integrated working

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30 September 2015

Dear

**NHS West Suffolk Clinical Commissioning Group Outline Commissioning Intentions 2016/17**

We are pleased to enclose a copy of West Suffolk Clinical Commissioning Group's (WSCCG) Commissioning Intentions for 2016/17. This sets out the context within which we will be commissioning services and outlines how we wish to work with all our providers and system stakeholders. The framework of our Commissioning Intentions is to deliver even better care for the people of the west of Suffolk within a more sustainable system. These Commissioning Intentions also provide details of the key initiatives and changes that we expect to implement in 2016/17.

This document sets out the direction the CCG intends to take for 2016/17 and the services and the priorities we will be focusing on as we enter into a new contractual year. Key to our success is the strong relationships we have built with our partners and we look forward to continuing working with you in a proactive and positive manner.

2016/17 presents the west Suffolk health system with a series of significant challenges including maintaining and improving quality in the face of ever tighter budgets and demand pressures relating to on-going demographic changes. Our Commissioning Intentions signal the need for commissioners and providers to work together to integrate care wherever possible to improve outcomes for our population and a shared approach to development will remain key to our continued success.

Please do not hesitate to contact us should you have any further questions.

Yours sincerely

**Julian Herbert**
**Chief Officer**

**Dr Christopher Browning**
**Chairman**

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West Suffolk
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**WEST SUFFOLK CLINICAL COMMISSIONING GROUP**

# Commissioning Intentions for 2016 – 17

## September 2015

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# COMMISSIONING INTENTIONS – 2016/17

## 1. INTRODUCTION

This letter sets out the initial outline Commissioning Intentions of the NHS West Suffolk Clinical Commissioning Group (WSCCG) for 2016/17. These have been built on work that we have undertaken with our partners, through continuous engagement with providers, patients and other stakeholders to develop our strategic plans.

The development of these Commissioning Intentions is intended to clearly set out our priorities for service developments/changes that will impact on the services we commission and as such it signals the start of the 2016/17 contract negotiation process. There are existing projects and programmes of work that the CCG will continue to implement and develop with providers. This document does not include on-going review of existing contracts for services which are a recurring requirement. The focus of this document is to signal either a new or extension of existing developments that will be a priority in 2016/17.

The development of this document has been co-ordinated by the CCG's Chief Contracts Office (CCO) working in conjunction with other directorates in the CCG and the lead GP Executive Board members. The GPs leading the clinical workstreams will be steering the development and implementation of these intentions in 2016/17.

## 2. CONTEXT

### 2.1 DEMOGRAPHICS

A summary of the demographic features of our population is set out below:

**Demography:**

- The number of registered patients in general practices in West Suffolk CCG as at quarter 3 of the financial year 2014/15 was 243,117 persons of all ages (males: 120,460; females: 122,657).
- As at quarter 3 of the financial year 2014/15, persons aged 65 years and over formed 21.8% (53,103/243,117) of the population of registered patients in the area covered by the CCG.
- The resident population of west Suffolk is increasing in size and ageing. It is projected to continue to increase in size, rising to 255,900 persons in 2036. In 2016, persons aged 65 years and over will form 21.8% of the resident population. In 2036, persons aged 65 years and over will form 29.4% of the resident population.

**Deprivation:**

- West Suffolk is generally an affluent area, with pockets of relative deprivation in Bury St. Edmunds and the small towns of Haverhill, Mildenhall, Brandon, Newmarket and Sudbury,
- The most deprived general practices include Haverhill Family Practice, Clements Christmas Maltings, Siam Surgery and Hardwicke House.

**Life expectancy and main causes of death:**

- Life expectancy in west Suffolk is relatively high. In 2010-12 life expectancy at birth in males was 81.0 years, and males could expect to live 81.9% of their life in "good health". In 2010-12 life expectancy at birth in females was 84.5 years, and females could expect to live 80.2% of their life in "good health",
- In 2010-12, life expectancy at age 65 was 19.6 years in males and 22.1 years in females,
- In the calendar years 2012-14 the main causes of death in west Suffolk CCG were neoplasms (29.7% of all deaths in 2012-14 (1,948/6,555), diseases of the circulatory system (28.0% (1,832/6,555)) and diseases of the respiratory system (13.4% (880/6,555)).

