



integrated working

## GOVERNING BODY

<b>Agenda Item No.</b>	<b>09</b>
<b>Reference No.</b>	<b>WSSCG 19-62</b>
<b>Date.</b>	<b>27 November 2019</b>

<b>Title</b>	<b>West Suffolk CCG and Ipswich and East Suffolk CCG 2020-21 Commissioning Intentions</b>	
<b>Lead Chief Officer</b>	Richard Watson, Director of Transformation and Strategy	
<b>Author(s)</b>	Nicola Brunning, Acting Deputy Chief Contracts Officer and Richard Watson	
<b>Purpose</b>	For information	
<b>Applicable CCG Clinical Priorities:</b>		
1.	Develop clinical leadership	✓
2.	Demonstrate excellence in patient experience & patient engagement	✓
3.	Improve the health & care of older people	✓
4.	Improve access to mental health services	✓
5.	Improve health & wellbeing through partnership working	✓
6.	Deliver financial sustainability through quality improvement	✓
<b>Action required by Governing Body:</b>		
To note.		

## **1. Background**

- 1.1 Each year, the Clinical Commissioning Groups are required to produce commissioning intentions that describe to local providers how we intend to shape local healthcare services, describe what services we want to buy, and the health outcomes we wish to achieve for our local population.
- 1.2 Ipswich and East Suffolk CCG and West Suffolk CCG have developed a joint commissioning intentions letter for 2020/2021.
- 1.3 The letter has been shared with all our main providers and added to the CCG websites.
- 1.4 In 2021-2022, the three CCGs in the Integrated Care System will publish a joint commissioning intentions letter.

Our Ref: 2020/2021 Commissioning Intentions

3 October 2019

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Dear

**Re: Commissioning Intentions 2020/21**

**1. Background**

2019/20 has been a year of significant change for the NHS, both nationally with the publication of the ten year national NHS plan and on a local level. Major developments locally include; the formal confirmation of Suffolk and North East Essex as an Integrated Care System (ICS), the development of exciting capital plans for changes at East Suffolk and North Essex Foundation Trust (ESNEFT) and the coming together of the management team within the three Clinical Commissioning Groups (CCGs) within the ICS.

During this period health, care and wellbeing partners across Suffolk have continued to work together to set the strategic direction for local services through the ongoing development of our two local Alliances: West Suffolk and Ipswich and East Suffolk as a key part of the wider ICS development.

This letter provides a summary of the progress made and our future plans, providing a summary of key commissioning intentions for the coming years and 2020/21 in particular within each of our system programmes. This should be read in conjunction with the ICS Five Year Strategic Plan which is currently in development and will be available at the end of November 2019 as this sets out more detailed ambitions and priorities for the ICS over the next five years.

**2. Our Integrated Care System**

**2.1 Introduction**

Since becoming a shadow ICS in 2018, we have worked together across sectors to develop an integrated governance framework that describes how we will work together. The process to develop this framework has been iterative with work undertaken by a small design panel with support from the King's Fund. Our governance framework makes it clear, that as an ICS, what we want to do is to make a difference to the issues that matter to people, that we are collectively responsible for and which we can only change by working together. It sets out how we intend to work more flexibly across our sector and organisational boundaries, adopt a common set of principles and leadership behaviours and develop an approach which is right for now but can evolve over time. It also makes clear that what we don't want to do is to add extra layers or complexity, create rigid, long-term structures or undermine the governance and statutory responsibilities of our individual organisations.

The vision set out in the NHS Long Term Plan (2019) is that local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems across the whole country by April 2021. The plan sees ICSs as central to the delivery of the Long Term Plan, stating that “An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action. They are a pragmatic and practical way of delivering the ‘triple integration’ of primary and specialist care, physical and mental health services, and health with social care“

As there is no statutory basis for the ICS, a system wide governance structure needs to be developed which ensures public accountability of the whole health and care system for the outcomes that are collectively achieved, works with and alongside existing accountabilities and structures, aligning with the roles and accountabilities of the NHS, Local Government, Health and Well-being Boards and Overview and Scrutiny Committees.

The seven principles of public life, which are intended to apply to anyone who delivers public services, focus on behaviour and culture rather than processes. In applying these principles, the ICS can ensure it is delivering integrated plans which spend public money wisely and deliver services that meet the needs of the local population. The seven principles for public life will therefore underpin how we will work as an ICS.

We want to avoid a hierarchical approach to our ICS so that it can work more as an ecosystem that can adapt and flex to meet the needs of the population.

The ICS, as a coalition of the willing, will exist through a conscious decision of locality Alliances, neighbourhood working and sovereign organisations to pool resources and efforts to achieve common goals when it makes sense to do so in the interests of the local population. This way of working will enable communities to shape their priorities and release the assets which contribute to their wellbeing, care and health, within a common set of standards which reduce unnecessary variations in performance and outcomes. By working with people in our communities we can develop trust and understanding with stakeholders about what matters. Consequently, they will own and deliver good outcomes.

## **2.2 Our Localities**

Localities provide a focus for smaller, identifiable populations based on particular characteristics or needs, agreed within Alliances. Without the need to meet the requirements of a fixed size or model, different areas can find different solutions for different problems. In Suffolk there are six localities within West Suffolk and eight localities within Ipswich and East Suffolk.

