans from 2015/16 onwards. The 2014/15 CQUIN for psychiatric liaison included extending the service to young people aged 13 – 18 and to address long term conditions. During 2014/15 the service has also piloted a focussed response in partnership with the WSFT obstetric department to...
support care planning for women with MH needs peri and post-natally, as well as targeted responses for people attending the hospital pain clinic, which we would look to develop further. We have prioritised the mainstreaming of the Service from 2015/16 onwards and will be working with the providers to further identify areas in to which the service will expand. These will support the CCGs planned care programme.

- Meeting the national access targets – the CCG is setting its performance trajectories for:
  - dementia diagnosis rates – to meet the 67% diagnosis against prevalence target
  - improving Access to Psychological Therapies access rates – 15%
  - and recovery rates – 50%
  - the proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who enter a course of treatment in the reporting period – 95% by April 2016;
  - the proportion of people that wait 6 week or less from referral to entering a course of IAPT treatment against the number of people who enter a course of treatment in the reporting period - 75% by April 2016

- Reprocurement of our Wellbeing Service in 2015/16 – the Suffolk Wellbeing Service which includes IAPT is due for reprocurement in 2015/16 and the CCG is working with partners including, Primary Care, Planned, Integrated and End of Life Care Leads, Suffolk County Council Adult and Children’s Services, to remodel the service so that it can focus on the whole life needs of people with mental and physical ill health in a seamless service between physical and mental health services and between primary and secondary mental health. The service model will be completed by July 2015 and the new service operational from 2016/17.

- In 2015/16, the CCG will look at the steps needed to develop our systems to be able to offer personal health budgets for people with mental health needs in line with national policy.

5.8.2 Identification and Support for Young People with Mental Health Problems

The CCG is working to improve mental health services for children and young people recognising that poor mental health starts in childhood. Initiatives include:

- perinatal and post mental health services: In 2014/15 we have taken part in the Sustain review of Perinatal Mental Health Services in Suffolk, and through our psychiatric liaison service have been testing a model of mental health support for women using maternity services in WSFT. In 2015/16 we plan to extend this approach through CQUINS with our acute and mental health trusts.

- in partnership with Social Care we have commissioned a team of primary mental health workers from April 2014 working with primary care, social care and schools to support children, young people and families. In 2015/16 we would like to further develop this service as part of a resilience hub model to develop a co-ordinated approach to the identification and support for children and young people across all providers.

- we have committed funding to address the service gap for children and young people aged under 18 with eating disorders and commissioned a new service which became operational in 2014.

- in partnership with East Suffolk we have drawn down funding for a support service in a dedicated venue for CYP aged 17 and 18, in partnership with Suffolk Mind and the YMCA. We will pilot this service in 2015/16 with a view to mainstreaming the function pending successful evaluation.

The CCG will support the national ambition for “two-thirds of the estimated number of people with dementia in England to have a diagnosis and appropriate post-diagnosis support”. The CCG will strive to deliver this locally by March 2016 through its local action plan. The CCG’s plans also include:
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- developing (during 2014/15) a comprehensive post-diagnostic service model for people with dementia and their carers for procurement in 2015/16. This work is being undertaken jointly with Ipswich and East Suffolk CCG and Suffolk County Council;

- we are currently re-modelling the Learning Disability services to meet the new service specification we have developed in partnership with Ipswich and East Suffolk CCG. This is for a new community-wide and modernised learning disability service to be commissioned in partnership between the CCGs and Suffolk County Council, and will support a move away from in-patient services to a community model of support. Community based link workers are planned to be operational from June 2015.

- working jointly with health and social Care commissioners to set out formally the scope and extent of joint commissioning arrangements and the governance underpinning them. This will include modelling of new community based rehabilitation pathways and remodelling of our mental health pooled fund;

- working closely with Norfolk and Suffolk Foundation Trust during as it further embeds its service redesign to implement its new operating model and achieve 20% savings by 2017. The CCG will continue to work with the provider to address any performance and contractual issues and to support them in their service redesign. Areas of particular focus will include:
  - in patient Services;
  - crisis care;
  - personality disorder;
  - substance misuse;
  - rehabilitation pathways;
  - implementation of Mental Health Payment by Results (MHPbR).

- investing additional recurrent funding from 2013/14 in response to identified service gaps, specifically in:
  - Adult and Youth Autism Services – pilot services in place no service for these areas. Investment £273k pa.
  - Children and Young Peoples Eating Disorder Services – service commissioned. Investment £184k pa.
  - Enhanced provision of Memory Assessment Services to ensure service resilience to meet the rising demographic. – service commissioned Investment £147k pa.
  - Improved Emotional Resilience for Children and Young People – PMHW service operational (see 2 below)

5.8.3 Access to Psychological Therapies

Evidence suggests that, where people with mental illnesses are able to access psychological therapies, this has a significant impact on their quality of life. Improving access to treatment for those with mental health illnesses is also a vital part of improving parity of esteem between mental and physical health.

The CCG is committed to improving access to therapies and improving access to treatment. Working with Norfolk & Suffolk Foundation Trust (NSFT), an action plan has been developed (Appendix C), specifically focusing on these areas. The CCG has planned to increase the numbers of patients accessing psychological therapies to 15% of the total number of people with depression or anxiety disorders, by March 2015, and to increase the number of people who have completed treatment and are moving to recovery to 50%. The action plan will underpin delivery of this.

The CCG will improve the delivery of psychological therapies for people with primary mental health needs as set out below:

- the Wellbeing Service includes Improving Access to Psychological Therapies and the target for the service for 2014/15 will be to achieve 15% access rates;
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- the specification for the Wellbeing Service includes the requirement to improve access for older people and their carers and the service will review progress on this area in 2015 and make necessary adjustments;
- the service delivers therapeutic support for people with long term health conditions;
- the three year contract for the Wellbeing Service will come to an end in July 2015 and the CCG will review the delivery of the service and redesign the specification to adjust delivery to meet the needs and requirements of our local population.

5.8.4 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.

The CCG continues to work in partnership with health and social care commissioners and statutory providers as key members of the Suffolk Joint Commissioning Group for Mental Health and Learning Disabilities, and the Children’s Joint Commissioning Group (which both report to the Suffolk Health and Wellbeing Board and support the delivery of the Health and Wellbeing Board Action Plan).

Through this, the CCG actively contributes to the planning and development of working arrangements which will directly benefit the health and wellbeing of people with mental illness and supports the Health and Wellbeing Board priorities, specifically in ensuring that people in Suffolk have the opportunity to improve their mental health and wellbeing. This includes ensuring that mental health is everyone’s business, not just health, social care and the voluntary sector but employers, education and the criminal justice system.

The CCG’s plans for mental health services will respond directly to the recommendations of the Suffolk Joint Strategic Needs Assessments, specifically focusing on the following:

- Mental Health (currently under production);
- Children’s Mental Health Needs Assessment 2013;
- Maternity Needs Assessment 2013;
- Dementia Needs Assessment 2013;
- Needs Assessment of Children with Communication Difficulties (2013);

The CCGs programme of work aims to support physical health needs including:

- development of the Suffolk Mental Health Strategy
- ensuring parity of esteem for mental health
- embedding the Improving Physical Health Care CQUIN with NSFT to reduce premature mortality in people with severe mental illness
- address the social components which cause poor physical health such as housing, employment, integration into society – our Plans for the Suffolk Wellbeing Service reprocurement and the Mental Health Pooled Fund specifically target the social components of ill health
- recognition that mental ill health often starts in childhood and through our early intervention for Children, Young People and their families work by joint working with partners on the action plan for the Children’s Emotional Wellbeing Group and the commissioning of primary mental health services and eating disorder services for children and young people together with improved post and perinatal mental health support for mothers
- early intervention to prevent mental health problems escalating through the access targets of the Suffolk Wellbeing (IAPT) Service and the remodelling of the service specification to include specifically targeted work at mental health and long term physical health conditions
- improving our crisis response to help prevent the escalation of mental health crises (better support) both in the community through the Crisis Concordat and to look after people with mental and physical health needs in our acute hospital.
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- developing an integrated post diagnostic service for people with dementia which supports the Suffolk Integrated Care programme to improve the system response to people with long term health conditions
- targeted work to improve the pathway of care for people with autism and learning disabilities
- we have commenced conversations with public health colleagues including Live Well Suffolk to see how the strategies for improving public health relate to people’s mental health. Suffolk Public Health is a partner in our Mental Health and LD Business meetings.

5.9 Improving Early Diagnosis of Cancer and tracking survival rates

The CCG’s Cancer worksstream’s primary objective is to improve cancer outcomes by ensuring cancers are diagnosed promptly, services are compliant with Improving Outcomes Guidance and care is delivered in the most appropriate setting.

5.9.1 Early Diagnosis of Cancer

The CCG and local GPs have been involved in various initiatives to promote the benefits of early detection which has included twice yearly cancer awareness education days as well as involvement with the Strategic Clinical Cancer Network around taking part in the ‘Be Clear on Cancer Campaigns’.

Links have also been made with the ACE Programme (an NHS England led early diagnosis of cancer initiative) that is delivered with support from Cancer Research UK and Macmillan Cancer Support. Its objective is to put in place a central approach to help Accelerate, Coordinate and Evaluate (ACE) learning from projects led locally by the NHS that are exploring best practice and innovative ideas, producing a national body of evidence and evaluation that is robust and can be used by commissioners.

The CCG submitted a ‘Weight Loss Pathway’ (which was accepted and through to the next stage of the programme) that has recently been developed in partnership with West Suffolk GPs and our local acute trust clinicians, aimed to ‘fast track’ individuals who present with weight loss but no other clearly identifiable symptoms that place them on a tumour specific two week wait pathway. The above initiative, on-going will aim to further support recent data that demonstrated that 59% of cancers in the CCG area are diagnosed at stage one or two - higher than anywhere else in England and is significantly above the national average of 41%, which means patients in the area have a better chance of survival and recovery.

5.9.2 Survivorship

The National Cancer Survivorship Programme, or Recovery Package, is aimed at supporting cancer patients and their carer’s at the end of treatment. A time when many feel very isolated and require support in order to move on with their lives. The programme has many elements, e.g. the HOPE programme, education days, holistic needs assessment, end of treatment summaries and care plans all of which are aimed at supporting patients to ‘self-manage’ post diagnosis and treatment.

Whilst many of these elements are already embedded and being routinely offered to cancer patients at the end of treatment, the initiative is being further supported by Macmillan Cancer Support who are funding additional nursing posts in order to ensure ALL cancer patients at the end of treatment have access to the above programme.

The CCG will also be focusing on risk stratification of follow-up pathways. Urology was the focus during 2015/16 with plans now to look at breast and colorectal; again with support from Macmillan funding additional posts.

The CCG will focus on an identified group of patients in delivery of the National Cancer Survivorship Initiative (NCSI) to ensure that those living with and beyond cancer get the care and support they need to lead as healthy and active a life as possible, for as long as possible.

Risk-stratified pathways involve the clinical team making a decision about the best form of aftercare for a person living with cancer. It will be based on:

- their knowledge of the disease (what type of cancer and what is likely to happen next);
- the treatment (what the effects or consequences may be both in the short term and long term);
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- the person (whether they have other illnesses or conditions, and how much support that they feel they need);

These new pathways of care will be underpinned by care co-ordination systems and include robust remote surveillance, so that patients will automatically be recalled if there is a problem identified in their tests, and rapid access to appropriate services if the patient has a concern or there is suspicion of further disease.

Latest figures report that, in West Suffolk, 72% of people diagnosed with cancer in 2012 lived for over one year. This was higher than the national average of 68%, and also the highest survival rate in East Anglia.
6. Improving Services for Local People

6.1 Introduction

It is acknowledged that significant changes to the way health services are delivered will be required if the above outcomes for local people are to be fulfilled. Within "Everyone Counts: Planning for Patients 2014/15 to 2018/19", NHS England 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:

- new approach to ensuring citizens fully included in all aspects of service design and change, and patients empowered in their own care;
- wider primary care provided at scale;
- modern model of integrated care;
- access to highest quality urgent and emergency care;
- step change in productivity of elective care; and
- specialised services concentrated in centres of excellence.

This section sets out the CCG’s plans for implementing these models of care to improve the services delivered to local people, ensuring that a patient-centred, high quality, modern and efficient health service is provided locally for all.

6.2 Empowering patients

The CCG fully recognises that the people in west Suffolk 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; to have access to data and advice about health and services; and be able to choose which health services they can use and how to access them.

The CCG 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.

Additionally, the CCG has decided to introduce Shared Decision Making across the health economy in West Suffolk to support the patients who want to be involved in clinical decision making about their care. Please click here for further information about this process, in which patients are supported and encouraged to participate in decisions about their treatment when there is more than one reasonable option available.

The Community Engagement Group (a sub-committee of the Governing Body) is made up of appointed members of the public who influence and scrutinise the CCG at a strategic level. Meetings are held in public across West Suffolk. Members of the Community Engagement Group continue to play an active role in some of the CCG’s workstreams to ensure the patient voice is heard, for example; urgent care review meeting, integrated care workshop and dementia engagement. This work will continue during 2015/16 and beyond.

In addition, the CCG has established a number of other means for patients and the public to be at the heart of decision making and participate in the design of local services. These will continue to be developed during 2015/16 and beyond:

- **Health Forum**: This is the free membership of the CCG. Members of the public register an interest in hearing updates from the CCG and opportunities to get involved at meetings and events. As a result, members receive a bi-monthly newsletter from the CCG, as well as being the first to hear the latest news from health partners and the latest consultations, surveys, meetings and events. Members of the public are invited to join the Health Forum at numerous public engagement events and through the CCG’s publications, swelling membership to over 550;
• **News from West Suffolk CCG**: This is the bi-monthly newsletter that gives members of the Health Forum updates on any service improvements and any other health-related news from the CCG or its partners. The newsletter is also available for all to view online by clicking here.

• **Patient Revolution events**: These are the large, annual CCG ‘open space’ conferences. The agenda is set by members of the public who attend can set up discussion groups on the issues that are most important to them. The CCG has used the comments and feedback from these events to shape its planning of services. In July 2015 the CCG will seek to grow these events further to attract even more than the 170 people that attended in 2014. Staff are currently exploring how best to develop Patient Revolution to maintain interest and generate input. The findings from Patient Revolution actively influence the work of the CCG, and details of how this happens can be read online by clicking here;

• **Public meetings**: Governing Body and Community Engagement Group meetings are held in public to promote transparency and greater involvement from the public. Papers from both of these meetings are made available on the CCG’s website a week prior to the meetings. The Community Engagement Group holds its bi-monthly meetings at each of west Suffolk’s six market towns to ensure everyone is able to access them;

• **‘Plan on a page’**: The CCG’s Operational and Strategic plan is shared with all stakeholders and interested members of the public;

• **Health needs assessment**: The CCG has worked closely with its partners in public health to develop a specific health needs assessment for the town of Haverhill. This involved holding two community events to listen to the views of members of the public and marrying this with public health data to develop a full health needs assessment. One of the key outputs from this work was the development of a directory of health services for the town, which was widely distributed, after concerns about a lack of understanding of the health services available;

The CCG has produced a number of Service Guides to navigate local people to the health and care services available in their areas. The Haverhill booklet has now been updated and the guides have been replicated for the Forest Heath towns on Newmarket, Brandon and Mildenhall. A guide is currently being produced for Sudbury following the opening of the new Sudbury Community Health Centre.

The scope of the guides has also been widened as, working with public sector colleagues in the local authorities to include details of services such as libraries, town councils, local authorities and more. The CCG has also worked closely with partners in the voluntary and community sector to ensure many of the services they offer in each town are included.

Once completed and printed, the guides are made available to be collected at key points in the town such as GP surgeries, council offices, newsagents, leisure centres and many more. They are also available upon request and are distributed at engagement events. These guides can all be viewed online by clicking here.

Other key areas of focus for patient and public engagement are:

• **Social media**: The CCG launched an official Facebook page in January 2014 and can be followed on Twitter. The CCG keeps these social media streams updated with live coverage from our events, and now has an outreach to nearly 1,500 people. There will be further development in this area, including using Patient Opinion to support live feedback on patient’s experience of healthcare;

• **Market stall events**: During the last two summers, the CCG has taken a health roadshow around West Suffolk marketplaces, giving local people the opportunity to find out more about the CCG and local health services, and for patients and public views to be listened to. In 2014
6. Improving Services for Local People

these market stalls were extended so that the CCG also had a presence at numerous summer fairs. These events also served as a vital opportunity to get the public’s feedback surrounding the Health and Care Review, which was subsequently used to shape the Review going forward and have also been used to help distribute the aforementioned health directories. The organisations at the roadshow has grown, with partners from statutory and voluntary groups including Suffolk Family Carers, Suffolk County Council, Age UK, Care UK, and more all attending. In 2015 the health roadshow will return with even more health partners and will help to direct those present to Patient Revolution 2015;

- **Video:** As part of the CCG’s seasonal work to spread good health messages through winter, a GP wrote a song to the tune of ‘Good King Wenceslaus’ and a local choir performed the song. This was coupled with a storyboard promoting the 111 service as the first port of call for non-life threatening injuries rather than A&E. The video was published on YouTube before Christmas and has been viewed more than 1,100 times. It can be seen by clicking here. The CCG is looking to build on this success by creating more videos to spread good health messages and promote changes;

- **Mental Health Conversations:** A series of events have been held to help form a Mental Health Strategy based around direct input from service users. This was a joint scheme by NHS West Suffolk CCG and NHS Ipswich and East Suffolk CCG. Around 40 people attended each of the four events in West Suffolk to provide invaluable feedback around topics focused on prevention, crisis and recovery. These have been held in Bury St Edmunds, Newmarket and Haverhill;

- **Health and Care Review focus groups:** Three focus groups were held to get detailed qualitative feedback on the Health and Care Review, with around 30 people attending each in Bury St Edmunds, Mildenhall and Sudbury;

- **Visual minutes:** Following the popularity of visual minutes being employed for purposes such as *The King’s Fund*’s ‘Alternative Guide to the NHS’ video, the CCG has used a member of staff to produce these at different events. There has been unanimously positive feedback on using this format as an alternative to merely listing feedback points to people, with them instead illustrated and becoming easier to digest. Examples of visual minutes from the Mental Health Conversations can be viewed on the CCG’s social media by clicking here;

- **Supermarkets:** CCG staff attended supermarkets in each of West Suffolk’s six towns through winter to spread good seasonal health messages and distribute the new health services guides. This resulted in an outreach to hundreds of members of the public;

- **Dementia workshops:** Building on the success of the Mental Health Conversations, two Dementia workshops have been launched in partnership with NHS Ipswich and East Suffolk
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CCG. These are being held in Stowmarket, and more than 70 people attended the first event to share their views on Dementia and how to address issues going forward.