**Morbidity and hospital activity, including mental illness:**

- During the period 2008/09-2012/13, standardised emergency admission ratios for coronary heart disease (87), stroke (89.2) and myocardial infarction (91.2) in west Suffolk were significantly low compared to England as a whole (100),
- In 2007-11 a standardised incidence ratios for all cancers (104.7), colorectal cancer (114) and prostate cancer (138.3) were significantly above England as a whole (100),
- Dementia is a main cause of ill health in west Suffolk, mainly in the elderly. It is projected that there will be 3,776 persons aged 30 years and over with dementia in 2016 and 4,397 persons with dementia in 2021,
- In 2012/13 the QOF crude prevalence of depression in persons aged 18 years and over was 6.4% (12,233 persons on QOF depression registers; England: 5.8%).

**Lifestyle:**

- In 2013 the estimated prevalence of smoking in persons aged 18 years and over in west Suffolk was 15.3% (estimated number of smokers in CCG: 29,438; England: 18.4%),
- In 2011-13 the alcohol-specific mortality rate in persons of all ages in was 9.4 deaths per 100000 residents (60 deaths; England: 11.9).

## 2.2 STRATEGIC DIRECTION

NHS England's **Five Year Forward View** sets out the direction for the NHS and shows why change is needed and what it looks like. It identifies the need to take decisive steps to break down the barriers in how care is provided between family doctors and hospitals, between physical and mental health, and between health and social care. The vision includes more care delivered locally but with some services in specialist centres organised to support people with multiple health conditions and not just single diseases.

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 will put them in a much better position to match investment decisions with the needs and aspirations of their local communities.

Locally, the **Suffolk Health and Wellbeing Board** has set out a vision for the people of Suffolk to live healthier, happier lives with reduced inequality of life expectancy. The Board has agreed four strategic outcomes based on information from the Joint Strategic Needs Assessment and evidence that shows action in these areas will help us to attain our strategic aims, which are that:

- Every child in Suffolk has the best start in life,
- Suffolk residents have access to a healthy environment and take responsibility for their own health and wellbeing,
- Older people in Suffolk have a good quality of life,
- People in Suffolk have the opportunity to improve their mental health and wellbeing.

This vision will be delivered through the strategy which is set out in the 5 year Strategic Plan. This was informed by the Health and Care Review programme which is developing plans to design and commission integrated services focusing on three key strategic areas:

- A national drive looking for integrated health and care which improves outcomes and experiences for patients and local people; and saves money;
- A wish to work better together locally across the system to ensure that we make best use of resources and minimise impacts of savings on patients' care;
- To take full advantage of the potential of partnership working to prevent ill-health and increase people's independence,

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 is currently implementing the new arrangements. During 2016/17, the CCG will be entering into discussions with NHS England to consider its approach to fully delegate commissioning of primary care services, and to understand the financial implications of this.

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.

Since November 2013, the CCG has worked closely with partners, in particular NHS Ipswich and East Suffolk CCG, Suffolk County Council and Healthwatch, to engage the wider Suffolk community on the future of health and social care services in Suffolk.

A review of the feedback, local experience, national policy and evidence has identified a number of key themes which have been progressed in the service redesign over the last year and will guide our continued work in 2016/17:

- 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 cooperation 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 the county's hospitals are under severe pressure, and the system needs to ensure that their expertise is focused on genuine emergencies with other professionals supporting urgent care cases.

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

- The major building blocks of the new system are Integrated Neighbourhood Teams. social care, community health services and some aspects of mental health services are beginning to be organised and delivered at neighbourhood level, starting in Sudbury. In particular, there will an increased emphasis on the teams managing their local population 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 reviewing our NHS '111' and GP 'Out of Hours' services during 2016/17 so that we look to create a more integrated urgent care model in line with the emerging national model;
- 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.