Alliances will play a key role in oversight and support of effective locality arrangements that deliver for local populations. These localities are based around GP catchment areas overlaid with local health and social care teams and with the development of Primary Care Networks (PCNs) we will ensure that each locality is clearly defined. At locality level the role of district and borough councils and the voluntary and community sector are also key.

The Integrated Neighbourhood Teams bring together physical, mental health and social care practitioners that work with General Practices within each locality to provide a single coordinated care response for people, underpinned by prevention, self-care, early intervention, reablement and rehabilitation, (including people living in nursing and care homes).

There are four main objectives:

- Fewer people need unplanned care and support (reduction in crisis situations).
- Greater numbers of people have access to, and are supported by activity outside of statutory services.

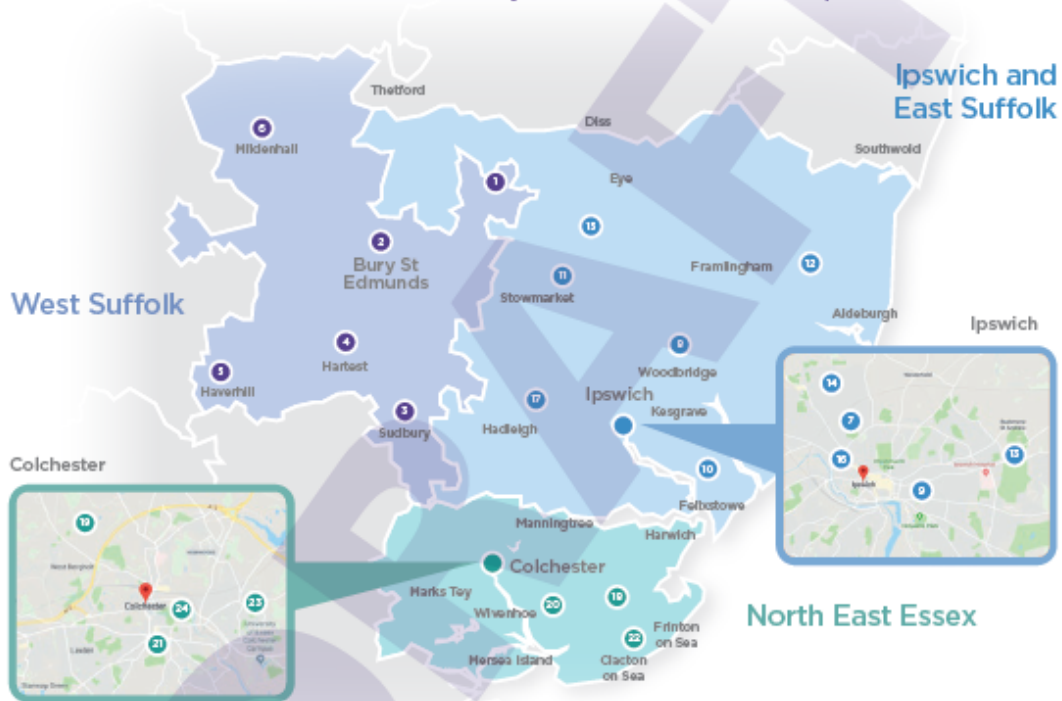
- Resources in the delivery of community-based health and care support are used more efficiently.
- The ongoing costs of supporting people are reduced as people's independence is increased.

In Suffolk, there is a focus on the Integrated Neighbourhood Teams identifying local issues that relate to their specific populations, and developing a joint plan as to how they, as a system, can begin to address these, with support of the CCG. We are at the stage of developing locality level strategic needs assessment and then local delivery plans for each.

The Integrated Neighbourhood Teams are supported by the wider Connect Programme. The Connect Programme is supported by the CCG, county and district council teams who provide data analysis, performance information, administrative and other support to help the Core Management Group and Integrated Neighbourhood Team practitioners focus on delivery. We now have the opportunity to closer align these teams with the Primary Care Networks (PCNs) which now cover our whole area and each of which has a Clinical Director.

PCNs are crucial to the implementation of the Long Term Plan, both through more effective delivery of primary care in local neighbourhoods, and the integration of health and care services to better respond to the characteristics and needs of the local population. PCNs are key to addressing the wider ICS ambitions to improve population health and wellbeing, and to building lasting relationships between our partners.