- **Youth engagement:** The CCG has started a series of youth engagement events at West Suffolk College in Bury St Edmunds and Castle Manor Academy in Haverhill. Following talks at assemblies and feedback from around 300 students, a number of drop-in sessions will be held over lunch periods. Partner organisations including school nurses, The Matthew Project, Live Well Suffolk, Abbeycroft Leisure and several GPs have joined or will join CCG staff at these events to hear the thoughts and concerns of young people;

- **BME engagement:** CCG staff are currently considering ways to better engage with west Suffolk’s Black and Minority Ethnic communities. Past events have included speaking at and distributing material at factories which employ large numbers of migrants and doing likewise at eastern European supermarkets. Relevant information has also been published in a national Portuguese newspaper. Census information has been used to identify the largest BME groups in west Suffolk, with work underway on a translation policy to offer translation to those languages that have the greatest need and to ensure equitable access to health services. CCG staff will look to grow engagement with BME communities through these and more innovative methods.

The CCG recognises that communicating effectively is important to everything we do. The CCG has a high quality and professional service to promote and protect the organisation, and to provide strategic advice on how to manage its communications. The CCG aspires to the highest levels of honesty, openness and transparency, and actively promotes 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.

In August 2013, the CCG launched its new website which is a tool to promote the work we do. The CCG has continued to develop and improve the site, particularly sections on choice and the NHS Constitution.

The service works closely with media partners and regularly issues press releases. Recently, the CCG has used social media to promote its work, particularly using blogs and Tweets in the campaign aimed at reducing demand on NHS services.

The CCG also uses two newsletters to promote our work. Firstly there is a bi-monthly public newsletter, which is published on the CCG website and posted directly to Health Forum members. For details see the CCG website: [www.westsuffolkccg.nhs.uk/news/wsccg-newsletter](http://www.westsuffolkccg.nhs.uk/news/wsccg-newsletter)

Since November 2013, a new monthly newsletter (Jigsaw) has been distributed to staff across our provider organisations, setting out our work on integrating services between the NHS, third sector and social care.

A significant amount of focus has been targeted at reaching new audiences. For example, there is a migrant worker population which have contacted through agencies and cafes, using leaflets and translated materials. The CCG has made links with a Portuguese paper, which is published nationally, and has contributed relevant articles. This is an area for continued development and focus.
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The CCG regularly produces information for patients and public around their general health and wellbeing and has worked alongside LiveWell Suffolk at our market stall events across West Suffolk.

6.2.1 Emergency Planning Communication

There is a robust strategy for communicating in a crisis, which sees the CCG working closely across partners and including major businesses. The details of this are set out in the Suffolk Emergency Response Plan, which establishes the framework for the CCG’s response in the event of any emergency or major incident, regardless of cause. The Plan has been prepared in accordance with the provisions of:

- Civil Contingencies Act 2004;
- NHS Emergency Planning Guidance;
- National Commissioning Board Command & Control Framework;
- National Commissioning Board Core Standards

Whilst this Plan provides the overall framework for the CCG’s response to any type of emergency, individual plans exist to address specific issues, e.g. vaccination and treatment, business continuity, flooding etc. A key objective of the Response Plan is to ensure the continued provision of identified essential services by the local health community and to further mitigate any public health effects of the incident on the public and staff.

6.2.2 Establishment of System Resilience Groups and Resilience Planning

The West Suffolk System Forum (System Resilience Group) - formerly Urgent Care Network - provides a forum for partnership working in order to undertake day-to-day system resilience work to ensure effective operational management of the local health and care system. The Forum forms part of the integrated health and social care governance structure, answerable to the Suffolk System Leaders Partnership and ultimately to the Health and Wellbeing Board.

The key functions of the Forum are to:

- provide senior leadership oversight to the development and delivery of a locally defined joint vision and plan that delivers on the joint Suffolk wide strategic aims and ambitions;
- identify and agree on areas of beneficial joint working priorities;
- scrutinise progress of the joint delivery workstreams and remove blockages to progress;
- scrutinise system performance against the system wide metrics that require cross-organisational co-operation;
- deliver system leadership in the optimum use of resources to deliver the best overall outcomes for West Suffolk residents;

During 2014/15, the Forum approved the following schemes to address the additional pressures seen through the winter period:

- **Sub-acute model of care**

  The sub-acute model of care focuses on a different cohort of patients to the medically fit (see below) but with similar aims. Typically these patients are requiring IV management and monitoring although increasingly are extending to other cohorts of patients. WSFT have stated that the main outcomes of this model relate to a reduction in length of stay. The medical governance sits with WSFT with a view to move to GP’s in future.

- **Medically Fit**

  The Medically Fit model of care is aimed at a group of complex patients who are clinically unstable but medically fit to leave hospital. The model aims to work with social care and community services to create new solutions to managing these patients out of the acute trust. Underlying the model of care is a recognition that the current community provision does not provide sufficiently for this group of patients with complex care needs. The model aims to facilitate the necessary changes needed across the whole patient pathway to support the patient getting home and ultimately improve their long term outcomes and experience. The funding aims to complete the transformational change and is expected to be self-sustaining at the end of the funding period.
6. Improving Services for Local People

- **Enhanced Early Intervention Team (EEIT)**

The focus of this model is on bringing together all key services to manage admission avoidance pathways from Emergency Department (ED) and early pull-based discharge from AMU or base wards.

The Forum will be responsible for the formal evaluation of these schemes and for approval of system resilience plans (including financial resources), and new ‘winter’ schemes during 2015/16.

The Forum will also be responsible for designation and then assurance of the quality of urgent care facilities in line with national guidance planned for summer 2015.

### 6.2.3 Delivering better care through the digital revolution

Changes in technology and the way we communicate have made vast differences to everyone’s lives. The CCG needs to ensure that it supports the NHS to harness the use of this to deliver better care and to make it more convenient for patients. For example, the CCG expects all people with a long-term condition to have a personalised care plan which is accessible, available electronically and linked to their GP health record, and that conforms to the best-practice standards that we will be developing. That will mean patients receive safer care and don’t need to repeat their details at every new contact.

Greater access to web tools like NHS Choices and the creation of a digital ‘front door’ will help transform the way patients, their families and carers access information about NHS services and will provide self-management materials and information to further empower them to manage their own condition. There are links to this on the CCG’s website.

Greater use of tele-health and tele-care will also be important in supporting people with long-term conditions to manage their own health and care. The CCG is committed to ensuring that nobody is left behind as we give patients and the public a greater say in controlling their health care.

### 6.2.4 Transparency and sharing data

For too long the NHS has been unable to share the information patients need to understand their condition and make choices about the best treatment for them; including where and how they receive it. NHS England is determined to make apparent the different clinical outcomes that different treatments, organisations and individual specialists achieve. Consultant level activity and clinical outcomes data for ten surgical specialties have now been published. This gives patients and citizens, as well as their commissioners and clinicians, enhanced access to data and information. NHS England plan to extend this so that data from all appropriate NHS funded national clinical audits is made available before 2020. This will continue to provide vital insight for both patients and healthcare professionals about the care that is provided and lead to improvements in quality.

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**Case study:**

**Enhance Early Intervention Team**

*By Gylda Nunn, Integrated Therapies Manager, West Suffolk NHS Foundation Trust and Gareth Blissett, EEIT Team Lead*

Since April 2014 more than 1000 patients have had support from the new Enhanced Early Intervention Team (EEIT), saving them and their family upheaval, stress and discomfort.

EEIT integrates key services to manage admission avoidance pathways from the emergency department (ED) and the short stay acute medical unit at West Suffolk Hospital. This means these patients have either not had to be admitted to hospital in the first place or have not had to stay in hospital as long.

The EEIT team reduces the length of hospital stays through the early supported discharge of patients and supports admission avoidance by closely working with the Community Admission Prevention Service. The team is funded by a joint pot of money from the acute and community services.

EEIT intervention sees, on average, 35 patient discharges each week - in one week it has been as high as 54 - from the emergency department, clinical decision unit and short stay unit. This is achieved by ensuring patients see the appropriate professionals at the front end of the hospital. Patients are provided with the necessary treatment and advice which enables them to return home to manage their own condition with the appropriate support.

The service has been showcased at the East of England Emergency Care Conference and used by the Emergency Care Intensive Support Team as an example of excellent integrated working.
NHS England also knows that effectively collecting, sharing and interpreting data is fundamental to the transformation we need to deliver. The steps already taken include the promotion of a single set of data and data transmission standards to facilitate a nationwide exchange of health information. Called care.data this will safely join up existing clinical data sets, held securely within the Health and Social Care Information Centre, and extend and expand them so that they provide the data that commissioners need to support the delivery of high quality care and improved outcomes. Offering the opportunity for patients to access their own health information also forms part of this ground breaking work.

These opportunities have been factored into the CCG’s plans. The CCG is working towards having data in GP practices linked to hospital data in accordance with national guidance.

6.3 Wider primary care, provided at scale

6.3.1 Opportunities to work with primary care

The CCG is committed to providing access to a broader range of services in primary care to support those patients with moderate mental or physical long-term conditions. This entails transforming primary care services with an expanded role for GPs to coordinate and deliver comprehensive care with community services – putting those healthcare professionals at the heart of a more integrated system of community-based services.

NHS England have created the strategic framework for this approach and the CCG will work within this framework to stimulate new models of care and to develop innovative forms of commissioning and contracting to support these new models.

6.3.2 Co-commissioning of primary care

Primary care is central to the new population-based health care models described in the NHS England Five Year Forward View.

CCGs have a duty to work with NHS England to ‘improve the quality of primary care’. In May 2014, NHS England circulated a letter inviting CCGs to submit an expression of interest to co-commission primary care services. NHS England describes co-commissioning as:

’a key enabler in developing seamless, integrated out of hospital services, based around the diverse needs of local populations… Co-commissioning gives CCGs the option of having more control of the wider NHS budget, enabling a shift investment… and by aligning primary and secondary care commissioning offering the opportunity to develop more affordable services through efficiencies gained’.

Case study:

**West Suffolk Community Diabetes Service**

By Dr Emma Reed, Associate GP for Diabetes, West Suffolk CCG.

Diabetes is one of the major challenges facing the NHS, being the long term condition with the fastest rising prevalence. In 2012/13 there were 11,139 adults diagnosed in West Suffolk and it is estimated that a further 2,510 are undiagnosed.

In 2013, a pilot project ran with four surgeries in Forest Heath. Diabetic nurses from West Suffolk Hospital ran joint clinics with practice nurses on a weekly basis to engage with patients and improve their ability to manage their diabetes.

The project team were delighted when they were shortlisted as finalists at this year’s General Practice Awards.

Denise Unsworth, Diabetic Specialist Nurse at West Suffolk Hospital, said “We are all honoured to have been finalists and being part of an exciting productive project.”

Inspired by the success of the pilot project, West Suffolk CCG will respond to the findings of the National Diabetes Audit, build on this successful partnership project, and work with all GP practices to launch an improved community diabetes service for the patients of West Suffolk in 2015.

Work has already started and all West Suffolk GP practices have been contacted to seek their views on the diabetes service that would best support their patients’ needs.

The integrated community diabetes service is expected to be launched in Spring 2015.
6. Improving Services for Local People

The CCG submitted a high level Expression of Interest in June 2014. NHS England categorised the CCG’s Expression of Interest as seeking a ‘joint commissioning’ arrangement.

In September 2014, NHS England published further guidance, describing in more detail what might be included in co-commissioning and requiring CCGs to confirm which approach or model, they wished to adopt. The functions which NHS England describes as being covered by co-commissioning include:

- GMS, PMS and APMS contracts, including the design of PMS and APMS contracts, monitoring of those contracts and taking contractual actions, such as issuing remedial notices and removing a contract;
- newly designed enhanced services (‘Local Enhanced Services’ and ‘Directed Enhanced Services’);
- design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF);
- the ability to establish new GP practices in an area;
- approving practice mergers; and
- making decisions on ‘discretionary’ payments, e.g. GP returner and retainer schemes.

The CCG has been approved to jointly commission primary care services, and will be working with NHS England on the local implementation of the new arrangements from April 2015.

Underpinning these arrangements are the principles set out in the strategic framework, which establishes that:

- care is integrated and provided in a joint way to meet the needs of the whole person;
- people are able to play a full part in the management of their health and wellbeing;
- care is clinically effective and safe, delivered in the most appropriate way;
- primary care plays a full part in helping the wider healthcare system make the best use of limited resources;
- we create an environment which ensures that we are able maintain and develop a motivated, skilled and dedicated primary care workforce;
- there is a shared understanding of individuals rights, responsibilities and expectations;
- there is equity of “offer”, equity of “access” and equity of “outcome” for all patients.

The CCG recognises that primary care plays a critical role in the prevention of ill health and the management of people with long term conditions. The CCG places primary care at the heart of its joint plan to support people at home through the implementation of risk stratification, integrated community teams, case management and care coordination.

This Operational Plan aims to consolidate on the work already commenced around integrated health and social care teams and drive the next phase of implementation of the Suffolk Health and Care Review. Primary care is a major part of the Operational Plan and general practice have contributed to the development of the priorities through a number of engagement events and as a member of our integrated care forums.

The CCG will continue to support practices through this period of significant change.

6.3.3 Opportunities to work with community pharmacies to deliver our objectives

Opportunities exist to work more collaboratively with community pharmacists to ensure the efficient and effective delivery of the essential and advanced services of the community pharmacy contract. These are:

**Essential services**

- dispensing medicines (including implementation of the electronic prescription service);
- dispensing appliances;
- repeat dispensing;
- clinical governance;
- Public Health (promotion of healthy lifestyles);
- disposal of unwanted medicines;
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- signposting;
- support for self-care.

**Advanced services**

- medicines use reviews;
- new medicines service;
- appliance use reviews;
- stoma appliance customisation.

The CCG also recognises that opportunities also exist to support the delivery of locally commissioned community pharmacy services, working in partnership with different commissioners including local authorities and NHS England. Such services include needle and syringe exchange, stop smoking, emergency hormonal contraception and chlamydia screening and testing.

**Case study:**

*Is your medicine cabinet fit for the winter?*

*In December 2014 an article was placed in the Jigsaw newsletter, reminding staff, and their patients, that having a first aid box or medicine cabinet at home that contains a range of products to treat minor ailments means that patients can react quickly when illness strikes – potentially avoiding a trip to the GP or even to A&E.*

Furthermore, the CCG will look to maximise the role of community pharmacy in delivering a sustainable, affordable and long term solution to the pressures on the local urgent and emergency care system. There is recognition that community pharmacy plays a vital role in local communities in providing medicines, and as a trusted source of health and wellbeing advice. Locally commissioned community pharmacy services could be developed further, e.g. as promoted in "Community Pharmacy - helping with winter pressures - high quality care for all, now and for future generations (December 2013)” and in "Community Pharmacy - helping provide better quality and resilient urgent care (November 2014)".

The accreditation of community pharmacies as Healthy Living Pharmacies (HLPs) will enable the pharmacy teams to help reduce health inequalities within the local community, by delivering high quality health and well-being services, promoting health and providing proactive health advice.

### 6.4 A modern model of integrated care, providing access to the highest quality urgent and emergency care

The CCG fully supports the government’s ambition to embed tailored care for vulnerable and older people through the development of a modern and sustainable model of integrated care which directly supports those people with complex health and care needs (‘complex’ means that the individual will have a combination of the following: co morbidity of long term conditions; poly pharmacy; requires a number of services for support; frailty; socially isolated; chaotic lives; frequent users of resource; be a Family Carer).

It is also recognised that local people deserve access to the highest quality urgent and emergency care services when they need it. The CCG is working with partners and stakeholders to deliver a vision for urgent and emergency care services that aligns to the national focus, that:
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- for people with urgent care needs, a highly responsive service should be provided that delivers care as close to home as possible, minimizing disruption and inconvenience for patients and their families; and
- for those people with more serious of life threatening emergency care needs, they are treated in centres with the very best expertise and facilities in order to maximise the chances of survival and a good recovery.

Organisations in Suffolk 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. Suffolk County Council’s adult social care transformation programme ‘Supporting Lives Connecting Communities’ is fully in line with the direction of travel outlined in this Operational Plan.

**Case study:**

**Looking back on what we have achieved**

By Dr Emma Derbyshire, Lead GP – Integrated Care, WS CCG

It was a year ago when we introduced Mrs. Smith, a fictitious 86 year old who had suffered falls and had several hospital visits - and uncoordinated care from health care professionals. Over the last year, health and social care professionals and voluntary sector partners have made inroads into supporting Mrs Smith more than ever before.

Now in west Suffolk there are neighbourhood teams and comprehensive assessments of individuals to find out what each needs to be as successful as possible. There are Suffolk Family Carers based in GP practices, supporting 270 family carers, 93 of which were identified from GP referrals, compared to 28 in the previous financial year. A psychiatric liaison service for over 18s is based at West Suffolk Hospital, which supports wards and those who attend A&E. Suffolk Community Healthcare has introduced more integrated community services, working together with social care and West Suffolk Hospital. Age UK Suffolk’s Welcome Home service was expanded.

These are just a few examples of what happened last year. And as each partner works together more closely, Mrs Smith benefits more.

In Autumn 2012, the west Suffolk health and social care system and its wider service partners developed a vision that local people:

- would not have to navigate around a complex system to find the right information, care or service that meets their needs;
- would have their health or care need identified early before a crisis occurs;
- would have access to a range of local services that focus on supporting people to self-care and supporting primary prevention;
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- would have their care co-ordinated across clinical/care and service areas without duplication (improving urgent care performance through the delivery of an integrated care programme)

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 to embed a more integrated system will help us to manage demand pressures, as well as give us the ability to use funding more effectively.

To do this the Suffolk system, including all our local health services, care services, district and borough councils, Suffolk County Council, the three Suffolk-based CCGs, our local GPs and our voluntary sector and communities are further developing our united vision, focused on outcomes for integration which allow localised transformation to happen. To deliver this we will provide determined leadership to build a different system, one that works for our customers and patients, but is financially sustainable into the longer term.

The Suffolk Commissioning Group (SCG) has already been established to identify joint commissioning intentions and joint commissioning frameworks, starting with areas identified in the Tricordant Joined up Services for Older People review. Areas where work has already started include:

- carer support;
- accelerated discharge;
- dementia management;
- integrated falls provision.

At a local level, neighbourhood teams are developing as multi-disciplinary networks for pro-active health and social care, with shared information, assessment and care planning processes. They will cover a range of activities such as population risk stratification, self-care and carer support, active communities, integrated crisis response, case management and integrated care teams as well as discharge co-ordination.