The focus of 2016/17 will be on the continued development and implementation of this significant system reform and on redesigning the way health and social care systems work, in particular through the development of an Integrated Care Organisation (ICO) bringing together system partners in a different delivery vehicle as described in the next section.

## 2.3 INTEGRATED CARE ORGANISATION

The Health and Care Review has developed a model for delivery of integrated health and care in Suffolk. System partners have agreed that they wish to pursue working towards an Integrated Care Organisation (ICO) which will aim to:

- Work with system partners to deliver the agreed health and care model;
- Join up acute, primary care, community and social care services more effectively;
- Deliver efficiencies for the health and care system;
- Promote Suffolk as the location of choice for recruitment and retention.

A Shadow ICO Board has been set up to oversee the development of plans through a phased implementation during 2016/17. System-wide workstreams will progress the detailed planning and implementation of this. The CCG and providers will need to work together in close partnership to develop new payment systems, contracting methods, technology improvements and workforce plans in order to support the new model of integrated care. New payment systems are likely to include a combination of activity-based, outcomes-based and capitated payment approaches which will, together, most benefit patients.

It is the CCG's intention to develop a capitated payment system with the ICO accountable for a wider range of population needs compared with individual provider organisations. There will be greater incentive for coordinated, integrated working across health and social care with risks identified early, earlier intervention and the right treatment arranged at the right place at the right time. The payment system will be designed to:

- Promote primary, secondary and tertiary prevention:
  - To keep people healthy (and not requiring costly intervention),
  - Promote early diagnosis and treatment,
  - Invest in recovery, rehabilitation and reablement.

- To keep people healthy (and not require costly interventions), ensuring that the ICO:
  - is able to judge the best intervention,
  - incentivised to provide care in the most appropriate and lowest cost care setting,
  - is able to invest in care coordination.

- Promote investment in productivity and innovative solutions.

The payment system will promote the long-term, sustainable well-being of local people by reimbursing providers for delivering specified quality outcomes for patients rather than particular treatments or inputs. It will incentivise best practice, efficient and accessible delivery of care, to make sure that NHS funding goes as far as it can for patients.

The payment system can help to make sure that financial risks in the NHS, caused by demand pressures or operational performance, sit with those organisations, whether commissioners or providers, who are best able to influence or absorb them in the context in which they arise. The CCG and providers will work together to agree the risk sharing arrangements that minimise financial risks to local health systems and maximise benefits to patients from NHS funding.

During 2016/17, work will continue towards this system reform, where the concepts will be tested, and used as an opportunity to understand the key components of building a more cohesive health and care system with cross-organisational working.

### 2.4 FINANCIAL CONTEXT

The health system in West Suffolk faces significant financial challenges that require a different approach going forward if we are to build a sustainable service in the future. A considerable amount of work designed to address this is already underway across the system but it is important that we set out the financial context for 2016/17 and how we expect this to impact on contracts.

The CCG financial allocation has been above its 'fair share' target for some years. In order to bring all the CCG's closer to target 'fair share' by 2018/19 we only expect to see a minimal growth in funding over the next few years which will therefore leave a substantial financial gap that will have to be closed. We recognise the difficulty of this and therefore, we intend to work closely with providers to ensure efficiency across the west of Suffolk system.

## 3. CLINICAL PRIORITIES & IMPROVEMENT AMBITIONS

### 3.1 INTRODUCTION

The CCG has developed its own distinctive ambition to provide a local approach for delivery of the Five Year Forward View and the local 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:

- development of clinical leadership;
- demonstration of excellence in patient experience and patient engagement;
- improving the health and care of older people;
- improving access to mental health services;
- improving health and wellbeing through partnership working;
- delivering financial sustainability through quality improvement.