## Suffolk & North East Essex Primary Care Network Footprint



### West Suffolk PCNs

- 1 Blackbourne Rural
- 2 Bury St Edmunds
- 3 Sudbury GP Network
- 4 WGGL
- 5 Haverhill
- 6 Forest Heath

### Ipswich and East Suffolk PCNs

- 7 Barrack Lane and Ivy Street
- 8 DHG South
- 9 East Ipswich
- 10 Felixstowe
- 11 Mid Suffolk
- 12 North East Coastal
- 13 North East Ipswich
- 14 North West Ipswich
- 15 North West Suffolk
- 16 Orwell
- 17 South Rural

### North East Essex PCNs

- 18 Tendring Primary Care Network
- 19 Creffield Medical Group with NCHC and Tollgate Medical Practice PCN
- 20 COLTE Partnership PCN
- 21 Colchester Medical Practice PCN
- 22 Clacton Alliance PCN
- 23 East Hill & Abbeyfields PCN
- 24 Bluebell, Highwoods, Lawford, Mill Road, Winstree PCN

It is increasingly recognised that PCNs play a significant role as an integral building block to support the national and local ambitions. With increased focus on PCNs, it is crucial to support and facilitate the clinical leadership and core teams to enable the capability and leadership to meet that expectation, deliver the national specifications and the local ambition. We are committed to the well-established clinical leadership programmes and intend to expand these further to other clinical and managerial staff. This approach to combined leadership supports the fundamental blocks to integration, and as a means for PCNs to interface with one another. Clinical Directors will be providing leadership, both strategically and clinically to the Alliances at 'place' level.

The focus of Alliances and localities, including PCNs, is to progress against the maturity matrix so that all streams of activity are following the same broad developmental stages. This is totally in line with national policy, moving primary care and community services towards integration and collaboration at locality level.

PCNs will deliver against the seven new service specifications that will be introduced over the next few years; Structured Medications Review, Enhanced Health in Care Homes, Anticipatory Care, Personalised Care, Supporting Early Cancer Diagnosis, CVD Prevention and Diagnosis and Tackling Neighbourhood Inequalities.

To ensure PCNs are in the best place to mature and thrive, and to enable them to deliver the expectations set out within the service specifications, the Alliances will put in place high quality support and development, working hand-in-glove with PCN Clinical Directors, and critically the wider primary care partners including opticians, dentists, pharmacists, patients, Healthwatch, community providers, the voluntary sector and local government.

We will facilitate this via structured Training and Educations sessions, Patient and Participation Groups and other opportunities, recognising the need to break down organisational and professional barriers to deliver personalised care in the way that best meets the needs of local people. We will support PCNs in building partnerships with Healthwatch, drawing on success already achieved for individual practices in improving access and patient experience.

Our plans between 2019/20 – 2023/24 to integrate healthcare in local neighbourhoods will include:

- Further developing and delivering local estates strategies and plans.
- Enabling primary care to improve health in care homes with development of the Care Home Enhanced Service.
- Developing local incentive and quality improvement schemes.
- Reviewing and expanding public and stakeholder engagement plans to help shape primary care services.
- Developing an approach to balance increased patient care within communities whilst also ensuring the development of a more resilient Primary Care system.
- Working across our Alliances to ensure Pharmacists, Opticians, Dentists, GPs and other partners are involved within the PCNs. This will build on our Healthy Living Pharmacy programme in particular.
- Supporting the integration of mental health services into PCNs.
- Management of complex patients to localities with PCNs and Integrated Neighbourhood Teams.
- Support existing and new Social Prescribing schemes; ensuring that learning is shared between localities and completing a full evaluation of impact by March 2021 to enable informed decisions about future models and long-term investment.

## **2.3 Our Alliances**

Local ‘place-based’ systems of care involve multiple partnerships, including NHS organisations and the local government, working together to provide integrated care across organisational boundaries to improve the health and wellbeing of their populations. In Suffolk and North East Essex ICS there are three ‘place-based’ systems of care called Alliances.

Our three Alliances are North East Essex, West Suffolk and Ipswich and East Suffolk, with each defined by the footprint of local health and care partners as well as natural geography, developing differently according to local circumstances. As in localities, Alliances need to act as a three-dimensional model interpreting need in many ways. The Alliances provide the focus for planning and delivering meaningful integrated care and services to the local population with partners working closely with the voluntary and community sector, independent sector organisations and communities.

Alliances will provide the focus for:

- System and service transformation across sectors
- Securing and delivering integration
- Ensuring clinical engagement
- Relationship development and management
- Ensuring the principles of good system governance are embedded

- Reducing health and social inequalities across each Alliance
- Producing and resourcing a detailed plan to deliver the overarching strategy
- Ensuring public involvement in planning, development, design, priority setting and decision making
- Demonstrating accountability to Alliance members, local people, stakeholders and regulators
- Ensuring continuous improvement and innovation in the quality and delivery of services
- Ensuring the delivery of high quality, safe and caring services
- Ensuring good financial management, financial governance and value for money

We will continue to work with our Alliances to engage in a range of activities to develop solutions for their local populations:

### **Public Involvement**

- Work with citizens to understand the wellbeing, social and healthcare needs of the local population
- Create, grow and develop solutions to improve outcomes for the local population
- Co-produce outcomes to reflect the lived experience

### **Continuous Improvement/Innovation**

- Review and redesign local services
- Work collectively to shape and deliver improvements collectively
- Use innovation, including digital solutions, to enable system change and improve outcomes for the local population

### **Reducing Health and Social Inequalities/Population Health/Planning**

- Assess the wellbeing, social and healthcare needs of the local population
- Conduct strategic planning across our local population; identifying opportunities for transformation and improvement
- Develop and implement delivery plans