Working with local partners and stakeholders, the CCG aims to provide care and support to people in their own homes and communities, with person centered outcomes that:

- improve the quality of the services across health and social care for our local population;
- reduce inequalities of both access and outcomes;
- co-ordinate around individuals and are targeted to their specific needs;
- reduce premature mortality and morbidity;
- improve the experience of care, with the right responses available in the right place at the right time;
- maximise independence by constructing, individual, family and carer resilience at home and in the community;
- empower people to manage their own health and wellbeing;
- through proactive and joined up case management, avoid unnecessary admissions to hospitals and care homes, and enable people rapidly to regain their independence after episodes of ill-health;
- secure a stable future for all health and social care organisations;
- improve the efficiency in the provision of the services.

6.4.1 Suffolk Health and Care Service Model

Locally, the model of integrated care and improved access to high quality urgent and emergency care will be delivered through the Suffolk Health and Care Service model.

Since November 2013, the CCG and Ipswich and East Suffolk CCG have worked closely with partners, in particular Suffolk County Council (SCC) and Healthwatch, to engage the wider Suffolk community on the future of health and social care services in west Suffolk and east Suffolk.

A number of themes have been incorporated into the system design, based on feedback from above, local experience, national policy and evidence:

- the major building blocks of the new system will be Integrated Neighbourhood Teams. Social care, community health services and some aspects of mental health services will be
organised and delivered at neighbourhood level, serving the population of an average of four general practices and mindful of natural geographic factors. In particular, there will an increased emphasis on the teams managing their populations in a systematic way, using risk stratification tools to identify the individuals at higher risk, and placing care plans which are joint between all relevant agencies. Some individuals will be sufficiently complex to require a case co-ordinator; the most appropriate person for this role will depend on the team’s view on which professional is most appropriate to that individual’s needs;

- communication between healthcare professionals will be improved. One component of this is commissioning an NHS 111 service that goes beyond the national minimum requirements. In particular, there will be a dedicated line for professionals to access a strengthened Directory of Services (DoS) that will allow them to link them to partners; for example, a paramedic attending a patient who needs care will be able to access community alternatives to hospital treatment. For patients calling NHS 111, their service experience will be improved by stronger clinical support;

- services at the acute trust will be strengthened by a significant primary care presence. The Primary Care Foundation, College of Emergency Medicine and Royal College of General Practitioners all agree that a significant proportion of patients present to Accident and Emergency with a primary care problem, in good faith that they consider themselves to have an urgent or emergency problem. The national term for this element is an Urgent Care Centre, and it will help to protect scarce emergency centre expertise and there will be an increased emphasis on moving patients into the community rather than hospital beds.

The diagram below sets out how health and care services integrate as a pathway: from prevention and care co-ordination through to urgent care response and treatment and, finally, returning people back home swiftly so that their independence is restored and they are once again able to self-care and manage their own condition. The prevention of illness is the driver of the model.

**Integrated Health and Care Pathway**

During 2015/16 work will continue towards this system reform and redesign of the way the local health and social care systems work. This will be initially in Sudbury as an “Early Adopter” site where the concepts and practical applications of the model will be tested, and used as an opportunity to further understand the key components of building a more cohesive health and care system with cross-organisational working.
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6.4.2 West Suffolk Health and Care (“forerunner site” bid)

NHS England’s “Five Year Forward View” sets out a number of options for local and national organisations to work together to accelerate the design an implementation of new models of care which will underpin a sustainable NHS going forwards.

The CCG submitted an Expression of Interest to introduce a local ‘Health & Care’ strategy and the primary and acute care system (PACS) model for delivery in West Suffolk. It has been created by a wide range of partners as part of the ‘Suffolk Health & Care Review’, including service users, health and care providers and commissioners, voluntary and community partners, district and borough councils.

The strategy has four main objectives, which are aligned to those of the wider Health and Care review:

- people manage their own health and social care with the right support when needed;
- our communities are easy and supportive places to live with a health or care need;
- our health and care providers are co-ordinated by one clinically-led organisation;
- higher cost interventions are replaced with lower cost interventions

Four key programmes of work will underpin delivery of the strategy:

- **Neighbourhood Networks** are concerned with keeping people happy and healthy in their own homes supported by a range of support networks. These networks include local people, groups, organisations and statutory services which a person uses to improve or maintain their vision of a good life.

- **Integrated Neighbourhood Teams (INTs)** ensure health and care interventions are planned, proactive, and reduce the need for crisis and urgent intervention. The INTs include a core range of generalist services from community health, adult social care, primary care and mental health brought together as one co-located team within our six localities.

- **Urgent Care** for people requiring urgent care response the INTs will co-ordinate care so that people are treated promptly by the most appropriate service, discharged and returned swiftly back to their own home from acute care.

- **Specialist interventions.** Some services such as interface geriatricians, community hospitals and specialist dementia advice are organised on a wider geography provided by a range of organisations and work to a common set of processes and service delivery principles. Many of these specialist services will work alongside the INTs, and join them for MDT meetings to both mitigate risk of exacerbation and to respond appropriately at times of crisis. They may also hold a small caseload for focused and time limited work where there are complex needs.

The CCG’s application was shortlisted by NHS England, but was not successful in being selected as one of the national sites. However, the strategy will continue to be rolled out locally as part of the wider Health and Care review, and further opportunities to seek national support will be explored.

6.4.3 Better Care Fund

The Better Care Fund provides a further opportunity to accelerate progress in delivering the vision of the Suffolk Health and Wellbeing Board and facilitating the Suffolk Health and Care Review, with a particular focus on early intervention and prevention, ensuring services are integrated at the point of delivery, and that there are seamless services in place, including mental health.

The Better Care Fund schemes are as follows:

- Integrated Neighbourhood Teams;
- Access to Specialist Services and Support;
- Admission Prevention;
- Reablement;
- Support for Carers.
- Integrated Sudbury ‘Early Adopter’ site:
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- test concepts;
- practical application of Health and Care Review model;
- Evidence gathering.

Performance metrics has been developed as set out below:

- **national planning assumption** that this will be in the region of a **3.5% reduction in non-elective emergency admissions.** In Suffolk a target of a 3.5% reduction = 2,241 admissions has been set (includes all commissioners) – saving approximately £1.7m;

**Mandatory**

- **permanent admissions (65+) to residential and nursing care homes** per 100,000 population - number of admissions in 2014/15 and 2015/16 held at 2013/14 levels (995) which reduces the rate by 8% by 2015/16 (ie mitigating increase in 65+ population)
- **reablement** – proportion of people at home 91 days after discharge from hospital into a reablement / rehab service - 5% increase by 2015/16
- **delayed transfers of care** - 4.5% reduction by 2015/16
- **patient / service user** metric (GP patient survey: Have you had enough support to manage LTCs?) - baseline 72.7%, increase to 73.7% by 2015/16 *(NB Suffolk already scores high nationally)*

**Local metric**

- **dementia diagnosis rate** - increase to 67% in 2015/16 *(National target)*

These will be reported and monitored through the following framework:

<table>
<thead>
<tr>
<th>Will receive</th>
<th>Will produce</th>
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<tbody>
<tr>
<td>Health and Wellbeing Board</td>
<td>Quarterly performance updates</td>
</tr>
<tr>
<td>System Leaders Partnership</td>
<td>Monthly programme updates</td>
</tr>
<tr>
<td>Integrated Care Boards/ICS Programme Board</td>
<td>Requests from the SLP for remedial action where plans are off track</td>
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Reports outlining remedial actions where plans are off track
Requests to delivery projects for remedial action where plans are off track
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6.5 A step-change in the productivity of elective care

Planned or elective care supports patients throughout their pathway of care; from referral to intervention (if required) until the episode of care is completed. The Planned Care workstream is overseen by a GP Clinical Lead who is a member of the CCG’s Executive. The ambitions of the Planned Care work stream are to:

- develop and manage local services in the community where possible which are clinically evidenced and appropriate;
- promoting shared decision making throughout the pathway;
- supporting patients with long term conditions;
- promoting an integrated approach between healthcare providers with timely communication;
- getting the patients right care in the right place at the right time.

The Planned Care system recognises the need to design and manage services through a patient pathway to achieve quality, deliver greater clinical outcomes and deliver the major step change in productivity with patient’s involvement at the heart of this transformation.

Case study:

Hip & Knee Assessment Service

Patients in West Suffolk suffering from osteoarthritis of the hip and knee are benefiting from a service which allows them to be involved in choices about their treatment.

The service was piloted from November 2012 and is set to become part of the standard range of services offered by community physiotherapists.

Instead of going to hospital, most patients are referred by their GP to a specialist service provided by physiotherapists where they are able to discuss their treatment options and decide the best course of action.

Dr Rakesh Raja, GP Lead for Planned Care, said: “Patients can participate in group sessions which help them understand their condition and enable them to improve their health and lifestyle. Many patients find this gives them the tools to manage their pain without the need to consider surgery.”

When patients clearly need an operation they are referred directly to an Orthopaedic Consultant by the physiotherapist and can still take part in the programme to prepare for surgery and make sure they are fit and ready to get the best possible outcome.

Belinda Perkins, senior physiotherapist explained: “One of the most important aspects of this service is listening to the patient to identify how the problem is restricting their life. By discussing the problem we can get the best diagnosis and together reach the right treatment plan.”

Dr Raja concluded: “The feedback so far is positive. Being able to avoid an operation with appropriate therapy and advice is fantastic for patients and means that those who do need surgery can be treated more quickly.”

The NHS ‘Everyone Counts: Planning for Patients’ guidance requires local providers to achieve a 20% productivity improvement within 5 years.

Working closely with our main local acute provider, West Suffolk NHS Foundation Trust, the Planned Care Clinical workstream has agreed to focus on the specific areas below to deliver productivity improvement:

- developing integrated services in pain and diabetes;
- use of technology to deliver better care through technology such as Teledermatology, supporting virtual clinics;
- pathway development design in Dermatology, Ophthalmology and Respiratory;
6. Improving Services for Local People

- sustaining and refining our work undertaken in musculoskeletal services, trauma and orthopaedics to gain greater outcomes in quality and productivity;
- GP Practice Referral Support and use of Clinical Management Service (electronic referral and advice).

In addition, the CCG and West Suffolk NHS Foundation Trust have agreed a mature ‘open book’ specialty by specialty approach, when considering and future proofing local acute services. The CCG and hospital will work collaboratively and supportively to ensure that local specialty development and plans are evidenced-based and appropriate for the needs of the local population, whilst delivering within the challenging financial climate.

6.6 Specialised services concentrated in centres of excellence.

NHS England is the primary commissioner of specialised services. Specialised services include those services, often provided in relatively few hospitals, accessed by comparatively small numbers of patients, but with catchment populations of more than one million. These services tend to be located in specialist hospital trusts that can recruit staff with the appropriate expertise and enable them to develop their skills. Examples include long-term conditions such as renal dialysis, complex interventions such as liver transplants, rare cancers and secure forensic services. NHS England is striving to reduce the number of centres providing NHS specialised services and, through this, ensure that high quality services are consistently delivered in these centres.

From April 2015, the following services will no longer be commissioned by NHS England and will be reflected in CCGs contracts with providers where appropriate:

- specialised wheelchair services
- outpatient neurology referrals made by GPs to Adult Neurosciences Centres
- outpatient neurology referrals made by GPs to Adult Neurology Centres

In addition, the following services will no longer be commissioned by CCGs; these services will be reflected in NHS England contracts from April 2015:

- some highly specialised adult male urological procedures
- some adult oesophageal procedures
- services for patients with homozygous familial hypercholesterolaemia
- some adult specialist haematology services

NHS England has recommended to the Prescribed Services Advisory Group that the following services currently commissioned by NHS England should in future be commissioned by CCGs:

- renal dialysis (excluding encapsulating sclerosing peritonitis surgery)
- surgery for morbid obesity

NHS England will be establishing arrangements to co-commission the majority of specialised services in partnership with CCGs. This will enable better aligned decision making to help restore pathway integrity and improve the transition for patients between specialised and non-specialised services. The detailed arrangements for co-commissioning are being developed and will be fully supported by the CCG going forwards.
7. Access

7.1 Convenient access for everyone

Patients have consistently said that they feel it important that they do not have to wait for treatment, and evidence suggests that waiting for treatment can not only be distressing, but also have an impact on outcomes. The CCG recognises that the services provided can only improve outcomes for patients if they are readily available to them, they receive treatment in a timely manner, when and where they need them, and in a time and place that is convenient for their lifestyle.

The Sudbury Community Health Centre was commissioned by the CCG, and opened in January 2015.

Initial plans for the building were displayed at a public event in January 2011. This event gave local people the opportunity to comment on the design. Changes to the design happened as a result of the feedback.

The new facility will see services currently outdated facilities all being provided under one roof. Services will include:

- paediatrics, dermatology, audiology, gynaecology, rheumatology;
- musculoskeletal physiotherapy, podiatry, speech and language therapy and continence clinics;
- x-ray;
- community midwifery, health visitors and community therapy;
- neurology, urology, ophthalmology and orthopaedics;
- GP services from Siam GP surgery

7.2 Meeting the NHS Constitution standards

The NHS Constitution sets out the rights and pledges to which patients are entitled, and to which the CCG is committed to delivering. The CCG will commission a sufficient level of activity to ensure the rights and pledges are met. The trajectories for delivering each of the NHS Constitution targets are set out below:

Referral To Treatment waiting times for non-urgent consultant-led treatment:

- admitted patients to start treatment within a maximum of 18 weeks from referral – 90%;
- non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%;
- patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%.
7. Access

**Diagnostic test waiting times:**
- patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral – 99%;

<table>
<thead>
<tr>
<th>E.B.4</th>
<th>Number waiting &gt; 6 weeks</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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<tbody>
<tr>
<td>Total Number waiting</td>
<td>1983</td>
<td>2277</td>
<td>2552</td>
<td>2326</td>
<td>2581</td>
<td>2590</td>
<td>2793</td>
<td>1939</td>
<td>2168</td>
<td>2134</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>0.9%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>1.0%</td>
<td>0.9%</td>
<td>1.0%</td>
<td>1.0%</td>
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</tbody>
</table>

**A&E waits:**
- patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department – 95%;

<table>
<thead>
<tr>
<th>E.B.5</th>
<th>Number waiting &gt; 4 hours</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Attendances</td>
<td>15931</td>
<td>16170</td>
<td>15719</td>
<td>15643</td>
<td></td>
</tr>
<tr>
<td>% &lt; 4 hours</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.0%</td>
<td>95.0%</td>
<td></td>
</tr>
</tbody>
</table>

**Cancer waits – 2 week wait:**
- maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%;
- maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (cancer not initially suspected) – 93%;

<table>
<thead>
<tr>
<th>E.B.6</th>
<th>Cancer - All Cancer two week wait</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 2 weeks</td>
<td>1796</td>
<td>1710</td>
<td>1617</td>
<td>1707</td>
<td></td>
</tr>
<tr>
<td>Total number waiting</td>
<td>1936</td>
<td>1659</td>
<td>1737</td>
<td>1834</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>93.1%</td>
<td>93.1%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>E.B.7</th>
<th>Cancer - Two week wait for breast symptoms (where cancer not initially suspected)</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 2 weeks</td>
<td>328</td>
<td>279</td>
<td>233</td>
<td>361</td>
<td></td>
</tr>
<tr>
<td>Total number waiting</td>
<td>312</td>
<td>299</td>
<td>304</td>
<td>367</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>91.2%</td>
<td>91.4%</td>
<td>91.4%</td>
<td>91.8%</td>
<td></td>
</tr>
</tbody>
</table>

**Cancer waits – 31 days:**
- maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%;
- maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%;
- maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%;
- maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%;

<table>
<thead>
<tr>
<th>E.B.8</th>
<th>Cancer - Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis.</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 31 days</td>
<td>338</td>
<td>335</td>
<td>352</td>
<td>300</td>
<td></td>
</tr>
<tr>
<td>Total number waiting</td>
<td>352</td>
<td>348</td>
<td>366</td>
<td>312</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>96.0%</td>
<td>96.3%</td>
<td>96.2%</td>
<td>96.2%</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>E.B.9</th>
<th>Cancer - 31 Day standard for subsequent cancer treatments - surgery</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 31 days</td>
<td>79</td>
<td>80</td>
<td>71</td>
<td>85</td>
<td></td>
</tr>
<tr>
<td>Total number waiting</td>
<td>80</td>
<td>85</td>
<td>75</td>
<td>90</td>
<td></td>
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<tr>
<td>%</td>
<td>95.0%</td>
<td>94.1%</td>
<td>94.7%</td>
<td>94.4%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>E.B.10</th>
<th>Cancer - 31 Day standard for subsequent cancer treatments - anti cancer drug regimens</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 31 days</td>
<td>137</td>
<td>141</td>
<td>149</td>
<td>164</td>
<td></td>
</tr>
<tr>
<td>Total number waiting</td>
<td>139</td>
<td>143</td>
<td>152</td>
<td>167</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>98.6%</td>
<td>98.6%</td>
<td>98.0%</td>
<td>98.2%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E.B.11</th>
<th>Cancer - 31 Day standard for subsequent cancer treatments - radiotherapy</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 31 days</td>
<td>147</td>
<td>135</td>
<td>126</td>
<td>138</td>
<td></td>
</tr>
<tr>
<td>Total number waiting</td>
<td>156</td>
<td>143</td>
<td>133</td>
<td>146</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>94.2%</td>
<td>94.4%</td>
<td>94.7%</td>
<td>94.5%</td>
<td></td>
</tr>
</tbody>
</table>
7. Access

Cancer waits – 62 days:
- maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%;
- maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%;
- maximum 62-day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers) – no operational standard set;

<table>
<thead>
<tr>
<th>E.B.12</th>
<th>Cancer - All cancer 62 day urgent referral to first treatment wait</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 62 days</td>
<td>136</td>
<td>134</td>
<td>154</td>
<td>139</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>85.0%</td>
<td>85.4%</td>
<td>85.1%</td>
<td>85.3%</td>
<td></td>
</tr>
<tr>
<td>Total number waiting</td>
<td>150</td>
<td>157</td>
<td>181</td>
<td>163</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E.B.13</th>
<th>Cancer - 62 day wait for first treatment following referral from an NHS cancer screening service</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 62 days</td>
<td>32</td>
<td>38</td>
<td>22</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>91.4%</td>
<td>90.5%</td>
<td>91.7%</td>
<td>90.0%</td>
<td></td>
</tr>
<tr>
<td>Total number waiting</td>
<td>35</td>
<td>47</td>
<td>24</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E.B.14</th>
<th>Cancer - 62 day wait for first treatment for cancer following a consultant’s decision to upgrade the patients priority</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number waiting &lt; 62 days</td>
<td>13</td>
<td>9</td>
<td>14</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>%</td>
<td>92.9%</td>
<td>90.0%</td>
<td>91.3%</td>
<td>92.3%</td>
<td></td>
</tr>
<tr>
<td>Total number waiting</td>
<td>14</td>
<td>10</td>
<td>15</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

Category A ambulance calls:
- category A calls resulting in an emergency response arriving within 8 minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately);
- category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%;

Mental Health:
- dementia diagnosis rate – 67%;

| E.A.S.1                      | Dementia - Estimated diagnosis rate | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   | %   |
|------------------------------|-------------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
|                              | Estimated dementia prevalence (65+ Only [CFAS III])                  | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 | 302 |
|                              | %                                  | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% | 67.02% |
### 7. Access

**IAPT access proportion – 15% annually**

<table>
<thead>
<tr>
<th>E.H.1 - A1</th>
<th>The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 6 weeks of referral</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>655</td>
<td>655</td>
<td>655</td>
<td>655</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E.H.2 - A2</th>
<th>The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 18 weeks of referral</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>830</td>
<td>830</td>
<td>830</td>
<td>830</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E.A.3</th>
<th>The number of people who receive psychological therapies</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).</td>
<td>23254</td>
<td>23254</td>
<td>23254</td>
<td>23254</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E.A.5.2</th>
<th>The number of people who finish treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved ‘closeness’ and at final session did not).</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The number of people who finish treatment having attended at least two treatment contacts and coded as discharged minus The number of people who finish treatment not at clinical closeness at initial assessment</td>
<td>268</td>
<td>268</td>
<td>268</td>
<td>268</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E.A.5.2</th>
<th>The number of people who finish treatment having attended at least two treatment contacts and coded as discharged minus The number of people who finish treatment not at clinical closeness at initial assessment</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>585</td>
<td>585</td>
<td>585</td>
<td>585</td>
</tr>
</tbody>
</table>

**IAPT recovery rate – 50%**

<table>
<thead>
<tr>
<th>E.A.5.2</th>
<th>The number of people who finish treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved ‘closeness’ and at final session did not).</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The number of people who finish treatment having attended at least two treatment contacts and coded as discharged minus The number of people who finish treatment not at clinical closeness at initial assessment</td>
<td>268</td>
<td>268</td>
<td>268</td>
<td>268</td>
</tr>
</tbody>
</table>

In addition, the Standard NHS contract details the requirement for providers to comply with the NHS Constitution. The CCG will monitor delivery of this through monthly contractual and Service Level Agreement (SLA) meetings with providers, and apply contractual consequence for providers failing to meet the mandated operational thresholds. These include sanctions that can be applied if planned operations are cancelled, feedback and complaints.