The following improvement ambitions have been set in response to the changing needs of the local population, and these form the basis of the CCG's 5 Year Strategic plan:

- increasing additional years of life for local people by reducing potential years of life lost from those causes from which premature death should not occur;
- 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, and more integrated care in community settings, achieved by reducing emergency admissions;
- increasing the 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; and, positive experience of care outside of hospital, in General Practice and in the community;
- making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

In conclusion, organisations in the west of 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. The difference we shall make to the health and social care outcomes for all people in the west of 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;
- 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.

The following sections set out how the CCG will develop and implement its strategic vision of system reform and redesign, and how it will deliver against its overarching ambition and clinical priorities.

## 3.2 INTEGRATED CARE

The Integrated Care programme for 2016/17 will focus on three main work strands:

- Development by October 2016 of an integrated urgent care specification to support reactive care; for mobilisation by September 2017;
- Development by October 2016 of a community services specification to support proactive care; for mobilisation by September 2017;

- Implementation of the Integrated Health and Care strategy '*Connect'* across west Suffolk by March 2017.

The Integrated Care programme will be underpinned by the following priorities and principles:

- Care is coordinated around the individual, not the organisation;
- Prevention, self-care and shared decision making are promoted as key enablers to supporting and empowering individuals to take responsibility for their own health and wellbeing; and to seek help through proactive care reducing the demand on urgent and emergency reactive care services;
- There will be greater formal recognition of the role of family carers, the voluntary care sector and independent organisations as partners of care through the neighbourhood networks;
- There will be increased co-ordination and co-operation at the point of delivery between health, social care and voluntary sector services through the integrated neighbourhood teams;
- Organisations will work together as collaborative partners to:
  - provide a single holistic physical, emotional, mental and social wellbeing assessment framework;
  - collectively co-produce shared care and support plans with patients /family carers;
  - co-locate where this is practically possible;
  - develop and use a common standard operating framework;
- There will be alignment of service access to reduce the number of entry points to the system ensuring, where this is possible, that access is via one single coordinated care function;
- There will be greater access to a range of system services offering 7 day provision to strengthen operational resilience and user experience.

The 2016/17 Integrated Care programme will specifically co-design with our partners a new integrated urgent care access, treatment and clinical advice service specification. This will support the provision of a 24/7 reactive care pathway and the procurement timetable for out of hours primary care and 111 services. It is proposed that the design work will consider the provision of existing community and acute urgent care services to ensure the wider range of clinical expertise and provision is available. The design will reflect the learning from 'Connect Sudbury' and the recommendations and guidance from the new forthcoming national specification and will include:

- A review of the accuracy, accessibility and utilisation of the 111 Directory of Services;
- Development of a clinical hub of coordinated expertise to support a range of clinical pathways and highly complex high volume service users;
- Coordination of the availability and access of special patient notes, advance care plans and end of life plans in the point of the patient pathway that ensures appropriate care is provided;
- Provision for direct access to contact social care specifically home care support.
- A review of ambulatory emergency care including:
  - a formal review and revision of the primary care Local Enhanced Service (LES) for the detection and management of Deep Vein Thrombosis;
  - a formal review of the respiratory pathway (building on the COPD review 2014/15).

- Co-design with our partners and in particular Suffolk County Council, a new integrated community services specification. This will support the provision of a 7/7 proactive care pathway and the procurement timetable for the existing community services contract. The design work will run in partnership with the Urgent Care specification and will reflect the learning from Connect Sudbury.

- Extend the implementation of Connect Sudbury to other areas of west Suffolk ensuring that both the proactive and reactive elements of the care pathway are integrated across all organisations:

- Progress the implementation of an integrated reablement, rehabilitation and recovery pathway through the Integrated Neighbourhood Teams and Neighbourhood Networks and to include:
  - The re-provision of jointly procured community beds with Suffolk County Council to support step up and step down pathways;
  - The reconfiguration of therapy provision across the acute and community (health and care) interface to ensure integration of provision to meet the shift towards proactive care;
  - The use of technology to support more people to live independently at home.