### **Delivery**

- Responsibility for local service provision. Those defined as Specialised Services may be commissioned a system level, but delivery will remain at provider-led alliance level
- Managing risk – finance, quality and performance
- Holding colleagues to account

### **Integration**

- Work with system partners to align and integrate service delivery across sectors to create efficiencies in practice and improve outcomes for the local population
- Build and manage relationships across the Alliance network
- Work as part of the ICS to inform and deliver systems ambitions

### **Financial/Contracting**

- Shared decision making
- Undertake procurement where required, and manage ongoing contractual arrangements
- Local financial management



## 2.4 Our CCGs

The CCGs are evolving the way in which they work to enable effective collective commissioning across the ICS, within each Alliance area, and at a Neighbourhood Team level to make sure that the benefits of integrated care at every level can be fully realised. Commissioning is much more than just the procurement and contracting process. Commissioning for integrated care is about wrapping around all elements of the system in an integrated manner using co-design to work with communities on ways to respond to the needs of a defined population irrespective of size.

The needs of our population, national policies and plans, require that we take much more decisive action on prevention and population health; investing in new, more integrated, more efficient and more locally applicable models of health and care. Fundamentally, we also need a totally different relationship with our communities to enable them to shape the priorities and release the natural assets which will contribute to their wellbeing, care and health. We are responsible for making the best use of the resources we have in our system, and more effective commissioning and grant making has a major part to play in this. Over time, we aim to see a greater emphasis on efficiency coming from wider system improvements.

Statutory commissioning bodies responsible for health, care and wellbeing will need to take every opportunity to work with partner organisations/groups/bodies to think outside our current paradigm of what a health and social care system is, to have maximum influence on the causes of causes/wider determinants of health. This must include finding new ways to maximise the added value of voluntary and non-statutory resources that exist in the health, care and wellbeing sectors. Our approach to commissioning must also be driven by the latest evidence, insights and intelligence. To achieve the changes required, all current commissioning and provider organisations in Suffolk and North East Essex are seeking to find a new locally relevant, less hierarchical way of organising and delivering our wellbeing, care and health system.

In Suffolk and North East Essex we are committed to an emphasis on working predominantly at Alliance level and with the CCGs as equal partners in the ICS alongside local government, providers and the voluntary and community sector.

The three CCGs now have a single Accountable Officer and by December 2019 will have created a single management team, delivering a recurrent 20% running cost saving. The single management team will also play a significant role in supporting the Chair and Executive Lead of the ICS and in building an effective working relationship with the Regional and National teams of the NHS. The new team has five directors with cross-cutting responsibilities across the whole ICS footprint and a locality director aligned to each Alliance.

In 2020/21 the CCGs will:

- Continue to co-operate with one another and each working increasingly as integrated partners within Alliances with governance to support local decision making;
- Establish joint governance across the three CCGs able to support decision making where it is needed across the whole ICS footprint;
- Explore closer working with Local Authority commissioning partners, including Public Health;
- Explore the potential of integration of direct commissioning of specialised services at an ICS level;
- Conclude discussions on the organisational form of the CCGs.

## 2.5 Aligning Incentives to Deliver Change

In recent years we have worked together to agree fixed income contracts which have enabled our local providers and the CCGs to plan with greater financial certainty and to

focus our clinical and managerial expertise on working together to improve the quality of services. We believe that the system of fixed income contracts is one of the key enablers of success in the system; allowing all partners to concentrate on developing the most appropriate pattern of services rather than being driven by particular financial incentives.

Our closer working as an ICS has been demonstrated by the adoption of a system-wide control total along with the supporting mechanisms for its management through the Alliances and ICS. This mechanism creates greater flexibility and helps take forward our collaborative approach. We also recognise that we need to balance the need for a consistent contracting approach with our providers with the different historic position of the CCGs, the pattern of service provision and the particular priorities of each local Alliance. To this end we have agreed that for 2020/21, as in 2019/20, we will set a standard uplift level on the Guaranteed Income Contracts with providers, which will be related to the growth figure received by the CCGs, leaving an element of growth to be determined locally by each CCG to deliver nationally determined priorities alongside local priorities agreed by the Alliance partners.

The CCGs will continue to ensure that Mental Health Services are prioritised in our investments, through ensuring that the mental health investment standard is met, maintaining the share of our overall expenditure which is allocated to this area, regardless of the pressures being felt elsewhere in the local system.

Subject to the system financial position, the CCGs will look to provide a third year of transformation funding for Ipswich and East Suffolk and West Suffolk building on our work over the last two financial years. This will be influenced by the investment priorities in the NHS Long Term Plan. We believe that the Fund provides an opportunity to pump prime a range of partners to deliver on the priorities outlined in the Alliance Strategies.

We will be looking to work in partnership with providers of care in Suffolk to meet our statutory requirements and to deliver the constitutional standards of the NHS. As such, the priority of financial investment remains foremost to deliver constitutional performance, with subsequent investment to complement and enhance performance against our Alliance ambitions and objectives.

The CCGs will procure services in accordance with regulations, its scheme of delegation, with reference to the evolution of Alliances and with regard to the regulations on procurement, competition and choice. The regulations are intended to give commissioners flexibility and adopt a principles based approach as opposed to providing prescriptive rules on procurement. The regulations do not mandate that services must be competitively procured. The decision of which services to commission and how to procure them remains a decision for commissioners.