If further escalation is required, under the terms 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.

In addition, the CCG will attend provider operational meetings, as appropriate, to ensure that standards are delivered and to ensure that areas of concern are escalated through the contractual monitoring processes.

The CCG regularly reports the latest contractual performance report by provider, including details of current contractual consequences imposed. These are contained within the Integrated Performance Report in the Governing Body papers available on the CCG’s website.
### 7. Access

#### 7.3 Other National Targets – Primary Care Satisfaction Measures

In addition to the targets established under the NHS Constitution, the CCG will also set out performance targets for primary care satisfaction measures to reflect its commitment to jointly-commission high quality primary care services. Performance will be measured against satisfaction with the quality of consultation at a GP Practice, satisfaction with the overall care received at the surgery, and satisfaction with accessing primary care.

<table>
<thead>
<tr>
<th>E.D.1</th>
<th>Satisfaction with the quality of consultation at GP practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aggregated percentage of patients who gave positive answers to five selected questions in the GP survey about the quality of appointments at the GP practice</td>
<td>2015/16</td>
</tr>
<tr>
<td>E.D.2</td>
<td>Satisfaction with the overall care</td>
</tr>
<tr>
<td>The percentage of patients who gave positive answers to the GP survey question ‘Overall, how would you describe your experience of your GP surgery?’</td>
<td>2015/16</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>E.D.3</td>
<td>Satisfaction with access to primary care</td>
</tr>
<tr>
<td>The percentage of patients who gave positive answers to the GP survey question ‘Overall, how would you describe your experience of making an appointment?’</td>
<td>2015/16</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>
8. Improving Quality of Services

8.1 Introduction

In its report ‘Quality in the new health system – maintaining and improving quality from April 2013’ the National Quality Board set out its expectation that quality is the ‘organising principle of the NHS and that a ‘relentless focus on quality means a relentless focus on how we can positively transform the lives of the people who use and rely on our services’.

The CCG is responsible for meeting the needs of its population though the commissioning of high quality services and to work as part of the whole health and social care system to safeguard high quality and patient safety through integrated planning or these services.

The Health and Social Care Act 2012 requires that CCGs have a duty to ‘exercise their functions with a view to securing continuous quality improvement in the quality of services and the outcomes that are achieved from this provision’. In setting the bar high for quality the CCG will work with its providers to ensure that not only do they deliver the essential standards of quality and safety regulated by the CQC, but they also strive for excellence and innovation in practice to drive up those standards for patients and their families.

It is imperative that the CCG also ensures that early warning systems both locally and in conjunction with NHS England’s Quality Surveillance Group are utilised to detect the signs of a failing service or provider organisation or where patient safety is being compromised. Early intervention with stakeholders and partners to prevent the major failings highlighted by the Francis report must be a priority for the CCG and its systems, processes and governance. The Government response to the Francis report ‘Hard Truths: essential actions’ outlines its commitment to a duty of candour to patients and families where care failings occur and the CCG will promote and monitor this approach in its commissioned services.

Patient Safety has also been highlighted as of primary importance by Professor Don Berwick in his report ‘Improving the safety of Patients in England’ stating the NHS should “Place the quality of patient care, especially patient safety, above all other aims”. The CCG will engage with the new patient safety collaborative being set up by NHS England and with the new systems for reporting and learning from patient safety incidents to prevent reoccurrence and to drive improvements in practice and service delivery. In particular the culture of reporting and learning is key to this and the CCG will be seeking engage with providers to achieve this aim in relation to key outcomes.

8.2 Response to Francis, Berwick and Winterbourne View

8.2.1 Francis Report

In February 2013 the Francis report 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.

The report stressed that to achieve this would not require radical reorganisation but re-emphasis of what is truly important:

- 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 CCG has responded to the findings and recommendations in the following ways.

- following on from the initial authorisation process, the CCG has established processes, to ensure that patterns of concern are recognised and compliance with essential standards of quality and safety are maintained. Through joint working with the Local Authority and NHS England’s Area Team, the CCG is seeking to ensure openness, transparency and candour throughout the system about matters of concern. These are discussed regularly by the CCG governing bodies and with other stakeholders, e.g. at the Local Area Quality Surveillance Group.

- contract specifications and incentives, for example CQUIN, are being used to enable improvements 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 will continue to consult with patient forums and local representative groups. They have developed an inclusive approach to decision-making processes through Board and public meetings and other stakeholder events. The CCG maintains high visibility through interactions with their local communities and provider services to promote a recognisable identity which becomes a familiar point of reference for stakeholders.

The CCG is committed to working with our acute hospital and organisations providing healthcare in our area to ensure that our patients receive the best possible care, have a positive experience of healthcare and are treated safely. The CCG is actively working with the public, patients, patient groups 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.

The CCG will continue to consult with patient forums and local representative groups, and have developed an inclusive approach to decision-making processes through Board and public meetings and other stakeholder events. The CCG maintains high visibility through interactions with their local communities and provider services to promote a recognisable identity which becomes a familiar point of reference for stakeholders. 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.

8.2.2 Berwick Report

8. Improving Quality of Services

The report echoes concerns underlined in both Mid Staffordshire NHS Foundation Trust Public Inquiry and the Keogh Report, which brought into question the quality of hospital standards. In a coordinated effort to improve services every hospital in the country is to be inspected by CQC by 2015 and the outcomes of these inspections will be monitored by the CCG and assurance sought that improvements in care and services that are identified as being necessary are implemented and reviewed to ensure quality and safety is assured.

The report made ten recommendations to help the NHS make care safer:

**The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning:**

Learning from incidents and serious incidents is regularly scrutinised by the Quality and Patient safety team. The CCG Governing Body and Clinical Scrutiny Committee overview and scrutiny of trends and themes occurs and the monitoring of improvement plans and quality standards and performance supports and triangulates findings.

The CCG will continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning. The CCG will maintain and develop a patient safety strategy; which will be in partnership with providers across Suffolk. This will ensure learning from incidents and serious incidents is reviewed, identifying trends and themes triangulating this with other quality indicators to identify early warning signs in the system. The CCG is strengthening its patient safety function through the recruitment of key staff to support both the prevention and control of infection and the learning from the reporting of serious incidents. The CCG will also strengthen links with the patient safety collaborative, co-ordinated by the Academic Health Sciences Network to address local priorities and support continued service improvement.

The publication of the Statutory Duty of Candour in October 2014 has both enforced existing contractual requirements and sets clear standards against which all healthcare organisations are being closely monitored to ensure they are being open and transparent in order to promote a culture supportive of continuous improvement in patient safety. Increased reporting will be paramount to this as this will be a clear indicator that each commissioned provider has a no blame culture and is using patient safety metrics as a learning tool to improve patient outcomes.

The CCG will develop models, systems, and processes for assessing and improving safety and the quality of care. Patient safety measures will be evidenced as a priority in provider contracts and for future service design.

The CCG will engage positively with Health Education East of England (HEE) to ensure sufficient staff is available to the local health system in future years. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.

The CCG will ensure 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 Higher Education Institutes (University Campus Suffolk). Safer staffing levels and the professional development of key staff is regularly discussed and monitored through quality review groups and quality improvement visits to providers.

**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 operates a programme of Quality Improvement visits to engage with providers and increase visibility of commissioners to ensure 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.**
8. Improving Quality of Services

The CCG is committed to the active engagement of patients and the public in our work. One of our six priorities is to demonstrate excellence in patient experience and patient engagement. We have put in place a number of mechanisms to make sure that patients and carers can be involved at all levels:

- the Community Engagement Group – this is a subcommittee of the governing body made up of appointed members of the public, who influence and scrutinise the CCG at a strategic level. Meetings are held in public across West Suffolk. Members of the Community Engagement Group have already linked in with some of the CCG’s workstreams to ensure the patient voice is heard in our commissioning – e.g. urgent care review meeting, integrated care workshop and dementia engagement. This work will continue.

- Shared Decision Making – this is when the clinician and patient discuss options for treatment when there is no single treatment that is better than another. This allows the patient to think about possible outcomes, positive and negative, and to discuss what is most important to them. As a result, the clinician and the patient work together to make the best choice that meets the patient’s preferences.

We have launched a programme of Shared Decision Making, beginning with clinical specialties at West Suffolk NHS Foundation Trust, but it will be expanded across the hospital and into other local health providers, leading to a real change in culture

- support for carers – the CCG launched a one year project to help GPs identify and support family carers. Two family carer advisers have been appointed to deliver the project, which is being run by Suffolk Family Carers. The advisers work with GP practices to help them identify family carers, and to appropriately support them and signpost them to other helpful organisations

- the Health Forum – this is the free membership of the CCG. Members of the public register an interest in hearing updates from the CCG and opportunities to get involved at meetings and events. As a result, members receive a bi-monthly newsletter from the CCG, as well as being the first to hear the latest news from health partners and the latest consultations, surveys, meetings and events.

- Patient Revolution events – these are the large, annual CCG conferences for patients, the public and stakeholders. The twist is that there is no set agenda; people who attend can set up discussion groups on the issues that are most important to them. The CCG has used the comments and feedback from these events to shape its planning and regularly keeps in touch with attendees to report back on actions taken as a result;

- in February 2014, the CCG began using Patient Opinion to help collect and collate patient feedback to provider organisations. Plans are underway to promote the use of Patient Opinion to the public;

- market stall events – during summer 2014, the CCG took a health roadshow around West Suffolk marketplaces, giving local people the opportunity to find out more about the CCG and local health services. This will continue into 2015. As well as taking the CCG out to a different audience of people that may not book onto events, it also resulted in a great deal of comments and feedback that was taken back to the relevant teams and colleagues for action.

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.

The monitoring of capacity of organisations to deliver safe services through well trained and adequate staffing resource occurs through CCG quality and contractual monitoring systems.

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
8. Improving Quality of Services

The CCG will need to ensure 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.

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.

The CCG currently holds Investors in People Gold Level award. The Personal Development Process places an emphasis on line manager supporting learning intervention, our values and behaviours Patient Centered, Respect, Enabling Excellence and Integrity describe how for example; we will listen and act on what the public say and keeps them informed of what is happening; support a no blame culture and recognising that we are all accountable for our behaviour towards others; develop confidence and maximise potential through learning, nurturing and development; regularly benchmarking work to the appropriate standards of quality and excellence (e.g. researcher publications, programmes and league tables).

Transparency should be complete, timely and unequivocal. All data on quality and safety, whether assembled by government, organisations, or professional societies, should be shared in a timely fashion with all parties who want it, including, in accessible form, with the public.

The CCG’s Integrated Performance Report, which reports on clinical quality and patient safety issues is presented monthly to the Clinical Scrutiny Committee and the public meetings of the Governing Body. 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 CCG actively seeks continuous improvement through the complaints process and welcomes and respond positively to complaints. All complaints are investigated thoroughly, being transparent to the patient and their family using a coordinated approach with other agencies if care has overlapped. The CCG uses the patient voice (as set out above) to improve the quality and safety of care.

The CCG promotes a duty of candour implemented by providers alongside public involvement in service redesign and scrutiny.

The CCG monitors the implementation of patient safety alerts issued through NHS England in monitoring of its local contracts and quality measures with providers.

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 NHSIC to monitor and benchmark the quality of local services.

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 monitor the implementation of patient safety alerts issued through NHS England 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 willful 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 NHSIC to monitor and benchmark the quality of local services.
8. Improving Quality of Services

8.2.3 Transforming Care (Winterbourne)

The Department of Health published Transforming Care: A national response to Winterbourne View Hospital which described the changes needed in the system and the lessons learnt.

The review indicated that failings were widespread within the Winterbourne View organisation but also across the wider care system. The ongoing review of care for this cohort of clients seeks to address poor and inappropriate care and achieve the best outcomes for people with a learning disability or autism, who may also have mental health needs or behaviour that challenges.

A new monthly data collection will enhance public reporting on progress to implement the NHS commitments in the Winterbourne View Concordat robust. It will also be used to triangulate with the Learning Disability Census after February 2015.

The Winterbourne report sets 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.

In response to Transforming care, the CCG will:

- ensure that the, the cohort of Suffolk winterbourne clients continues to be a focus for discharge to an appropriate setting in the community reviewed as outlined in the per winterbourne concordat;
- ensure all Suffolk clients have had a joint review by their CCG, Norfolk and Suffolk NHS Foundation Trust and Suffolk County Council and identified that all clients have potential discharge dates and are supported to access supported living arrangements in Suffolk where appropriate. Those clients who are still residing in care settings and awaiting suitable care provision to meet their needs were offered a further care and treatment review in December 2014 to facilitate their discharge from hospital to a community setting. This will enable robust transition and discharge plans to be formulated and delivered to ensure the most appropriate care package is commissioned for the client.
- a joint Winterbourne sub-group will feed into a joint working and commissioning by health and social care partners continues to develop forums to ensure the needs of the learning disability clients within Suffolk have the right services in place to ensure they are supported to live as independently as possible.
- the winterbourne concordat report of Sir Stephen Bubb published in November 2014 – ‘Winterbourne View – time for change’ will also provide a backdrop for and inform the commissioning approach going forward for the improvement of services for other vulnerable people with learning disability and/or autism.

8.2.4 Timescales

The timescales that apply to the Winterbourne View are 31 March 2015 where this is appropriate.
8. Improving Quality of Services

In relation to the Berwick Report, the development of a Patient Safety Strategy is scheduled for May 2015, with an action plan for 2015/16 available from May 2015.

Timescales on Francis Report, linked to the updates and progress, will be monitored routinely through the Health and Wellbeing Board. Safer staffing are monitored though Quality monitoring meetings from and this will be on-going in 2015/16. Reporting in provider’s quality accounts of patient safety and quality improvements and plans will be available from June 2015.

New systems and mechanisms for reporting incidents and for receiving alerts are being put in place from April 2015 in the CCG, subject to new national reporting consultation outcomes. Additionally, the improved reporting of all incidents by providers will be developed and monitored as part of the approach to delivering the CCG Quality Premium for 2015/16.

8.3 Patient safety

The Suffolk strategy for patient safety focuses on the three domains of quality defined in High Quality Care for All (2008):

- safety: ‘do no harm’ – keep patients as safe as possible;
- effectiveness: ‘success’ – clinically effective and cost effective treatments; and
- patient experience: ‘quality of caring’ – understanding patient satisfaction through their experiences.

The CCG will commission services that are safe, clinically effective and support a positive care experience.

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 will enable the consideration of emerging themes and trends in patient safety and harm to patients. This is supported by an evidence-based dashboard for the CCG Governing Body that provides both assurance and early warning of quality concerns in commissioned services. Review the quality assurance mechanisms that are in place across the range of commissioned services and ensure appropriate quality monitoring and governance arrangements are in place.

Other key programmes of work include:

- development of a system wide professional and public communications campaign for harm free care;
- full implementation of the Clostridium difficile reduction plan;
- commissioning 100% use of high impact intervention;
- working with health care regulators, the Local Authority, Healthwatch and other commissioners to share information and support continuous quality improvement;
- developing and implementing a commissioning Infection Prevention and Control Strategy.

The CCG will also cooperate with and participate 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 be promoted through contractual and quality improvement discussions with providers and stakeholders. Monitoring of the levels of reporting through the NRLS system and through Serious Incident reporting routes will support the NHS Outcomes framework aim of higher reporting and the emergence of diminishing levels of harm are achieved by providers of services through the application of best practice and innovative approaches to service delivery. E.g. pressure ulcer prevalence.

The CCG will 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. Participation in quality surveillance group to identify early warnings of service and quality failings in order to address the risks to patient that they potentially raise.
8. Improving Quality of Services

8.3.1 Venous thromboembolism (VTE)

Venous thromboembolism (VTE) prevention is recognised as an international patient safety issue, and prevention is about saving lives and reducing long term ill-health and avoidable harm to patients. Providers are required to undertake audit of thromboprophylaxis and root cause analysis of all cases of VTE events associated with hospitalisation as specified in the NHS Standard Contract.

The CCG’s contract with its local provider contains a requirement to audit appropriate thromboprophylaxis and to scrutinise Root Cause Analysis for cases of VTE. The requirements are:

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<td>VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance</td>
<td>95%</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £200 in respect of each excess breach above that threshold</td>
<td>Monthly</td>
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The CCG will incorporate VTE risk assessments in its quality monitoring processes going forwards, and any deterioration in performance, or performance failure, will be escalated through the contractual Service Level Agreement (SLA) meetings, with appropriate contractual sanctions being applied.