- Identify and implement a coordinated case management approach to the top highly complex high volume service users namely:
  - Care Home and very sheltered housing residents;
  - Frequent A&E attenders;
  - Frequent Admissions;
  - Frequent Green 2 callers to East of England Ambulance Service Trust (EEAST).

- Building on the Interface Geriatrics pathway, develop access to a range of clinically led consultant interface pathways for the top high demand pathways namely:

  - Falls
  - Respiratory
  - End of Life

The Integrated Care Programme will be delivered with our partners through the Integrated Care Delivery Group and the West Suffolk System Forum (System Resilience Group).

**Cancer**

The Cancer programme for 2016/17 will focus on three main work strands:

- Improving and sustaining cancer performance through the implementation of:

  - the eight key priorities in the NHS England Guidance on Cancer waiting time standards

  - locally agreed treatment protocols for acute oncology presentations.

- Developing, as part of our local delivery model, an approach to apply complimentary therapy as part of the core offer.

- Reviewing and defining the specification for the provision of wigs to ensure there is equity and choice to all west Suffolk residents undergoing cancer treatment.

## 3.3 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.

Priorities for Planned Care programmes of work have been guided by national benchmarking utilising the following tools and Data Sources:

- Commissioning for Value packs published by NHS England;
- Payment by Results (PbR) Capita;
- Better Care Better Value;
- Sentif Intelligence;
- Medicines Optimisation Dashboard;
- Secondary Uses Service (SUS( data processed by Data Services for Commissioner Regional Office (DSCRO);
- Royal National Institute for the Blind (RNIB) Sight Loss Data Tool;
- External Review (areas not already progressed)

**Cardiology**
The CCG will conduct a transformational review of community and hospital services from prevention and diagnosis through to rehabilitation including a detailed review of fragmented acute and community contracts (i.e. heart failure, cardiac and pulmonary rehabilitation). The required outcome will be a full redesign of the pathway including a streamlined set of cost efficient services which enhance the patient experience.

**Gastroenterology**
In response to benchmarking highlighting the CCG as an outlier, and in light of changes to cancer targets, the CCG will conduct a review of community and hospital gastroenterology services from prevention and diagnosis through to rehabilitation in order to scope transformational changes to the service.

**Trauma and Orthopaedics/Musculoskeletal**
The community contracts review offers an opportunity for the CCG to optimise a range of musculoskeletal services including post-operative physiotherapy, carpal tunnel, outpatient hand therapy, podiatry, orthotics and foot surgery. In addition, physiotherapy clinics in GP practices to assess and signpost patients presenting with musculoskeletal conditions will be piloted.

**Dermatology**
The CCG, in partnership with providers, will develop an integrated dermatology model with a single point of entry/triage for the best outcome for the patient. This may incorporate tele-dermatology and the minor surgery community service. The tele-dermatology project will be evaluated and potentially re-procured either as part of the integrated model or independently. The CCG will review minor surgery in the community either independently or as part of the integrated dermatology model.

**Ophthalmology**
The CCG will develop a whole system approach to eye health to include triage, extended scope opticians, community ophthalmology and acute services along with the electronic platform that links the services together. The community glaucoma service will be reviewed following a one year pilot (joint West Suffolk Hospital Foundation Trust (WSFT)/ CCG procurement). There is an opportunity to extend scope beyond low risk glaucoma and link with a wider ophthalmology review.

**Diabetes**
The CCG will evaluate and agree the future direction for the WSFT community diabetes service. The Diabetes Education and Self Management for Ongoing and Newly diagnosed (DESMOND) contract will be reviewed as part of broader consideration of diabetes patient education.

**Clinical Thresholds/Low Priority Procedures**
The CCG will continue to work with WSFT to roll out the pre-procedure prior approval element of the Clinical Threshold Service (CTS) and will undertake a full evaluation of this during the period January-March 2016.

Following this evaluation, should the decision be made to roll this out on a permanent basis, the CCG will require all providers who treat patients registered with a West Suffolk CCG practice to seek WSCCG prior approval before any surgical procedure/medical intervention takes place. This will apply to any patient who requires a clinical threshold procedure, with effect from 1 April 2016.