### **3. Areas for Continued/Greater Focus in 2019/20**

The CCGs believe that the Alliance Strategies and ambitions/objectives set out above, provide the framework for our future commissioning plans, and the Alliance Delivery Plans will set out how the Alliances will deliver on these of which we will continue to play a key part.

Notwithstanding this, the CCGs believe that the following areas are of particular focus during 2020/21:

#### **3.1 Integrated and End of Life Care and Elective Care**

The following focus areas apply across both Ipswich and East Suffolk and West Suffolk CCGs:

- Continued roll out and further development of Integrated Neighbourhood Teams (INTs) across Suffolk to support delivery of local health and care improvement priorities through localised delivery plans and CCG wide transformation priorities. This includes managing demand at a local level, with a particular focus on Long Term Conditions management, Ageing Well and End of Life.
- Fully embed Discharge to Assess (D2A) across the four agreed pathways to continue to support effective patient care and support health and care system demand and capacity; achieving 3.5% or less delayed transfers of care and reduced levels of Stranded and Super Stranded patients and reducing delayed transfers of care at community hospital sites with an aspiration to achieve 3.5% supporting overall system flow.
- Fully embed Trusted Assessment across Suffolk, linked to priority integration projects including Integrated Neighbourhood Teams, D2A pathways, Care Homes and REACT (responsive home care and support).
- Further development of a Responsive Homecare and support service, joining up referral and assessment processes and longer term development of a Single Point of Access, co-location and linking with locality developments.
- Year 2 delivery of the system Managing Demand in Care Home programme of work with a focus on trusted assessor, responsive in-reach, dementia and tissue viability support and integrating care homes with locality developments
- Continue to roll out High Intensity User approach to all providers, supporting MDTs and shared care plans. Developing this further with primary care networks/integrated neighbourhood teams to support sustainability across the system.
- Delivery of a new integrated Family Carer Service Model that supports identification, assessment and review, support options and provides information, advice and guidance to carers.
- System-wide review of diagnostic capacity to deliver the elective and cancer performance standards via faster access and more pathways straight to test
- Continue to support our local trusts on decreasing waiting lists to ensure no long waiters, supporting the 26-week choice process to offer faster treatment elsewhere. Transformation will focus on redesign of outpatients and one-stop shops reducing the need for patients to travel for face to face appointments by one third over five years. At ESNEFT this will focus on 5/6 specialties (Big Six).
- Continue the implementation of large-scale change programmes with local acute trusts and partner organisations, including ophthalmology, gastroenterology, MSK and respiratory.
- Ensuring we address the opportunities identified in the Rightcare Programme mandated areas and for our CCGs.
- Support the development of additional neuro rehabilitation capacity in Suffolk with partner organisations.
- Supporting pharmacy staff to take on increased patient facing clinical roles and, through the Medicines Value Programme, help the NHS deliver better value from the £16 billion annual spend on medicines. This will include linking local screening and prevention initiatives with contractually-mandated pharmacy public health campaigns to maximise local benefit.

The additional specific focus areas for Ipswich and East Suffolk CCG are:

- Full implementation of the Front Door Transformation and specifically, the Integrated Urgent Treatment Centre at Ipswich Hospital site, and supporting

- its further development including integration of: GP Streaming and system-wide, urgent and emergency care resources including primary care, paramedic, pharmacist, therapists and developing a Mental Health Crisis element.
- Further development of the established 24/7 community based Reactive Emergency Assessment Community Team (REACT) admission prevention service to extend the Frailty Assessment Base, Dementia Intensive Support Team and mental health provision to 7 days a week service.
  - Exploring the introduction of a Rapid Intervention Vehicle to bolster the urgent community response and specifically Ageing Well.
  - Upscale the Proactive Frailty Offer to Felixstowe (LIFT) and consider roll out to other areas such as Aldeburgh and Hartismere to support the community out of hospital model for frailty.
  - Delivery of the End of Life (EOL) care review recommendations including mobilisation of funded schemes/initiatives including EOL training for front line teams and care homes, building capacity in primary care to support advance care planning, extension of preferred place of care pilot and development of a digital offer with public facing EOL website/App.
  - Co-production of a 24/7 EOL Service Model and specification with system partners, with a key focus on supporting preferred place of care and managing demand.

The additional specific focus areas for West Suffolk CCG are:

- Development of an integrated front door model that streams all minor illness and injury activity.
- Development of Health and Wellbeing Hubs including phase two of the Newmarket site.

Finally, the NHS Plan identifies four key areas for delivery for elective care, which we will continue to progress across Suffolk: 1) Ensure all local transformation plans reflect the recommendations in the elective care specialty handbooks, where a relevant specialty has been identified as a priority; 2) We have one First Contact Practitioner (FCP) pilot and look to participate in the national evaluation process, and roll out FCP services more widely where opportunities are identified locally; 3) We have implemented failsafe processes within our acute trust in ophthalmology and will continue to manage the risk of harm to ophthalmology patients, and act on the outcomes from the eye health capacity reviews; 4) We look to utilise capacity alerts on the NHS e-referral Service as a tool to support shifts in flows of activity identified in local commissioning plans and as a tool to support recovery where referral or activity plans are not being delivered in year.