8.3.2 Sepsis and acute kidney infection

NHS England has identified tackling sepsis and acute kidney injury as two specific clinical priorities for improving patient safety in 2015/16. It is predicted that improving care in these areas would have a significant potential impact on reducing premature mortality over a five year timeframe.

In response to this, the CCG will utilise contract specifications and incentives, for example CQUIN, to enable improvements in local services and to encourage and enhance the local providers of services to pursue high quality effective services. In 2015/16, there will be CQUIN schemes related to incentivising quality improvements specifically for sepsis and acute kidney injury. The CCG will continue to monitor quality information generated by providers collected through inspections carried out at Quality Improvement Visits, from investigations of incidents and from complaints. Providers are held to account for necessary improvements and action plans, and are required to report on themes and trends in their Boards and Annual Reports and Quality accounts.

8.4 Patient Experience

The CCG will encourage feedback and value the role of patients and healthcare professionals in shaping, monitoring and improving services The CCG will continue to report, monitor and provide feedback regarding concerns raised by the public and other agencies. Patient stories are shared at all levels of the organisation to illustrate patient experience and to determine commissioning intentions.

The CCG provides a framework and training to support involvement of members, lay personnel, GP practices and patients in quality assurance processes e.g. mystery shoppers and involvement in quality improvement visits. In addition, the CCG utilises Patient Advisory Groups, Patient Reference groups and other community groups to support patient experience feedback.

Quality dashboard reporting will assure each provider is performing against agreed metrics. Patient experience metrics will be triangulated with other quality indicators such as patient safety reporting and will have a high profile through quality sub group meetings for each contracted provider.

Safeguarding remains a priority for the CCG; ensuring compliance against legislation and national and locally agreed policies.
A Safeguarding dashboard will assure commissioners that reporting thresholds are robust, investigations are transparent and ensure learning is continuous to ensure the vulnerable achieve the best possible care and robust information sharing processes are in place providing a seamless transition between services. Patient experience metrics are reviewed contractually for all commissioned providers identifying trends and themes of the complaint 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.

Expansion of the FFT means that by April 2015 it will be introduced across NHS funded services including GP & Dental Practices, ambulance, mental health and community services as well as out-patients. It will be applicable to all providers, inpatient areas, A&E, paediatrics, obstetrics and gynaecology and outpatient clinics. Specifically:

- 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 organisation’s values and behaviours. Our quality improvement visit programme also focuses on feedback from patient and staff ensuring whistleblowing policies are known and understood and staff trusts the organisation has a no blame culture;

- the CCG’s CQUIN for FFT is driving an increase in the percentage of respondents who would recommend services concentrated within inpatient areas of all providers. This will provide an opportunity for providers to review patient safety clinical quality and patient experience metrics to improve the overall patient satisfaction in their experience of care;

- patient experience of vulnerable patients will be improved through learning from serious incidents and serious case review findings, and the further development of the Multi-agency Safeguarding Hub (MASH), a joint initiative between health, social care and the police for both children and adults.

- joint working with Suffolk County Council to ensure admission prevention strategies and early supported discharge is in place;

- liaison nurses for Psychiatry, learning disabilities and dementia forms part of the strategy of the CCG. Development of specific feedback mechanism related to each vulnerable group will be integral to capture issues important to them as well as capturing carer feedback. Through adult safeguarding forums and information sharing mechanisms with Health watch, CQC, SCC and the CCG will continue and strengthen by joining quality monitoring of providers, particularly in the care home sector and supported living

- the CCG will continue to review all patient experience feedback from both the provider and the CCG itself. These are reported monthly through performance reporting to both the Executive and Governing Body.

- the CCG will monitor staff feedback more consistently through the FFT test will provide an opportunity to monitor improvements month on month, work with providers to identify areas of concern and triangulate with patient safety and patient experience metrics. As this is a national initiative, the ability to measure against other providers will be beneficial as a benchmarking tool.

8.5 Improving antibiotic prescribing in primary and secondary care

Actions already completed:

- antibiotic formulary – has been updated for 2014-2016, in collaboration with microbiologists from West Suffolk NHS Foundation Trust and Ipswich Hospital NHS Trust, and is available on the CCG’s website and has been distributed widely;

- antibiotic monitoring – Antibiotic prescribing reports are available for all GP practices on the CCG’s website. They are updated each month;
8. Improving Quality of Services

- ScriptSwitch messages – 19 of the CCG’s 25 practices have ScriptSwitch installed. Regular messages are included that relate to safe and appropriate use of antibiotics;
- research – Web-based scrutiny of strategies that other CCGs are using (or have previously used) to improve antibiotic prescribing.

Current actions in progress:

- antibiotic formulary and ScriptSwitch - ensuring that all messages from the Antibiotic Formulary are fully embedded in the CCG ScriptSwitch profile;
- antibiotic monitoring - reviewing and updating the antibiotic monitoring that is currently underway, with an emphasis on accurate monitoring of formulary adherence. the CCG will then promote the updated antibiotic reports more widely to GP practices;
- antibiotic strategy - discussing a strategy for improving antibiotic prescribing at the clinical Prescribing workstream meeting;
- antibiotic prescribing reports – updating the reports that are already produced and creating summarised data for each practice that shows the percentage variance from the national average for all antibiotics (per standardised denominator) and percentage of antibiotics that are prescribed as cephalosporins, quinolones and co-amoxiclav (as these are known to predispose to C.difficile);
- C.difficile – working in collaboration with NHS England Infection Prevention and Control Lead to link antibiotic prescribing data with data on incidence of C.difficile.
- European Antibiotic Awareness – review of the materials and information that are available on the EAA website.

Further actions planned:

- Quality Premium – the CCG will aim to deliver any performance target set as part of the Quality Premium framework for 2015-2016 in respect of appropriate prescribing of antibiotics;
- Antimicrobial Resistance Strategy assigned to Public Health England – review and support;
- Primis GRASP Urinary Tract Infection (UTI) audit tool – under development and is likely to be useful for GP practices;
- Antimicrobial Stewardship – understanding the national position and initiatives that are being promoted;
- Medicines & Healthcare Products Regulatory Agency (MHRA) – review of work being done to address inappropriate/inaccurate recording of antibiotic allergies;
- involving community pharmacists – e.g. educational pack on prescribing behaviours includes antibiotic patient information leaflets for community pharmacists to promote;
- involving care homes – e.g. training care home staff to correctly diagnose UTIs.

8.6 Compassion in practice

Over the last few years there has been an increasing perception that the caring dimensions have been focused on targets, financial constraints, reduction in length of stay, increased acuity and technical competence (DH 2005; Burdett Trust for Nursing 2006; London Network 2007; Help the Aged 2008; Healthcare Commission 2009; Patients Association 2009). Alongside this has been a perception within the nursing profession that nurses have “lost their way” (Maben & Griffiths 2008). This has led to Compassion in Practice, the new three year vision and strategy for nursing, midwifery and care staff.

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.
8. Improving Quality of Services

The CCG’s strategy aligns to the national vision for nursing as described in *Compassion in Practice* and provides the opportunity for discussion at local level to plan how the vision will be realised. It outlines ways that individuals, teams, managers and organisations can demonstrate and embrace the six values (care, compassion, competence, communication, courage and commitment) and the actions that go alongside them. Specific areas are identified to work on to help these behaviours become embedded in practice.

Nursing is a major component of nearly every healthcare service that we commission from our providers - including hospitals, community services, mental health care, nursing homes or care provided in the home. The CCG recognises that nurses, midwives and care staff will lead or support many of the changes needed for us to realise our ambitions.

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, treat with dignity by a workforce who are competent, committed and have the courage to act as the patient advocate at all times. Each provider is developing value based recruitment, staff surveys as part of the Friends and Family Test, ensuring a workforce has high morale to deliver safe and effective care.

Addressing compassion in practice is fundamental to the approach the CCG takes to commissioning from all its providers across all settings and in developing integrated working with local stakeholders in social care and the voluntary sector. The Parliamentary and Health Service Ombudsman in 2011 in the report ‘Care and Compassion’ highlighted gaps in the promise of care and compassion and the personal experiences of in particular older people accessing NHS care. The CCG continues to develop its community and patient involvement strategies to ensure that the vision and culture underpinning the 6c’s are reflected across the health and care sector for the Suffolk population in its planning and design of services.

The CCG will work with providers of education to ensure that compassion in practice is a key component in education and training for all staff and that raising awareness in the workplace and settings were service users access care are prominent.

8.7 Staff satisfaction

Staff satisfaction as a metric is not only necessary for healthcare providers to encourage staff engagement (the process by which staff come to have a positive attitude towards the organisation and its values) but to accelerate it; evidence from a wide range of sources, highlights that:

- patient satisfaction is consistently higher in trusts with better rates of staff health and wellbeing;
- there is a link between higher staff satisfaction and lower rates of mortality and hospital-acquired infection;
- stress and burnout are more frequent in the NHS than in other sectors. Approximately 30% of sickness absence in the NHS is due to stress.

The CCG has taken the following steps to increase staff engagement, including:

- articulating values in plain English and showing how they translate into behaviours, this forms part of compassion 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 care in an emotional setting, allowing training for reflective practice;
- developing leaders ensuring they have the right management skills. This will include clinical staff;
- developing and implementing Health & wellbeing strategies.

Staff voices are heard through annual surveys, but the development of Friends and Family Test ensure the staff voice is heard continuously. 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.
8. Improving Quality of Services

The Quality Improvement visit programme represents an opportunity for commissioners to fulfill their duty to patients and the public for the quality of commissioned services by:

- connecting with patients, carers and staff at the point of care
- further developing relationships and understanding between clinical commissioners and providers
- developing a better understanding and experience of the care environment that has been commissioned
- enabling commissioners to triangulate evidence of adherence to care standards, achievement of Suffolk-wide Harm Free Care, CQUINS, Patient Experience and staff satisfaction.

The CCG has comprehensive appraisal process that supports the objectives of the CCG. The personal development needs are collated by HR and used to develop the CCG training plan.

The CCG undertakes staff surveys relating to EDS2, Behaviours and Values, and through a number of staff engagements groups. The Staff Partnership Forum, “Great Big Ideas”, Organisational Development Group, the Health & Wellbeing group and staff “Away Day” Group all have an in-depth understanding of the factors affecting staff satisfaction in the local health economy.

In terms of staff satisfaction locally, the CCG has been benchmarked against the Investors in People Standards. In March 2014. The CCG’s gained the Investor in People (iIP) Gold award. In 2013 and 2014 the CCG was once again recognised as one of the top ten NHS organisations at the HSJ Annual Awards for Staff Engagement. Following the staff “Away Days”, the CCG surveys its staff on their thoughts and views of the day. At the 2013 “Away Day”, two of the speakers were patient representatives – Ipswich Hospital User Group and West Suffolk Patient & Public Involvement (PPI). In 2014 the CCG took a different approach at its away day and learnt experiences from other organisations including the private sector on team motivation and the effect this has on the workplace.

The CCG has delivered a range of workshops, all day, half day and Lunch and Learn (1 hour) sessions on a range of areas that includes, the Francis Report; Stress Awareness; Communication Skills; and Integrated Service Planning.

Appraisal objectives and development needs are reviewed regularly to ensure that staff are on-line to meet their objectives and development needs. The KSF outlines provide clear and coherent standards that relate to the CCG objects – this work is supported by the findings of Borrell and West, which says that there is a clear correlation between patient outcomes and employee engagement and satisfaction.

The plans ensure that there will be a measureable improvement in staff experience in order to improve patient experience.

The CCG will also monitor staff feedback more consistently through the Friends & Family Test which will provide an opportunity to monitor improvements month on month, work with providers to identify areas of concern, and triangulate with patient safety and patient experience metrics.

8.8 Seven day services

“Everyone Counts: Planning for Patients 2013/14” first signalled that the NHS will move to providing routine services seven days a week. This will deliver a much more patient-focussed service and one which offers the opportunity to improve clinical outcomes. The NHS Services, Seven Days a week Forum was established to consider how NHS services could be improved and made available across the seven day week.

The Forum set out ten evidence-based clinical standards that were recommended as being adopted by the NHS to end current variations in outcomes for patients admitted to hospitals at the weekend.

- **Patient Experience** - Patients, and where appropriate families and carers, must be actively involved in shared decision making and supported by clear information from health and social care professionals to make fully informed choices about investigations, treatment and on-going care that reflect what is important to them

- **Time to first consultant review** - All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours of arrival at hospital
8. Improving Quality of Services

- **Multi-disciplinary Team (MDT) review** - All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant. An integrated management plan with estimated discharge date and physiological and functional criteria for discharge must be in place along with completed medicines reconciliation within 24 hours.

- **Shift handovers** - Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation from the relevant incoming and out-going shifts. Handover processes, including communication and documentation, must be reflected in hospital policy and standardised across seven days of the week.

- **Diagnostics** - Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:
  - Within 1 hour for critical patients
  - Within 12 hours for urgent patients
  - Within 24 hours for non-urgent patients

- **Intervention / key services** - Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols, such as:
  - Critical care;
  - Interventional radiology;
  - Interventional endoscopy;
  - Emergency general surgery.

- **Mental Health** - Where a Mental Health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week:
  - Within 1 hour for emergency care needs;
  - Within 14 hours for urgent care needs

- **On-going review** - All patients on the AMU, SAU, ICU and other high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway.

- **Transfer to community, primary and social care** - Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken.

- **Quality improvement** - All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement. The duties, working hours and supervision of trainees in all healthcare professions must be consistent with the delivery of high-quality, safe patient care, seven days a week.

The CCG incorporated delivery of the ten Clinical Standards by 2016/17 within the 2014/15 CQUIN Scheme, and has stipulated that West Suffolk NHS Foundation Trust develop an action plan (a requirement within the Service Development and Improvement Plan section of the NHS Standard Contract) to be completed in
8. Improving Quality of Services

Month 1. There is also a requirement for baseline collection against all standards and partial compliance of the Clinical Standards in readiness for 2016/17.

Nationally, the Seven Days a week Forum will set out further proposals for a fully integrated service delivering high quality treatment and care seven days a week. The CCG will embrace these findings in delivering services locally.

During 2013/14, an outcome based 7 day working CQUIN was delivered for the review of patients within 24 hours, including access to diagnostics and links to 24/7 critical care team. For 2015/16, the CQUIN will be a core principle that underpins service delivery across the health system through a comprehensive action plan against all the requirements of NHS Services, Seven Days a Week: Clinical Standards.

For the system to be most efficient and effective it needs to manage demand & flow across the health and care system and therefore needs to maximise utilisation of resources by ensuring the ‘best’ advice and support is available to the practitioner at the time of need. Through this, the system will:
- improve patient Family Carer experience;
- reduce avoidable admissions;
- reduce length of stay.

The CQUIN is part of a range of initiatives across providers to develop seven day working across the system, focusing on urgent and emergency care patients. It supports practitioners to:
- optimise clinical management of patients;
- avoid unnecessary admissions;
- improve overall length of stay and
- ensure shared care planning is in place.

The CQUIN aims to extend services that improve clinical outcomes, with the benefit of providing a more focussed patient service.

The CQUIN builds on the work undertaken by the system to integrate services, providing a streamlined, comprehensive offer to the adult patient and their family/carer, as well as the 2013/2014 7-day working CQUIN to ensure we meet the every day counts case. Milestones for this CQUIN are based on national clinical standards:

Year 1 (2014/15)

- provider to write a comprehensive action plan to be shared with the Integrated Care Steering Group designed to deliver baseline assessments of current weekend performance (quality and productivity) against all the requirements of NHS Services, Seven Days a Week: Clinical Standards. Plan to include Milestones for delivery.
- continued delivery of 2013/14 schemes:
  - all newly arrived ward patients during the week to be visited by a ward consultant within 24 hours and to have an admission and discharge plan;
  - all new arrivals to wards at the weekends to have consultant review within 24hours to agree admission and discharge plans;
  - diagnostic tests (CT, ultrasound) to be available at weekends if the referring clinician considers the test will change the clinical management of the patient or reduce Length of Stay (LOS);
  - weekend consultant to link with the 24/7 critical care outreach team in the management of deteriorating patients;
  - all patients admitted to the AMU (F8) will be seen by a Consultant each day of the week. All patients where there is a significant clinical concern at handover on a Friday evening or where such concerns are raised by ward staff during the weekend will be reviewed by a Consultant during the weekend;
  - access to diagnostic tests to be reviewed with expectation that faster turnaround times of some scans will expedite patient throughput;
8. Improving Quality of Services

- determine methodology and commence collection of baseline data for the Keogh’s NHS Services, Seven Days a Week: Clinical Standards.

Year 2 (2015/16): Trajectory by ward/service to achieving sustainable improvements including:

- levels of seniority by area at each point in the week;
- plans around how flow might be better co-ordinated for surgical and medical support;
- workforce plans (including revisions to job plans);
- resource plans;
- communications;
- inter-agency working.

8.9 Accountable Clinician and Informed Patients

The CCG fully endorses the Academy of Medical Royal Colleges’ “Guidance for taking responsibility: accountable clinicians and informed patient”, which articulates that a patient’s entire stay in hospital should be coordinated and caring, effective and efficient with an individual named clinician taking overall responsibility for their care whilst retaining the principles of multidisciplinary team working.

The guidance further ensures that every patient knows who their Responsible Consultant/Clinician, with this overall responsibility for their care is and also who is directly available to provide information about their care.

The CCG will work with providers during 2015/16 to embed the practice of clear clinical accountability, with a named doctor responsible for a patient’s care within and across different settings, and will work to embed this requirement into provider contracts through the 2015/16 contracting process.

8.10 Care Quality Commission (CQC) Inspection Reports & Ratings

The CCG will, together with its local providers, actively use CQC’s inspection reports and ratings, as they roll these out during 2015/16, to assure themselves of the quality of care being provided to patients in west Suffolk. Key points of learning will be drawn from reports where care is good or outstanding, and the quality of care further enhanced where this is possible. Where the quality of care requires improvement or is highlighted as being inadequate, the CCG will agree joint plans with providers (including with stakeholders from social care, where appropriate) to embed improvements in the areas identified.

8.11 Safeguarding

8.11.1 Adult Safeguarding

The Suffolk-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 Suffolk County Council, identifying reporting thresholds in line with the national guidance, and ‘No secrets’ guidance which is facilitated by the health sub group chaired by both Suffolk CCGs.

Adult safeguarding is similar to safeguarding children and young people and Suffolk County Council leads as the statutory agency. The adult safeguarding board hosted by the local authority has membership of all key stakeholders which includes membership of both commissioners and providers. The lead for safeguarding represents both Suffolk CCGs at the partnership board and chairs a health sub group to provide assurance that safeguarding processes across all commissioned services are in place. The health sub group also ensures key actions from the partnership is driven forward.

Information sharing practices are being evidenced through joint working and reporting of safeguarding issues through clinical quality reports for all providers to ensure key learning points and system wide learning is implemented.

Increased surveillance of all commissioned providers through quality improvement visit programme provides assurance that adult safeguarding processes, reporting, training and education is in place and recommendations for improvements are monitored through quality sub meetings that fit into the monthly contractual review process.
8. Improving Quality of Services

Reporting mechanisms in the form of KPIs will be clearly set out in each contract with providers and reporting on all aspects will take place monthly. Information from these visits is shared openly with the LA and the CQC to promote a system wide response to areas of concern or to disseminate good practice. Quality Inspection Visits are in place to review safeguarding systems and processes, as well as asking staff and patients for feedback.

Serious incident reporting from NHS providers is shared with adult safeguarding of the local authority to ensure how root cause analysis and lessons learned and implementation of are robust and provides the partnership board that health investigations identify change in practice to improve the overall patient experience. Safeguarding referrals and lack of reporting will be monitored through quality sub group meetings that fit within the contractual process.

Suffolk has two lead GPs that provide clinical leadership for Adult safeguarding, they assist with the strengthening of safeguarding processes within primary health care, raise awareness of the safeguarding agenda, identify education opportunities, provide advice and support to GPs and monitor outcomes and action from investigations.

All commissioned providers are undergoing a self-assessment to review adult safeguarding policies and procedures and education and training. This will be reported to the health subgroup developing actions plans with each provider which will feed into the adult safeguarding board work plan. A self-assessment on all clinical staffs understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLs). DOLs will coincide with this self-assessment and education and training will be developed Suffolk wide to address the training needs identified.

Adult safeguarding training will be standardised against the Bournemouth competency framework. The Mental Capacity Act/ DOLS competency framework will be developed and rolled out as a Suffolk-wide system within health. All providers are currently using the Social Care Institute for Excellence (SCIE) guidance around MCA and DOLS and all providers have an induction programme for all new starters as well as having yearly updates. The self-assessment will be completed by 30th June 2014 and reported to the August Adult safeguarding board.

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 is aimed at frontline staff and it is intended to give an awareness and understanding of the Prevent agenda, improve understanding of the processes used by terrorists to radicalise individuals, support professional judgement to recognise potentially vulnerable individuals who may be susceptible to messages of violence, give the confidence to use a common sense based response and ensure 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.

8.11.2 CCG Safeguarding Children Policy

In March 2014, West Suffolk CCG and Ipswich & East Suffolk CCG published a joint Safeguarding Children Policy, which will ensure keeping children safe will be at the heart of all planning and decision making for services commissioned through the CCG. The CCG will ensure that its contracts clearly specify safeguarding expectations and responsibilities for all health providers of services they commission as set out in its Safeguarding Children policy. A key component of this will be working together with partners to achieve this and make sure that all health staff across the geographical boundaries of the CCG understands their role in the safeguarding of children and young people health and promotion of their welfare.

Our Vision is to deliver a highly specialist, quality focused, safeguarding children’s service that places the child/children or young person not only at the centre of care, but at the centre of planning, contracting, delivery and performance monitoring of services to children and adults carers. We aim to:

- systematically improve and develop safeguarding and looked after children (LAC) practices through the application of consistent standards, learning from experience, audit findings, reviews, research and policy guidance;
8. Improving Quality of Services

- ensure that staff working in safeguarding children and LAC services demonstrate the value and competencies required for the job;
- work with different partners/organisations to promote the safeguarding children and LAC services;
- encourage consulting children, young people and their families/carers to ensure that their views are considered as part of service redesign or changes;
- ensure that children are not disadvantaged through diversity, learning, communication, or emotional and mental health problems.

A Safeguarding Children Outcomes’ Framework has been developed to identify the key standards required to ensure that safeguarding arrangements fit into the quality agenda and that there is a culture for improving the outcomes for children.

The CCG will gain assurance regarding the quality of safeguarding arrangements across the Collaborative through the Chief Nurse as the Executive Lead for Safeguarding Children and who represents the CCG on the Suffolk LSCB. The CCG Safeguarding Team will lead on providing analytical reports for the CCGs regarding the effectiveness of safeguarding arrangements, support and challenge commissioners and providers to improve the outcomes for children across the health economy.

The CCG will work in collaboration with the NHS Commissioning Board to ensure that safeguarding children arrangements are in place across the health economy and will co-operate with the local authorities in fulfilling duties towards looked after children, including health assessment and planning.

8.11.3 Dashboard and reporting

Work is progressing to include the information required from providers by commissioners in KPIs. A performance management tool has been developed by designated professionals. This will be used across the CCG to obtain key performance data from all health providers from April 2014.

As outlined in the revised Working Together’ (CCGs) will be the major commissioners of local health services and will be responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. The dashboard will be used as a tool to provide commissioners with assurance that providers are compliant with their safeguarding responsibilities.

Key Performance Indicators

<table>
<thead>
<tr>
<th>Standards/Key Indicators</th>
<th>Performance</th>
<th>Method of monitoring</th>
<th>Monitoring information prepared by</th>
<th>Minimum frequency of monitoring</th>
<th>Monitoring reported to</th>
</tr>
</thead>
<tbody>
<tr>
<td>A wide variety of standards and indicators set by the LSCB to confirm that in discharging its functions, WSCCG &amp; IECCG has regard for the need to safeguard and promote the welfare of children</td>
<td>A wide variety of standards are set by the LSCB to confirm that in discharging its functions, WSCCG &amp; IECCG has regard for the need to safeguard and promote the welfare of children</td>
<td>Section 11 audit (Section 11 of the Children Act 2004)</td>
<td>Designated Professionals</td>
<td>Annually</td>
<td>CCG Boards LSCB NHS England Chief Nursing Officers</td>
</tr>
<tr>
<td>As set by the NHS Chief Executive in July 2009 (the ‘Nicholson letter’)</td>
<td>Public declaration of safeguarding children arrangements posted on all CCG websites</td>
<td>As set by the NHS Chief Executive in July 2009 (the ‘Nicholson letter’)</td>
<td>Designated Professionals</td>
<td>Annually</td>
<td>CCG Boards Chief Nursing Officers</td>
</tr>
<tr>
<td>As set out in the CCGs Safeguarding Children Dashboard</td>
<td>Performance management dashboard to inform Board reports</td>
<td>As set out in the CCGs Safeguarding Children Dashboard</td>
<td>Designated Professionals</td>
<td>Quarterly with monthly performance updates</td>
<td>CCG Boards Chief Nursing Officers</td>
</tr>
</tbody>
</table>

A highly competent and skilled Medical and Nursing team has the necessary experience and knowledge to deliver in a very complex, high profile and priority area of health policy and practice. They have extensive
experience of working across different types of NHS Organisations, local authorities and partner agencies to help them understand the complexities of health responsibilities in Safeguarding children and the statutory nature of the responsibilities associated with its effective delivery.

The Safeguarding Children Policy provides support to the CCG and strengthens local safeguarding assurance arrangements for services commissioned for the local children and families. It also sets out a framework to underpin monitoring of safeguarding arrangements across the health economy.

The Director for Quality, Patient Safety and Nursing is the Executive Lead for Safeguarding Children and represents the CCG on the Suffolk Local Safeguarding Children Board. The Safeguarding Team consists of the Chief Nurse, Designated Doctors, Nurses and Lead GPs. This team will lead on providing analytical reports for the CCG regarding the effectiveness of safeguarding arrangements, support and challenge commissioners and providers to improve the outcomes for children across the health economy.

Currently the effectiveness of the safeguarding system is assured and regulated in a number of ways and include:

- via the Local Safeguarding Children Board
- via external inspection – Ofsted and CQC
- locally developed Peer Review processes
- action planning and monitoring processes following Serious Case reviews
- the safeguarding children dashboard
- section 11 audits

**Looked After Children - transition into adulthood**

There is a Care Leaver service in place commissioned by the CCGs and delivered through the SCC LAC specialist nurses which commences post 16 years and ends when a young person reaches 18 years. In relation to post-18 years mental health pathways for LAC – the CONNECT service – bespoke service for LAC ends at age 18.

Following on from this NSFT have developed the Youth Pathway for all young people (not just LAC) post 16 are considered to be in transition to adult services in mental health and these services go onto 24 years.

### Special Educational Needs

The Department of Education and the Department of Health have set out a joint vision for the special educational needs reforms and the case for change. It sets out that the needs for children and young people with special needs is the same as for all children and young people – that they achieve well in their early years, at school and in college; lead happy and fulfilled lives; and have choice and control.

The special needs reforms will implement a new approach which seeks to join up help across education, health and care, from birth to 25. Help will be offered at the earliest possible point, with children and young people with special needs and their parents or carers fully involved in decisions about their support and what they want to achieve. This will help lead to better outcomes and more efficient ways of working.

The overarching objective is that all those with special educational needs will have an Education, Health and Care Plans (EHC Plan). This includes making Personal Budgets available to those under 25 years old.

Local authorities are required to work with health and social care colleagues jointly to commission services to deliver integrated support for children and young people with special educational needs.

The Children and Families Bill includes the health commissioning duty: “where there is provision which has been agreed in the health element of the EHC plan, health commissioners must have arrangements in place to secure that provision. All provision reasonably required by a child or young person’s special needs must be included in the EHC plan.”

The CCG will explore ways of working with the local authority in the joint-commissioning of an integrated, personalised services and in the design of a local offer (including ensuring relevant contracts with providers
8. Improving Quality of Services

reflect the needs of the local population). Whilst details of funding are still to be decided, it is anticipated that it will be sourced though the £70m nationally awarded to Local Authorities through a Reform Grant.

8.12.1 Special Educational Needs and Disability (SEND) reforms.

The Children and Families Bill introduced new legal duties on local authorities and their partners (including CCG’s and health providers) to support children and young people with SEND from September 2014.

This will include the need for health to work jointly with the local authority to provide a single assessment process across agencies, joint Education, Health and Care (EHC) Plans and a clear offer to children and families what health services are ‘on offer’ to be provided. The guidance also points to the need for health and care to provide Personal Health Budgets (PHB’s) to children and families underpinning the SEND reforms.

Suffolk County Council has been allocated £887,780 through the SEND reform grant to assist the implementation process.

West Suffolk CCG (working closely with Ipswich and East CCG) and Suffolk County Council to ensure that the statutory changes are met. Personal Health Budgets (PHBs) are already in place (in Health) for those who have current Continuing Care, including Children, from October 1st 2014 and from 1st April 2015 for those with an Education, Health and Care Plan (EHC).

The CCG has embedded arrangements in Suffolk for joint commissioning children’s services including CAMHS, short break services and residential therapeutic provision on which to further build upon.
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9.1 Research and Innovation

9.1.1 Strategic Clinical Networks

The NHS Commissioning Board Authority has set out its plan for a small number of national networks to improve health services for specific patient groups or conditions. Called strategic clinical networks, these organisations will build on the success of network activity in the NHS which, over the last 10 years, has led to significant improvements in the delivery of patient care. The conditions or patient groups chosen for the first strategic clinical networks are:

- Cancer
- Cardiovascular disease (including cardiac, stroke, diabetes and renal disease)
- Maternity and children’s services
- Mental health, dementia and neurological conditions

East of England SCNs for all four patient groups have been established and are working collectively on these objectives. These will be supported by the CCG as appropriate.

9.1.2 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.

The EAHSN has developed an organisational network model that is designed to achieve full integration across our regional health system. The model requires effective and porous interfaces among academic departments, research organisations and delivery systems; this was best managed by creating a structure with a centre and four surrounding ‘nodes’.

Each node engages with partners from local government, primary, secondary and tertiary care, social care, public health and industry who became ‘members’ of the node, developing a network of robust relationships across the region encompassing all stages of the patient pathway.

Senior leadership and management from across the health system are integrated within the EASHN. The Chief Executive of WSFT is a Board Member on the EAHSN and Chair of the Cambridge and Peterborough node, which is the delivery arm focusing on work to innovate, adopt and spread best practice, deliver step change service improvement, and work collaboratively to generate wealth in the local health economy.

Both West Suffolk CCG and WSFT are members of the Cambridge and Peterborough node of EAHSN, helping to shape priorities from across the area and to influence projects in a way that works best for our system. The Chief Executive of West Suffolk NHS Foundation Trust is also part of the Chief Executives Forum representing the health system.

In the later part of 2013/14 the West Suffolk health system engaged in active conversation with the EAHSN to explore the application of telemedicine in preventing admissions from care homes and nursing homes. The viability of the project is currently being determined.

EAHSN is currently determining its priorities for 2015/16 and the plans of all commissioners within the EAHSN are being taken into account, including West Suffolk CCG’s.

9.1.3 Clinical Research Network: Eastern

The National Institute for Health Research (NIHR) Clinical Research Network – the clinical research delivery arm of the NHS in England - has embarked on a programme to update its organisational structure. The
9. Innovation

Organic growth has resulted in a complex structure of more than 100 local networks, some with overlapping boundaries, hosted by more than 70 different NHS Trusts and Foundation Trusts.

Over 2014-2015, the Clinical Research Network is carrying out a Transition Programme, which will see the organisation move to a more streamlined structure of 15 Local Clinical Research Networks, with boundaries that match those of the Academic Health Science Networks. These changes are being made to build on achievements to date, provide the platform for further service improvements, and develop the flexibility needed to respond to current and future changes in the NHS and research environments.

Each of the 15 Networks will be hosted by a single NHS Trust or Foundation Trust, which will manage funds for research delivery, and disseminate these resources to research-active providers of NHS services across its area. Every Local Clinical Research Network will deliver research studies across all therapy areas. Starting on 1 April 2014, the 15 hosts will be awarded five year contracts from the Department of Health, to act as the Network’s local branches.

They will take responsibility for performing the remit of the NIHR Clinical Research Network at local level and, collectively, will distribute £280 million of NIHR funding per year, to support the delivery of clinical research studies in their area.

The selection process was completed in September 2013 and Norfolk and Norwich University Hospitals NHS Foundation Trust has been appointed as host for the ‘Clinical Research Network: Eastern’, which encompasses WSFT.

In relation to clinical engagement, the Clinical Research Network will structure around specialties and themes. Each Local Clinical Research Network (LCRN) will determine how to configure its local specialty groups – the groups of clinicians who drive delivery of the local research delivery portfolio. The “map” below shows how the specialties/themes and the research delivery divisions relate to one another and this new structure will come into effect on 1st April 2014.

Within the Clinical Research Network: Eastern, six Research Delivery Managers have recently been appointed, who will plan the allocation of research delivery resources for the specialties in their division, facilitate day-to-day study delivery, and develop local stakeholder relationships to support the Clinical Research Network’s objectives.

The current Norfolk & Suffolk LCRN is a network that has been particularly successful since its inception in 2008. It has substantially increased the number of patients in our region being offered access to clinical trials, supported clinical researchers in getting their studies off the ground and delivered to time and to target, and has provided increasing value for money to the taxpayer.

The Primary Care Research Network (PCRN), LCRN & Norfolk & Suffolk Primary Care Research & Development, report on recruitment, number of studies approved and any pertinent additional activities to the Clinical Executive.

The role of the CCG research lead will input into the following strategic, operational and development areas:

- maintain a strategic overview of local and national research opportunities and ensure research updates are taken to CCG Executive Meetings.
- understand the national and local R&D strategy and priorities and agree research priorities for the CCG area with R&D, the CCG Exec and PCRN based on current activity and needs.
- promote the delivery of research within the CCG and, as appropriate work with R&D and PCRN to develop the research culture across the CCG area.
- in conjunction with R&D staff, be the point of contact between the NIHR Clinical Research Networks (CLRN, PCRN), and the CCG.
- work closely with other local CCG research leads, as well as regional and national leaders as required. Particularly contribute to the development of the new Academic Health Science Networks.

9.1.4 Primary Care Research Network East of England

PCRN East of England is one of eight regionally-based Local Research Networks which make up the National Institute for Health Research Primary Care Research Network in England. The region is split into smaller areas called locality teams enabling a more localised service with the aim of providing improved treatment and services for NHS patients by working in partnership with patients, researchers, and primary
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care practitioners in efficient and effective ways to deliver important and relevant research to the highest standards.

Current arrangements for promoting research will continue through the Suffolk Primary Care Research Network team.

The CCG has a Service Level Agreement with the local Research Network. The CCG has appointed 2 GP research leads who work across Suffolk and in partnership with the local Research Federation to support and encourage research in practice. Innovation is further supported through the contractual route by CQUIN schemes with providers of services.

9.1.5 Staff innovation

In 2014, the CCG was shortlisted in the Staff Engagement category of the HSJ Awards. The award is about recognising organisations that have turned the theory of engaging with staff into reality and can show how staff engagement is delivering innovation, higher quality services and contributing to the QIPP agenda. It recognises organisations that are able to demonstrate that staff engagement is at the heart of their culture - where they are at the heart of decision making processes, feel valued, and understand the values of the organisation.

The CCG is proud of its achievement particularly its work around engagement and partnership working with trade unions. The award recognised the environment that the CCG is creating where staff are at the heart of decision making processes, feel valued, and understand the values of the organisation.
10. Delivering Value and QIPP

10.1 Commissioning for Value

In October 2013 Sir David Nicholson set out ten key points to support planning for a sustainable NHS. Working with Public Health England and NHS Right Care, NHS England provided every CCG with a ‘Commissioning for Value’ data pack to support effective commissioning. The packs help CCGs identify the best opportunities to increase value and improve outcomes as well as supporting local discussion about prioritisation and utilisation of resources.

These packs are for use by the local health economy, its partners and CCG senior management teams - primarily those responsible for finance, QIPP or service reconfiguration. Clinical Commissioners and Governing Body members may use it to support strategic planning and decision-making. The localised information supports discussions about prioritising areas for change, utilising resources and will help local leaders make improvements in healthcare quality, outcomes and efficiency.

The analysis compares the CCG its ‘most similar’ CCGs which are:

- NHS South Norfolk CCG
- NHS Hambleton, Richmondshire and Whitby CCG
- NHS Herefordshire CCG
- NHS South West Lincolnshire CCG
- NHS Shropshire CCG
- NHS East Riding of Yorkshire CCG
- NHS South Lincolnshire CCG
- NHS Ipswich and East Suffolk CCG
- NHS South Worcestershire CCG
- NHS High Weald Lewes Havens CCG

The latest ‘Commissioning for Value’ data pack was published in November 2014.