## **3.2 Integrated Care System - Strategic Programmes**

The following are strategic programmes across our ICS:

### **3.2.1 Stroke Services**

Work with colleagues across the Region and locally to review the acute stroke unit configuration modelling for East of England. This will include a review of where the large centres (sometimes called comprehensive stroke centres, CSCs) local Intravenous Thrombolysis only units (sometimes called hyperacute stroke units, HASUs, or Primary Stroke Centres, PSCs) are located.

The choice between these models can depend on geography and travel times, availability of

experienced staff, urban/rural split, and other factors, including the maximum practical sizes of units. There will be exploration of the advantages and disadvantages of each model before a final decision on the distribution of thrombectomy and thrombolysis centres. We will support the introduction of an Integrated Stroke Delivery Network across the ICS/STPs in the East of England.

### 3.2.2 Diabetes

The focus areas for diabetes are:

- We will continue to identify people at risk of Type 2 diabetes, in particular those in high risk populations such as Black and Ethnic Minority communities and, have support to prevent individuals from developing the condition.
- We will be extending the NHS Diabetes Prevention Programme (DPP), including a digital option and enabling access to local programmes, by 2024.
- We will improve information, advice and support on weight management for people who are overweight and obese and their carers. We will increase awareness of our weight management programmes that can improve health and reduce health inequalities. Lifestyle services across the ICS offer an integrated healthy lifestyle service and the ICS is at the forefront of this work in piloting a Very Low Calorie Diet (VLCD) for patients prior to the national initiative due in 20/21.
- We will continue, in the Alliances to develop community-based services and support to help people change to healthier living. To support more projects such as community food growing and cookery classes help promote healthy eating. Local free or low cost activities such as Couch-to-5K and park runs to help people be more active. In part of the ICS we are developing a community Diabetes Prevention service known as the “Shotley” project which supports pre-diabetic and overweight patients in remote parts of the county through highly tailored local interventions. This project provides people with long-term peer group support and the concept was developed by the local people themselves. We will encourage more such schemes. Healthy meals and cooking skills are support by local restaurants to incentivise people to keep good diet self-management.
- Improving equality of access to high quality primary care, multi-disciplinary foot care teams and specialist diabetes support. We are continuing the roll-out of the diabetes foot care cards.
- The ICS has significantly increased the number of Structured Education (SE) places available for face-to-face learning for those with both Type 1 and Type 2 diabetes. This has been possible through the award of transformation funding from NHSE for the last three years. 2020/21 will be year three, so we can continue these projects. The CCGs of the ICS also pooled resources in order to procure and implement a digital SE pilot, which now has over 400 people; we hope to continue this approach.
- We will be developing support from mentors or buddies. Peer support is an important tool in living well with a long-term condition. A programme of work is underway to support diabetes patients with learning difficulties and services such as Live Well and Living Life to the Full are providing psychological and emotional support for diabetic patients.
- Some parts of the ICS have been developing hospital inpatient support with very positive results, which we intend to roll out to the wider system this year.
- We will enable people with Type 1 diabetes to monitor their diabetes more effectively and obtain the right support when they need it. This includes making available flash glucose monitors for everyone who meet the appropriate criteria with Type 1 diabetes,

including continuous glucose monitoring for all pregnant women with Type 1 diabetes, by March 2021.

- We will work within the PCNs ensuring that people with diabetes receive all treatment targets (nine annual health checks) in primary care. This will help to drive down unwarranted variation in services and minimise the risk of future health complications for people.

### **3.2.3. Cancer**

We will work to achieve the aims and objectives for Cancer detailed in the NHS long-term plan and the focus areas are:

- A focus will be on early diagnosis and increasing the percentage of cancers diagnosed at Stage 1 or 2 from the current 50% to the target of 75%
- We will work towards achieving all national cancer targets, including the new 28 day faster diagnosis target.
- We will support all national screening programmes and work to identify and correct inequality, and ensure new initiatives are made available promptly to our patients. We will work with our stakeholders across the ICS on prevention and awareness programmes.
- Similarly, we will, where appropriate, working with colleagues in specialised commissioning, to support technological advances in treatment so they are available to those eligible.
- We are committed to supporting advances in genomic testing, so this is available to all newly diagnosed cancers from 2021.
- The initiatives in living with and beyond cancer are vital, and we will provide personalized care based on a holistic needs assessment (HNA). This will be based on cancer care reviews in primary care, risk-stratified follow-up, and individual self-management plans with rapid self –referral back to secondary care when needed.
- We will implement the national pathways in lung, prostate, colo-rectal and upper GI cancers.
- We will work with and support PCNs in implementing the national cancer Direct Enhanced Service.
- We will continue to implement and develop Rapid Diagnostic Centres in line with the national specification.

## **3.3 Children and Young People and Maternity**

### **3.3.1 Children and Young People**

Working with our colleagues at Suffolk County Council and wider system partners we will continue to focus on our key work streams and priority areas. The main focus areas are:

- Ensuring the SEND Acton Plan is fully implemented. This should also include Service Delivery and Improvement Plans for each provider to progress the further development of Key Performance Indicators and Outcome measures over the next 12 months.