A summary of the key opportunities for the CCG for improving value is set out below. This is supported by a ‘pathway on a page’ analysis which provides comparative performance against of number of indicators across the whole patient pathway for a number of conditions. These have been reviewed by the CCG and have been reflected in the development of the QIPP programme of work as detailed at Section 10.3. The full ‘Commissioning for Value’ data pack is available at [http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/mids-eoe-2014/#eas](http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/mids-eoe-2014/#eas)

According to the latest Commissioning for Value benchmarking tool, there are programmes which seem to offer more opportunities for improving value:

![Value Opportunities Diagram](image-url)
10. Delivering Value and QIPP

- the programme areas that appear to offer the greatest opportunity in terms of quality/outcomes are: Endocrine, Nutritional and Metabolic Problems and Mental Health Problems;
- the same programme areas appear to offer the greatest opportunity for spend and quality/outcomes;
- a number of areas have also been highlighted that offer opportunities for financial savings in acute and prescribing spend. These are Cancer & Tumours, Circulation Problems (CVD, Genitourinary, Neurological System Problems, and Respiratory System Problems).

The CCG has analysed the opportunity in each area highlighted within the Commissioning for Value tool and, where appropriate, has embraced this with the development of the QIPP plans detailed at Section 10.3.

10.2 Financial resilience; delivering value for money for taxpayers and patients and procurement

The CCG is required to prepare financial plans for the next year which forms the second year of the five year Strategic Plan. The financial plan presented below has been constructed with due regard to the national business rules of financial planning, including surplus, contingency, and non-recurrent expenditure.

The financial plan for 2015-16 is based on 2014-15 forecast outturn to which a series of agreed principles and key assumptions are applied as laid out below. The starting point for the financial plan for 2015-16 is the planned 2014-15 position.

In arriving at the financial plan for 2015/16, the following business rules and assumptions apply, in compliance with national guidance:

- surplus/deficit 2015/16: CCG has plans in place to achieve the mandated surplus of £2.8m (1% of the allocation);
- underlying surplus/ deficit: CCG will ensure that the underlying surplus is maintained at the required level;
- drawdown: CCG’s drawdown will be in line with the NHS England guidance;
- investments: CCG has made provision for 1% Non-Recurrent funding as required totalling to £2.7m. Investment spend will agreed by Executive to ensure value for money;
- contingency: CCG has made provision for 0.5% contingency as required totalling to £1.5m;
- activity assumptions are in line with the planning guidance and are based on 14/15 forecast outturn with QIPP schemes in place to maintain activity at a similar level or to show a level of reduction;
- link to BCF plans: Non-Elective activity is planned to reduce by 2.5% in line with BCF assumptions.
10. Delivering Value and QIPP

The chart below shows the movement between 2014/15 outturn and 2015/16 planned surplus.

The CCG has planned to deliver the full mandated surplus of £2,875k at the end of 2015/16.

Key risks and mitigations to delivery of the financial plan are:

**Additional Risks**
- QIPP under-delivery
- Community tender & procurement
- Repatriation – if unsuccessful
- Over performance on acute contracts, CHC and Prescribing
- CUHFT – contract not yet signed

**Mitigations**
- Ring fenced non-recurrent funding - £0.9m
- Contingency - £1.4m
- Quality Premium - £0.2m
- Growth included in WSHFT contract

Underpinning the financial plan is the requirement to deliver £9,052k of QIPP savings. Currently, £5,914 (65%) of QIPP savings has been identified and these are detailed in Section 10.3 below.

**10.3 Quality, Innovation, Productivity, Prevention (QIPP)**

This plan reflects the CCG’s ongoing commitment to the delivery of QIPP for 2015/16 which underpins delivery of the CCG’s financial plan. Each programme is led by a GP through the clinical workstream governance arrangements set out in Chapter 11.

The headline programmes and the lead GP are identified below:

- Prevention
- Integrated Care Transformation
- End of Life
- Planned Care
- GP Prescribing
- Mental Health
- Children and Young People
- Cancer

Suffolk County Council
Dr Giles Stevens
Dr Simon Arthur
Dr Rakesh Raja
Dr Christopher Browning/Dr Dan Knowles
Dr Roz Tandy
Dr Rakesh Raja
Dr Andrew Yager

Each clinical workstream supports the delivery of the Health & Wellbeing Board outcomes. A brief description of the scope of each workstream is set in Section 4.1.3.
10. Delivering Value and QIPP

The full programme of work, together with a summary of their quality and productivity benefits are set out below. Individual project plans have been developed, detailing key milestones for delivery, key performance indicators, and expected outcomes.

During the year, the clinical workstreams will continue to explore and investigate further opportunities for efficiency savings to deliver the overall level of savings required.
## 10. Delivering Value and QIPP

<table>
<thead>
<tr>
<th>Programme of Work</th>
<th>Description</th>
<th>Activity Type</th>
<th>Pre-Threshold £</th>
<th>Post Threshold £</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain</strong></td>
<td>Pain Business Case</td>
<td>Outpatients</td>
<td>£259,952</td>
<td>£259,952</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatients</td>
<td>£153,742</td>
<td>£153,742</td>
</tr>
<tr>
<td><strong>Dermatology</strong></td>
<td>Teledermatology</td>
<td>Outpatients</td>
<td>£127,236</td>
<td>£127,236</td>
</tr>
<tr>
<td><strong>Ophthalmology</strong></td>
<td>Stable Glaucoma</td>
<td>Outpatients</td>
<td>£155,440</td>
<td>£155,440</td>
</tr>
<tr>
<td></td>
<td>Paediatric Ophthalmology</td>
<td>Outpatients</td>
<td>£39,864</td>
<td>£39,864</td>
</tr>
<tr>
<td></td>
<td>Evoluto</td>
<td>Outpatients</td>
<td>£40,000</td>
<td>£40,000</td>
</tr>
<tr>
<td><strong>Cardiology Pathways</strong></td>
<td>BNF Business Case</td>
<td>Echocardiogram Outpatients</td>
<td>£68,978</td>
<td>£68,978</td>
</tr>
<tr>
<td><strong>T&amp;QMSK</strong></td>
<td>Bunron LPP</td>
<td>Daycase</td>
<td>£51,678</td>
<td>£51,678</td>
</tr>
<tr>
<td></td>
<td>Hp replacement</td>
<td>Elective</td>
<td>£76,918</td>
<td>£76,918</td>
</tr>
<tr>
<td><strong>Care Homes</strong></td>
<td>Emergency Admissions - 20% reduction</td>
<td>Emergency Admissions</td>
<td>£424,387</td>
<td>£309,803</td>
</tr>
<tr>
<td><strong>Respiratory</strong></td>
<td>Emergency Admissions - 15% reduction</td>
<td>Emergency Admissions</td>
<td>£542,033</td>
<td>£395,684</td>
</tr>
<tr>
<td><strong>LTC</strong></td>
<td>Short stay admissions over 75's Bury - 8% reduction</td>
<td>Emergency Admissions</td>
<td>£39,818</td>
<td>£28,602</td>
</tr>
<tr>
<td></td>
<td>Short stay admissions over 75's Other - 8% reduction</td>
<td>Emergency Admissions</td>
<td>£21,071</td>
<td>£15,362</td>
</tr>
<tr>
<td></td>
<td>Dementia Emergency Admissions - 5% reduction</td>
<td>Emergency Admissions</td>
<td>£62,955</td>
<td>£45,957</td>
</tr>
<tr>
<td></td>
<td>UTI - Emergency Admissions reduction, More than 1 admission.</td>
<td>Emergency Admissions</td>
<td>£22,129</td>
<td>£16,154</td>
</tr>
<tr>
<td><strong>Paediatric Admissions</strong></td>
<td>Emergency Admissions - 5% reduction</td>
<td>Emergency Admissions</td>
<td>£120,829</td>
<td>£120,829</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>Emergency Admissions - 5% reduction</td>
<td>Emergency Admissions</td>
<td>£243,245</td>
<td>£177,569</td>
</tr>
<tr>
<td></td>
<td>Non-elective Excess Bed Days - 5% reduction</td>
<td>Outpatients Included in above</td>
<td>£30,000</td>
<td>£30,000</td>
</tr>
<tr>
<td></td>
<td>Outpatients First and Follow Up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E</strong></td>
<td>Reduction in A&amp;E Attendances</td>
<td>A&amp;E</td>
<td>£49,082</td>
<td>£49,082</td>
</tr>
<tr>
<td></td>
<td>WSFT TOTAL</td>
<td>698</td>
<td>£2,576,681</td>
<td>£2,210,630</td>
</tr>
<tr>
<td><strong>ADDENDROOKES TOTAL</strong></td>
<td>LPP</td>
<td></td>
<td>£395,305</td>
<td>£333,345</td>
</tr>
<tr>
<td></td>
<td>Prescribing</td>
<td></td>
<td>£400,000</td>
<td>£400,000</td>
</tr>
<tr>
<td></td>
<td>CHC</td>
<td></td>
<td>£750,000</td>
<td>£750,000</td>
</tr>
<tr>
<td></td>
<td>Lucentis</td>
<td></td>
<td>£1,000,000</td>
<td>£1,000,000</td>
</tr>
<tr>
<td></td>
<td>Corporate Running Costs</td>
<td></td>
<td>£870,000</td>
<td>£870,000</td>
</tr>
<tr>
<td></td>
<td>Total Identified QIPP</td>
<td></td>
<td>£3,914,176</td>
<td>£3,914,176</td>
</tr>
<tr>
<td></td>
<td>Unidentified QIPP</td>
<td></td>
<td>£3,137,976</td>
<td>£3,137,976</td>
</tr>
<tr>
<td></td>
<td>Total QIPP</td>
<td></td>
<td>£9,052,151</td>
<td>£9,052,151</td>
</tr>
</tbody>
</table>
The following section sets out the detail of the key programmes of work for 2015/16, which will deliver £5.9m of the £9.0m QIPP savings:

<table>
<thead>
<tr>
<th>Programme of Work</th>
<th>What are we doing</th>
<th>Why are we doing it</th>
<th>What evidence was used</th>
<th>What are the outcomes/impact</th>
<th>Financial value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Pain</strong></td>
<td>We have procured a Community (Tier 2) Pain Service in West Suffolk. To compliment we have developed a Medicines Management 'Pain Ladder' and are introducing Low Priority Procedure (LPP) policies for costly joint injections.</td>
<td>To date we have had a costly 'provider grown' tertiary pain service operating out of our local district general acute hospital (WSFT). We need a more appropriate local community model that treats patients in the community and only refers into hospital when necessary.</td>
<td>Benchmarking/Pain models from other CCG systems: Kent, Sheffield, East Riding. The model was also peer reviewed by a national pain expert to support local clinical 'buy in'.</td>
<td>Reduction in Tier 2 pain activity, recurrent joint injections and appropriate pain prescribing.</td>
<td>£413,694</td>
</tr>
<tr>
<td><strong>2 Dermatology</strong></td>
<td>Implemented a local 'telemedicine' (Vantage) service where GP’s send pictures electronically for clinical triage and assessment. Considering new local community options for dermatology services.</td>
<td>Year on year growth for dermatology services at WSFT. With an ageing population, the prevalence of skin conditions (including cancer) is increasing. Initial review of the Tele-dermatology model has shown savings to be in excess of £1m over five years along with offering immediate feedback to GP for education. A review of skin procedures in outpatient clinics and day cases has shown WSFT to be an outlier for the number undertaken as day case.</td>
<td>Benchmarking/service models considered from Bedford and I&amp;ECCCG. Telemedicine project had demonstrable savings delivered from 13 other CCG’s who have adopted the service.</td>
<td>13 CCGs using Tele-dermatology have shown that between 18%-25% of referrals require onward referral to secondary care. The remainder are locally managed in the community.</td>
<td>£127,236</td>
</tr>
<tr>
<td><strong>3 Ophthalmology</strong></td>
<td>Seek optimal output from our community ophthalmic triage provider (Evoluto). Jointly procure with WSFT a follow-up glaucoma service. Develop a new dry eyes and children's pathway.</td>
<td>Evolutio are commissioned by WSCCG to reduce avoidable referrals to the hospital eye service (HES) and enable integrated community care. Many patients with eye problems can be seen and treated in the community without the need to attend hospital, closer to their own home, reducing patient anxiety as they are treated in a more convenient setting. In turn, this releases additional capacity for the HES to focus on treating patients with more complex needs.</td>
<td>Extending community ophthalmology services is the next step in 2015/16. NICE estimates that of the 169,500 patients with COAG (glaucoma), suspect COAG and OHT currently managed in the hospital eye service, 56,320 could be managed in the community. This produces an estimated shift in resources of £7.4 million when applied to the estimated cost per year of more regular monitoring intervals of £132.50 per patient (NICE 2009a) (Better Eye Care Services).</td>
<td>To reduce number of first outpatient appointments and follow ups in secondary care as a result of patient management in the community. To scrutinise WSFT activity data and collate evidence from literature &amp; case studies to develop additional community pathways in collaboration with WSFT (glaucoma and children).</td>
<td>£265,312</td>
</tr>
</tbody>
</table>
## 10. Delivering Value and QIPP

<table>
<thead>
<tr>
<th>Programme of Work</th>
<th>What are we doing</th>
<th>Why are we doing it</th>
<th>What evidence was used</th>
<th>What are the outcomes/impact</th>
<th>Financial value</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Clinical Thresholds</td>
<td>Commission a Clinical Threshold Service (Nurse) to work within WSFT to uphold and support referrals for Low Priority Procedures (LPP) and clinical procedures with limited clinical value. To agree robust processes and support LPP retrospective audit. Implementation of a Knee Patella LPP for knee replacements.</td>
<td>To ensure WSCCG commissions clinically effective services and to ensure a rigorous system of review for procedures connected to clinical policies prior to the procedure. To review procedures of limited clinical value or with limited evidence on use for further policy development. To embed the use of the policies across the health system.</td>
<td>All current LPP policies are refreshed (3 years) and new LPP policies are NICE evidenced and clinically reviewed and overseen by the Suffolk Clinical Priorities Group (CPG).</td>
<td>Clinical interventions undertaken to be appropriate and in line with LPP guidance. Reductions in Knee Patella knee replacements.</td>
<td>£400,000</td>
</tr>
<tr>
<td>5 Cardiology Pathways</td>
<td>Implement the heart failure pathway incorporating brain neuropeptide (BNP) testing. Commission a revascularisation/pacing suite from WSFT.</td>
<td>Saving due to reduced hospitalisations as a result of early diagnosis. CCGs who have introduced BNP testing into their HF pathway have experienced cost savings (e.g. Lancashire and Cumbria, Bedford and West Hertfordshire, Blackpool, Plymouth)</td>
<td>NICE costing model (CG108): Improved patient quality due to earlier elimination of heart failure and accurate true diagnosis of condition. Commissioning for Value: Pathways on a page - November 2014 – worse than average 10 peers in Heart Disease – nonelective spend</td>
<td>Reduction in Direct Access Echo's and Cardiology 1st OP appointments. Improved patient experience with 95% positive heart failure diagnosis from BNP test.</td>
<td>£86,931</td>
</tr>
<tr>
<td>6 T&amp;O/MSK</td>
<td>Continue to embed Trauma and Orthopaedics (T&amp;O) OA pathways (Hip/Knee Shoulder). Mobilise and monitor single-provider contract for integrated community musculoskeletal (MSK) physiotherapy service. Work with physiotherapy provider to identify and implement further service improvement initiatives. Develop a Hallux Valgus (Bunion) LPP Pathway.</td>
<td>T&amp;O activity is one of our high volume and cost activity areas. National benchmarking identified these areas of worthwhile focus for WSCCG.</td>
<td>NICE guidance on the treatment of osteoarthritis recommends that GPs consider three core treatments - education and information; exercise; and weight loss. CCG has developed and piloted pathways for the referral and treatment of OA Hip, OA Knee conditions based on NICE guidance. Pathways will be monitored and embedded as standard, including integration with Map of Medicine. Commissioning for Value: Pathways on a page - November 2014 – worse than average 10 peers in hip &amp; Non-elective spend and Trauma &amp; injury – falls - hip &amp; Non-elective spend</td>
<td>Clinical interventions to be undertaken to be appropriate and in line with agreed pathways. Reductions in Hip replacement activity and Bunion.</td>
<td>£128,596</td>
</tr>
</tbody>
</table>
## 10. Delivering Value and QIPP

<table>
<thead>
<tr>
<th>Programme of Work</th>
<th>What are we doing</th>
<th>Why are we doing it</th>
<th>What evidence was used</th>
<th>What are the outcomes/impact</th>
<th>Financial value</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Care Homes</td>
<td>The overarching aim of the project is to reduce emergency admissions by improving the level and coordination of support to residents in care homes though the provision of proactive case management, system coordination and workforce development. This project will include focus on UTIs for Care Home residents.</td>
<td>This project aims to improve quality and safety standards across care homes in West Suffolk and create a network of support through a whole system, in reach approach targeting homes with the highest admissions to West Suffolk Foundation Trust. The project builds on the success in 2014/15 in reducing emergency admission activity, improving shared care planning and improving the interface between care homes, the acute hospital and primary care.</td>
<td>In Nov. 2014 Public Health Suffolk produced ‘Preventing avoidable emergency care transfers from care and nursing homes to hospitals’. Evidence included focus on residential homes linked to high hospital admission, targeting treatment pathways for some conditions requiring medical attention e.g. constipation, falls, pneumonia, influenza, urinary tract infection and hip fractures, consider developing guidelines for the prevention of falls, hip fractures.</td>
<td>15% reduction in non-elective admissions.</td>
<td>£309,803</td>
</tr>
<tr>
<td>8 Respiratory</td>
<td>Benchmarking exercise identified 1264 patients costing £30m over last 2.5 years, highlighting practice variation in service usage. Main speciality was respiratory. Papworth respiratory elective data analysed as a high use area. Focus is on 'frail elders' by developing a frailty tool in order to risk stratify and support early intervention and reduction in non-electives. Considering development of a local CPAP/Sleep Disorders service.</td>
<td>For many of the most complex patients it is a respiratory problem which leads to A&amp;E attendance or admission. But by managing frailty better, respiratory problems can be avoided.</td>
<td>Incorporating the Southend model which considers how mental health and wellbeing support can reduce demand on acute activity (readmissions and cancellations). Commissioning for Value: Pathways on a page - November 2014 – worse than average 10 peers in COPD, asthma - non-elective spend, Emergency admission rate for children with asthma (0-18yrs)</td>
<td>Reduced non-elective respiratory and other activity.</td>
<td>£395,684</td>
</tr>
</tbody>
</table>
## Delivering Value and QIPP

<table>
<thead>
<tr>
<th>Programme of Work</th>
<th>What are we doing</th>
<th>Why are we doing it</th>
<th>What evidence was used</th>
<th>What are the outcomes/impact</th>
<th>Financial value</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>LTC Building on the success of the WSFT based Enhanced Early Intervention Team, develop community services that provide a wrap around approach for the patient including; APS/CIS, Neighbourhood Teams, CGA/IG, DIST, Primary Care, EEIT. The model will be developed with input from all organisations included in the wrap around service. Specialist admission avoidance via the Acute Oncology Service based within WSFT. This specialist service for any oncological emergency will be available both within the acute and primary care settings.</td>
<td>Benchmarking identified an increase in over 75s NEL admissions.</td>
<td>Clear potential for many of this cohort who have no urgent diagnostic need to be managed in the community. The continued success of the EEIT has been mainly attributed to the single overall management structure of the service. In six months the service has been able to support more than 1000 people (an average of 35 patients a week with up to 54 patients supported at peak times). Similar approaches in the community in other areas have demonstrated an 8% reduction in admissions over a 4 month period. National guidance requires any acute trust with an A&amp;E department to have and Acute Oncology Service (AOS).</td>
<td>Reduction in non-elective admissions.</td>
<td>£106,095</td>
</tr>
<tr>
<td>10</td>
<td>Paediatric Admissions Establishing a paediatrician co-working with a number of GP surgeries (5 surgeries in BSE) to develop joint clinics, consultant outreach and learning for primary care. Roll out of Primary Care Advice and Guidance educational tools. Full deployment of Paediatric Epilepsy and Asthma Nurses at WSFT.</td>
<td>Growing demand year on year for non-elective admissions and Paediatric OP activity. WSCCG identified as an outlier in Epilepsy and Asthma related non-elective admissions.</td>
<td>King Fund evidenced review of paediatric community model based on West London service. Nice evidenced Epilepsy and Asthma Nurse models. Southend evidenced model for community paediatric nursing.</td>
<td>Range of initiatives to deliver a 5% reduction in paediatric non-elective admissions.</td>
<td>£120,829</td>
</tr>
</tbody>
</table>
## 10. Delivering Value and QIPP

<table>
<thead>
<tr>
<th>Programme of Work</th>
<th>What are we doing</th>
<th>Why are we doing it</th>
<th>What evidence was used</th>
<th>What are the outcomes/impact</th>
<th>Financial value</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 A&amp;E</td>
<td>Reducing the demand on Accident &amp; Emergency department at WSHFT</td>
<td>To reduce the number of A&amp;E attendances</td>
<td>National and local evidence of increase demand, and failure to deliver standard waiting time target.</td>
<td>Reduction in the number of A&amp;E attendances</td>
<td>£49,082</td>
</tr>
<tr>
<td>13 Prescribing</td>
<td>Encouraging GP’s to use Prescribing Recommendations and Drop List metrics</td>
<td>To reduce the overall prescribing spend</td>
<td>All DROP-List metrics are supported by PrescQIPP bulletins and briefings and also by WSCCG implementation procedures</td>
<td>Potential 12-month savings if treatments either stopped or switched to recommended alternative (based on Oct 2014 prescribing data)</td>
<td>£750,000</td>
</tr>
<tr>
<td>14 CHC</td>
<td>Moving to a block contract with the providers (Nursing Homes) in order to reduce costs. Joint Procurement with the council to negotiate standard rates for domiciliary care.</td>
<td>To reduce the CHC spend.</td>
<td>Providers are more willing to move to a block contract as they are guaranteed a fixed income flow. Spot purchasing packages is more expensive.</td>
<td>Reduction in CHC spend.</td>
<td>£1,000,000</td>
</tr>
<tr>
<td>15 Lucentis</td>
<td>The CCG is supporting the request to license Avastin as cheaper option to Lucentis for the treatment of Wet AMD</td>
<td>To reduce the High Costs drugs spend.</td>
<td>Published reviews on the cost savings, safety and effectiveness. This is also supported by other CCG’s.</td>
<td>Reduction in High Cost drug spend.</td>
<td>£870,000</td>
</tr>
<tr>
<td>16 Corporate Running Costs</td>
<td>Reviewing Budgets to identify potential savings</td>
<td>The running cost allocation has decreased by 10% and we need to stay within the allocation</td>
<td>N/A</td>
<td>Reduction in Running cost spend.</td>
<td>£350,000</td>
</tr>
<tr>
<td>17 CUHFT (Addenbrookes)</td>
<td>Aggregate savings from above programme of work, based on reduction in activity at CUHFT</td>
<td></td>
<td></td>
<td></td>
<td>£333,345</td>
</tr>
</tbody>
</table>

**Aggregate savings from above programme of work, based on reduction in activity at CUHFT:** £5,914,176
10.4  Incentives - CQUIN

10.4.1 Commissioning for Quality and Innovation (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) payment framework is a national framework for locally agreed quality improvement schemes. It makes a proportion of provider income conditional on the achievement of ambitious quality improvement goals and innovations agreed between Commissioner and Provider, with active clinical engagement. The CQUIN framework is intended to reward excellence, encouraging a culture of continuous quality improvement in all providers and in 2015/16 it is worth 2.5% of the contract value.

Contract specifications and incentives, for example CQUIN, will be used to enable improvements in local services and to encourage and enhance the local providers of services to pursue high quality effective services. For 2015/16, in response to national priorities, there will be CQUIN schemes related to incentivising quality improvements for sepsis and acute kidney injury.

The CCGs 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.

10.5 Monitoring Delivery of QIPP

In 2015/16, the CCG will closely monitor the delivery of QIPP through the ‘dashboard’ developed in 2014/15. A Programme Management Office approach will continue to track delivery of projects against key milestones and timelines, and will provide comprehensive detail and analysis of delivery of the QIPP projects.

Progress against QIPP projects will be reported through the accountable clinical workstreams on a monthly basis, and form part of the Integrated Performance Report presented monthly to Governing Body and Clinical Scrutiny Committee.
11. Governance and Risk

11.1 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 the CCG, and how this supports delivery of quality services;
- the agreed programme management approach to track delivery of QIPP;
- responsibilities and accountability for performance delivery, including financial balance and activity levels.

11.1.1 Governance arrangements

The CCG Governing Body 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 Clinical Scrutiny Committee meets alternate months to the Governing Body and has prime responsibility for the scrutiny and monitoring of performance delivery.

The Governing Body is supported by a weekly Executive meeting, where decisions are delegated as appropriate.

In addition, the West Suffolk Community Engagement Group will provide scrutiny of strategic and operational plans from a community perspective.

11.1.2 Governing Body

In accordance with statutory legislation, the Governing Body 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 Governing Body, 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 Governing Body will bring their unique perspective, informed by their expertise and experience. This will underpin decisions made by the group’s governing body 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.
- good governance remains central at all times.

11.1.3 Clinical Scrutiny Committee

Following an Audit Report recommendation, the CCG Governing Body has established a Clinical Scrutiny Committee (formerly Clinical Executive Committee) as an additional clinical governance sub-committee.
11. Governance and Risk

Along with the Audit and Remuneration and HR Committee, the Clinical Scrutiny Committee will be formal sub-committees of the Governing Body, and, as such, minutes from meetings will be published in the public domain as part of the Governing Body papers.

The purpose of the Committee is primarily to review and scrutinise clinical governance arrangements, with the main elements of the agenda being consideration of the Integrated Performance Report and Governing Body Assurance Framework. All other business is carried out within the weekly Executive Committee meeting (see below).

Meetings are held on a bi-monthly basis on the months that the Governing Body does not sit.

11.1.4 Executive Committee

The Executive Committee is the CCG’s engine of innovation, driving forward the development of new clinical pathways and delivering robust review and performance challenge. It will ensure that the CCG’s operational plan is executed in full with the resultant continuous improvement in services to patients and carers across West Suffolk. The Executive Committee will have the following objectives:

- to determine the direction of commissioning/decommissioning strategy for the organisation;
- to stimulate and lead innovation in care pathway re-design;
- to sustain and develop local GP engagement structures i.e. Locality and Development Groups;
- to deliver broad clinical engagement and support to GP practices;
- to monitor and challenge provider performance, as required;
- to monitor financial performance and propose action to the governing body to ensure a balanced budget;
- to ensure that clinical governance and quality standards are met;
- to ensure that all Key Performance Indicators and QIPP targets are met.

11.1.5 Clinical workstreams

The Clinical workstreams will lead the development and oversee the delivery of the redesign work programme for West Suffolk. The focus of the weekly meetings will be to agree, oversee implementation and evaluation of impact of a redesign programme that supports:

- the vision and priorities for the CCG as outlined in the Operational Plan;
- improving the quality of care delivery locally;
- delivery of the QIPP programmes of work;
- the principles of clinical leadership and public engagement.

The key responsibilities of the clinical workstreams are:

- to support the CCG Executive in delivery of its key priorities;
- to provide the CCG Executive with specialist advice, information and support in the delivery of its key priorities relating to the clinical workstream;
- to agree the priorities for the clinical workstream plan;
- to develop an action plan with performance metrics;
- to monitor and review system performance against metrics;
- to identify further risks and opportunities as part of the QIPP planning programme;
- to advice the CCG Executive on the wider strategic direction for the workstream;
- to advice the Contracting team on issues relating to service changes, risks to service delivery and performance of contract, opportunities for contract changes, service improvements areas.
11. Governance and Risk

11.1.6 Performance Delivery

The CCG has robust mechanisms in place to monitor and scrutinise delivery of nationally and locally defined standards and targets. Each month the Governing Body/Clinical Scrutiny Committee receives an Integrated Performance Report, covering the following areas:

- performance against key national and local targets;
- key clinical quality and patient safety issue;
- delivery of QIPP (Section 10.5 refers);
- financial performance;
- analysis of acute activity (including provider activity levels against plan).

The Report provides members 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. The Report also outlines the mitigating actions being undertaken to address the issues.

11.2 Risk

The Governing Body Assurance Framework (GBAF) provides the West Suffolk CCG with a simple but comprehensive method for the effective and focused management of risk. Through the GBAF the CCG Governing Body 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 Governing Body 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 should be seen as a working document and will be updated regularly by the Chief Officers Team, monitored by the Audit Committee and reported to the Governing Body at each of its meetings. The GBAF is linked to the CCG Risk Register, the content of which is also provided for review by the Chief Officers Team. A flow chart setting out how risks are identified and managed is set out overleaf.

In order to ensure consistency in the risk assessment process, the likelihood and consequences of all risks on the Risk Register are assessed against the former National Patient Safety Agency (NPSA) 5X5 risk matrix and those scoring 15 and above migrate to the GBAF and thereby inform the Governing Body agenda.

The 5X5 risk matrix and subsequent Red, Amber, Green (RAG) score identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action, and determines whether risks are to be accepted on the basis of the colour bandings and risk ratings. In terms of evaluation of effectiveness, the RAG rating system is also used to present how well the agreed controls are operating.

The governance arrangements for the management of risk are as follows:
11. Governance and Risk

![Diagram of Governance and Risk Processes]

- Workstream Risk Assessments
- QIPP Delivery
- Serious Incidents, Complaints, Public Health & Safeguarding Issues
- Public & Stakeholder Engagement
- Business & Service Delivery Plans
- External Assessment & Audit, Guidance & Alerts

CCG Senior Officers Own & Manage Risks + Review the Risk Register & GBAF

- Clinical Finance & Performance Risk Oversight by the Executive Team
- Governing Body Assurance Framework
- Overview & Scrutiny by the Audit Committee
- Assurance to the CCG Governing Body
Appendix “A” – Summary “Plan on a Page”

Three key areas of focus for the 15/16 operational plan:

1. Integration of local physical, mental health and care services to deliver a single primary and acute care system model (‘Vanguard’ bid) embedded in an integrated public sector with a clinically-led network of GP, community (including social care and voluntary sector) and acute service providers under one organisation.
2. Improving the transport to the local population who are at most risk including frail and people with LTCs ensuring the community offers a ‘bump around’ service supporting people at home and giving them greater access and support in managing their urgent care needs—primarily focusing on diabetes, respiratory, care homes and complex long term condition management whilst supporting self-care and shared decision making.
3. Development and implementation of safe, effective and efficient ‘end to end’ pathways across the local health system, including mental health—establishing integrated services which ensure procedures and service delivery are undertaken in a clinically appropriate and cost-effective setting.

Access

The NHS Constitution’s rights and privileges include delivery of:
- Maximum of 1.8 weeks from referral to treatment
- Minimum 6 weeks for diagnostic tests from referral
- Digital waits for referral and treatment
- Patient admission, transfer or discharge within 4 hours in A&E
- Minimum health access waiting time

The CCG has set out its plans to commission sufficient services to ensure delivery of these rights and pledges for patients to access treatment. A number of programmes of work e.g. admission prevention & early intervention, core care, integrated neighbourhood teams, patient resilience etc. will underpin delivery of the core standards. Current waiting times standards will be closely monitored to ensure delivery.

Accessing mental health services will be a priority and will be supported by the re-procurement of our Wellbeing Service in 2015/16 which includes A&I. The CCG is working with partners to remodel inpatient service so that it can focus on the whole life needs of people with mental and physical health problems who will use the new service in line with government’s plans to develop our systems to be able to offer personal health budgets for people with mental health made in line with national policy.

The CCG plans to increase the numbers of patients accessing psychological therapies to 1% of the total number of people with depression or anxiety disorders, and to increase the number of people who have access to community psychology services to 7%.

The CCG recognises that access to services provided can only improve outcomes for patients if they are readily available to them, that they receive treatment in a timely manner, when and where they need it, and in a way and place that is convenient for their need. For example, the Sudbury Community Health Centre, commissioned by the CCG, was opened in January 2015 and will have a number of services provided including primary care, mental health, a pole for patients, a pole for patients with dementia, audiologic, genetic, and eye care.

Outcomes

The CCG has set out plans to deliver significant improvements against the seven specific, measurable ambitions of the NHS Outcomes Framework for improving outcomes. This is based on the CCG achieving a level of ambition that is better than nationally or regionally-based averages, or to further improve in those areas where the CCG’s performance is already benchmarked favourably.

The CCG is working with Public Health and Suffolk County Council on an healthy outcomes programme aimed at improving population health by focusing on prevention to limit the onset, or reduce complications of conditions such as diabetes, cerebrovascular disease, other long term conditions which are associated with lifestyle.

The CCG will focus on enabling access to the alcohol and drug services commissioned by Public Health, review the obesity pathway and weight management treatment services, and ensure that primary services increase the numbers of babies, babies and other patients benefiting from breast feeding and supporting mothers.

The CCG will work closely with Health and Wellbeing partners to deliver the prevalence of smoking reducing the risk of vascular disease by controlling blood pressure and reducing cholesterol and other targeted groups to the Healthy Lifestyle Services.

The CCG will improve the delivery of psychological therapies for people with mental and physical health problems through its Wellbeing Service. In addition to reviewing the post-diagnostic dementia pathway it will be undertaken and commissioning of new services with local authority and re-modeling the learning Disability services to ensure the new service is commissioned. The programmes will include:
- Maintaining and signing audit plans for both adults and CCG to commission a dedicated psychological therapy service.
- Maintaining and supporting the mental health service.
- Rolling out the NIMH units to support carers.
- Developing a dedicated mental health pathway.
- Review and update our approach to suicide prevention.
- Supporting the modernisation of LD services into a community-based model.

Quality

The CCG will work with its providers to ensure that it delivers the essential standards of quality and safety regulated by the CCG. The CCG will implement NICE, reduction plans, work with providers to increase the reporting of harm of medicines related incidents, and improve antibiotic prescribing in primary and secondary care. The CCG will commission services that are safe, clinically effective and support a positive patient experience, focused on keeping patients as safe as possible, with clinically effective and cost effective treatments. The CCG will encourage feedback and value the role of patients and healthcare professionals in shaping, monitoring and improving services. The CCG will report, investigate and monitor all concerns raised by patients and carers (Patient Experience) and will ensure that procedures are put in place at the heart of the care they are given.

The Suffolk-wide system has reviewed its adult safeguarding strategy and is developing a comprehensive action plan. This includes considering ways to reduce the number of hospitalizations, improving mechanisms for alerting and incident reporting to Suffolk County Council, and identifying reporting thresholds in line with the national guidance.

The CCG will continue to increase staff engagement and embed its comprehensive appraisal process. The CCG will look to retain and invest in its Paediatric Unit status.

An outcome based 7 day working CQUIN has been delivered for the review of patients within 14 hours, including access to diagnostics and links to 24/7 clinical care team. For 2015/16, the CQUIN is to be extended to being a core principle that underpins service delivery across the health system.

The CCG has established processes in response to Francis, Darzi & Winbourne et al. to ensure that patterns of care are consistent and compliant with essential standards of quality and safety are maintained. The CCG will work with CCG commissioning and specifically supporting NICE in 18/18 and beyond and working with other statutory bodies. The CCG will use contract specifications and incentives to deliver high quality local services. Mechanisms are in place to ensure the public and patients can report poor and unsafe practice. The CCG will minimise patient harm by embracing an ethic of learning, maintaining and developing a patient safety strategy in partnership with providers. The cohort of winbourne clients will be a focus for discharge to appropriate settings and reviewed at the winterbourne biannual.

Delivering value

Financial resilience: delivering VFM for taxpayers and patients and procurement

Surplus/Deficit 15/16: CCG has plans in place to achieve the mandated surplus of £2.5m (1% of the allocation). Underlying Surplus/Deficit: CCG will ensure that the underlying surplus is maintained at the required level.

VFM will deliver a significant surplus in line with the NHS England guidance. Investment in CCG has made provision for 3% Non-Current funding as required totaling to £2.7m. Investment with an agreed Dec to ensure VFM.

Contingency: CCG has made provision for 0.5% contingency as requiring totaling to £1.5m. Activity assumptions are in line with the planning guidance and are based on 14/15 forecast outcome with QIP achieved in place to maintain activity at a similar level or above levels of reduction.

Transformation programmes, reconfiguration plans and procurement

A significant programme of investment, transformation programmes and reconfiguration plans will include:
- Continuous improvement of Community & Mental Health Services; reducing and developing pathways for, dermatology, orthopaedics, and heart failure; reviewing procedures for vital admittance, embedding clinical threshold policies, providing an integrated community (MAC) and improving pathway services.
- Integrate UFT guidelines for support prevention, early detection and management, developing an integrated system for the effective treatment and management of respiratory conditions; supporting patients at home and giving greater access to a proactive approach to managing their long-term conditions, developing an acute care pathway, improving the quality and safety standards in care homes to reduce harm, developing an integrated diabetes foot pathway, developing and implementing an integrated diabetes foot pathway, working with health and social care in partnership in order to modernise services and implement new statutory requirements for children, developing an integrated service that supports the patients and their care from diagnosis through the pathway of children’s development and integrating an integrated approach to service delivery as part of the Suffolk Health & Care Review, LTC management, care, effective GP prescribing.