- Implementation of the new model of care for Children’s Speech and Language Therapy. This should also be supported by an agreed mobilisation plan and recruitment plan from the service.
- Development and implementation of a new model of care for Neurodevelopmental and Behaviour including new pathways of delivery.
- Implementation of a new Mental Health model which will include:
  - Implementation of the THRIVE model while continuing to achieve the national access standards as a minimum
  - Implementation of new Mental Health Crisis Service, including outreach support
  - Further development of the Eating Disorders Service
  - Implementation of the new Mental Health Support teams in schools
  - Development of an outcome framework
- Further development of the Perinatal Service.
- Review of acute and community children’s services and development of a revised model of care.

### 3.3.2 Maternity Services

The five year forward view for Maternity Services, “Better Births”, was published in 2015. It clearly defined the manner in which maternity services should be transformed and delivered. The Local Maternity System (LMS) has, to date, been supporting provider trusts to fund and deliver the transformation programme. In 2020/21, the LMS will expect greater leadership from the Alliances to fully implement and embed the service pathways in their localities, whilst working with LMS partners to ensure consistent outcomes for women and babies across the ICS footprint.

The full deliverables are detailed within the Better Births, Saving Babies Lives care bundle version 2, and the Long Term Plan, as well as within the LMS programme plan. All deliverables must be achieved. In 2020/21 in particular, the Alliances will be expected to achieve:

- 100% compliance with Saving Babies Lives care bundle version 2 by March 2020, and embedded into practice during 2020/21.
- 20% reduction in stillbirths, neonatal and maternal deaths (since 2010 baseline) by March 2020 and 50% by March 2025.
- Delivery of provider and commissioner agreed postnatal care improvement plan. This will be based on national guidance and local best practice e.g. bereavement counselling, post-natal groups, pelvic health clinics.
- Creation and delivery of a plan to tackle health inequalities within the Alliances and LMS, with inequalities reduced from 2023, and 75% of women from Black and Minority Ethnic communities receiving Continuity of Carer by 2024.
- Patient portals in place by March 2020, to enable the roll out of a dynamic maternity electronic tool and personalised care plan model. An electronic patient record is fundamental to this development. The digital tool should be embedded into practice during 2020/21
- Delivery of Continuity of Carer roll out plan as per trajectories, to ensure coverage of 35% of woman by March 2020, 51% by March 2021, and 100% by March 2025.
- Improvement in Choice and Personalisation so that by March 2021 all women will have a personalised care plan, all women are able to make choices about their maternity care, during pregnancy, birth and postnatally, and more women are able to give birth in midwifery settings.
- Engagement with Operational Delivery Networks to deliver safe and sustainable models of Neonatal care across England by March 2021. This will include embedding pathways to ensure that all women who are likely to deliver before 27 weeks of gestation give birth in a maternity unit with an on-site Neonatal Intensive Care Unit, and all neonatal deaths are notified using the standardised Perinatal Mortality Review Tool.

- Active participation in NHS Improvement Maternity and Neonatal Quality Improvement programme by March 2021
- Embedding of the Maternity Incentive Scheme/10 Steps to Safety with continued oversight of the Trusts self-declaration.
- Active participation in system learning from serious incidents and clinical audits, and developing clinical governance arrangements across the LMS
- All services actively working with their local Maternity Voice Partnership group to embed co-production into service transformation and quality improvement activity.

### 3.4 Mental Health and Learning Disabilities

The focus areas are:

- Focus on service improvements at Norfolk and Suffolk NHS Foundation Trust given the most recent and pending CQC inspection (October 2019) outcome of 'special measures'.
- Continued development of our new model of care as described in the East and West Suffolk Mental Health and Emotional Wellbeing Strategy (January 2019) *#averydifferentconversation* focussing on integrating physical and mental health, supporting Long Term Conditions and providing greater support to primary care and community services. This also includes a continued commitment to co-production in the development of our future models.
- As part of our new system wide crisis model, implementation of 24/7 psychiatric liaison services in East and West Suffolk, implementation of the County wide Early Intervention in Psychosis (EIP) service, implementation of the Crisis Resolution and Home Treatment business case and development of alternative initiatives to mental health admission (including crisis cafes).
- Ongoing focus on dementia including diagnosis rate, annual review and pre and post diagnosis support.
- Full implementation of the Improving Access to Psychological Therapies (IAPT) business case focussing on increasing support for Long Term Conditions and delivering the 25% access target by 2020/21.
- Severe and Enduring Mental Illness - providing support, including Annual Physical Health Checks and Individual Placement Support (IPS).

### 3.5 Primary Care

We will continue to implement our Primary Care Strategies and GP Forward View plans including:

- Continued development of new models of care – enabling primary care collaboration and joined up care in our localities – through Integrated Neighbourhood Teams and enable PCNs and INTs to become increasingly coterminous.
- Delivery of high quality Dementia diagnosis services, Learning Disability and SMI Health checks – supporting local practices to enable these patient cohorts to access these services to meet their needs.
- Workload - support for the delivery of the Ten High Impact Actions in practices to reduce workload and manage patient care, including the roll out of social prescribing.
- Workforce – delivery of GP recruitment and retention programmes as well as support for the integration of new clinical roles in practice especially the



- new roles that will be rolled out via the PCNs (social prescribers, pharmacists, physicians associates, physiotherapists and paramedics)
- Workforce – delivery of a series of actions to support the recruitment and retention of practices nurses including the roll out of the GPN ten point plan
  - Mental health – work with local providers of mental health services to test and then implement the prevention, primary community element of the mental health strategy, within our Integrated Neighbourhood Team areas.
  - Access – enhancing access to GP-services including in evenings and at weekends and ensuring an efficient and effective transfers of care. We will work with local providers to implement the outcome of the national access review, once published in October 2019. We will work with local PCNs during 2020 to agree how we will ensure the smooth transfer of commissioning responsibility for GP+ to local PCNs.
  - Infrastructure – creating new physical environments for future care needs utilising the ETTF process and to facilitate the implementation of the NHS Long Term Plan ambitions.
  - Alliance strategy – working with local partners to implementation the Alliance Strategy.
  - Population health – to support the roll out of a Population Health approach, working closely with local PCNs.
  - Digital connectivity and digital first – we will work with local partners to facilitate the implementation of an IT infrastructure that supports the improvements to digital connectivity required in the NHS Long Term Plan and to enable patients to increasingly access services via a digital first approach.
  - Leadership – investing in clinical and management leadership within primary care and with secondary, community and social care partners in One Clinical Community. We will increasingly look to increase this approach to support the development of PCNs to ensure productive and effective working relationships.
  - CCGs will work across the ICS footprint where it makes sense to do so.
  - We will continue to provide leadership, an effective contractual framework and support for safe, high quality and cost effective prescribing. We will do this by working with local practices, wider clinical partners within our Alliances and across the East of England through the prescribing Priorities Advisory Committee and PRESCQIPP. We will retain particular focus on anti-biotic and Controlled Drug prescribing and management.
  - We will also continue our support for practices prior to and subsequent to CQC inspections to ensure shared learning.
  - We will continue to review the Primary Medical Services Development Framework and GMS LES to ensure that services respond to national and local priorities.

### **3.6 Ambulance 999 Commissioning**

We will continue to lead on the co-ordination of commissioning the 999 contract across the six STPs and six county footprint of the East of England Ambulance Service (EEAST). We will continue to explore ways of closer integration with urgent and emergency care patient pathways to improve patient outcomes and quality of care.

We are mindful that the 2017/18 Independent Service Review provides a broad contractual framework for the coming year and we will work proactively with our CCG partners and EEAST to ensure that we continue to have a fair and balanced approach that puts our patients first. We intend to ensure that EEAST work on the Carter Report initiatives to become more productive, whilst our commissioning of patient pathways will continue to seek treatment as close to home as possible for patients where appropriate.

Our priorities for 2020/21 are:

- Improving pathways for non-injury fallers and thereby reducing onward conveyance of these patients to Emergency Departments;
- Ensuring 'Ageing Well' and frailty programmes improve patient care to the elderly;
- Continuing to explore ways of delivering stroke patient testing and diagnostics on scene;
- Closer integration of our Clinical Assessment Services (111/Out of hours) with 999 pathways to provide improved responses to lower acuity patients. This will be informed by the Herts Urgent Care pilot and subsequent roll outs/testing elsewhere.

We intend to support EEAST to meet Ambulance Response Standards in 2020/21. In particular we will look at ways of supporting their workforce strategies to ensure existing front line staff can operate in the best environment possible and to ensure that we can support EEAST's retention strategies with a focus on developing career pathways for clinical staff within closer, more integrated services for urgent and emergency patient pathways. We also intend to support EEAST in providing key messages to recruit more staff into the ambulance sector, and we welcome the more diversified approach to recruitment that EEAST are taking.

## **4. Enablers**

Digital and IT Services, Estates and Workforce Planning are key underpinning enablers for the success of our ICS development and Transformation Programmes and therefore must be informed by clinical and service strategy.

By collaborative working and joint decision-making, we will make the best use of property, people and digital services to meet local health and care needs. Our focus will ensure these areas are fit for purpose, functionally suitable and commercially viable. The CCGs, working with Alliance partners have robust governance arrangements in place for ensuring that decisions about Digital, Estates and Workforce reflect local healthcare priorities and the current and future needs of the local communities.

The formation of the relevant ICS Strategy and Delivery Groups has enabled a greater focus on partnership working and enabled all health and social care providers who are members of the group to explore these areas in more depth and work together in line with our transformation plans.

We hope this letter helps clarify our current direction of travel and reinforces our commitment to joint working across Suffolk and the wider ICS.

Yours sincerely

A handwritten signature in black ink that reads "Ed Garratt". The signature is written in a cursive style and is underlined with a single horizontal line. A small period "." is placed to the right of the signature.

Ed Garratt  
**Chief Executive**  
**Ipswich & East Suffolk CCG**  
**West Suffolk CCG**