The CCG will circulate further details to providers on threshold policies and supporting documentation as required to support this process.

**GP Practice Referral Support**
The CCG will extend the Map of Medicine contract to August 2016, continue to support the implementation and use in all GP practices and evaluate the service to consider mainstreaming.

**Population Health**
The CCG will work with the health and care system to develop a culture and policy across west Suffolk to focus on prevention of ill health using the appropriate trigger points. Using an enhanced recovery process this will ensure better outcomes from elective surgery and reduce mortality and morbidity by supporting people to be fit for surgery.

**Long-term Conditions and Wellbeing**
The CCG will build on the respiratory wellbeing project work in 2015/16 to roll out the approach across other long-term conditions, including primary, community and secondary care, and seeking opportunities to extend across social care.

**Community Vasectomy**
The CCG will review the community vasectomy service including post vasectomy semen analysis.

**Lymphoedema**
The CCG will review its current lymphoedema service provision and agree the future service model and procurement.

**Elective Care – BMI Bury St. Edmunds**
The CCG will work with the BMI hospital to develop an elective care specification to offer elective options to patients and explore possible efficiencies through variation of tariff.

**Minor Surgery**
The CCG will scope and review provision of minor surgery services in the community.

**NHS Community Health Services**
The NHS community health services contract was awarded to West Suffolk NHS Foundation Trust working in partnership with Ipswich Hospital NHS Trust and Norfolk Community Health and Care NHS Trust for 12 months from 1st October 2015. The planned care services within the contract will be reviewed as part of the planned care programme of work where possible. Key planned care areas of interest include;

- Heart Failure Service / Cardiac Rehabilitation Service: - Considered within the Cardiology programme as set out above.

- Outpatient Hand Therapy Service / Podiatry / Orthotics / Foot Surgery:
  Considered with the Trauma and Orthopaedics / Musculoskeletal programme.

- Community Neurological Service:
  Considered options for future procurement.

- Bladder and Bowel Continence:
  Work with Integrated Care programme to scope the bladder and bowel continence services to maximise benefits for patients and the health system.

- General Rehabilitation:
  *Work with Integrated Care programme to consolidate elective rehabilitation services*.

## 3.4 MENTAL HEALTH & CHILDREN & YOUNG PEOPLE

The priorities identified in the 2016/17 Commissioning Intentions for the CCG will be achieved through working closely with our partners, in particular Suffolk County Council (SCC), Norfolk & Suffolk NHS Foundation Trust (NSFT), West Suffolk Hospital Foundation Trust (WSFT), the voluntary sector and our regional Clinical Networks including the Children, Young People and Maternity clinical network and the Mental Health, Dementia, Neurological Conditions, Learning Disability and Autism Network.

**Mental Health**

The CCG will work towards greater integration of specialist mental health services with the wider health and social care system as below, and will continue to work closely with Norfolk and Suffolk NHS Foundation Trust (NSFT) to review the existing Access and Assessment/IDT operational model and make changes where necessary. The CCG will support the national focus on new mental health access and waiting time standards being introduced from April 2016.

We have set out the topics of our 2016/17 Mental Health commissioning intentions under the three broad themes of our joint CCG/SCC Adult Mental Health Commissioning Strategy, which is due for completion in autumn 2015, namely Early Intervention and Prevention, Recovery and Rehabilitation, and Crisis (incorporating the MH Crisis Concordat).

- **Early Intervention & Prevention**

  - Primary Mental Health Service (previously Suffolk Wellbeing Service) - ensure the robust and successful implementation of the newly procured service from July 2016, including the extended scope to incorporate the commissioning of Primary Mental Health Workers (PMHWs) with SCC;

- Long Term Conditions - following evaluation in March 2016 of the Psychiatric Liaison and Wellbeing pilot to support patients with long term respiratory conditions, apply learning and approach to extend into other areas, including Dermatology and Cardiology.

- **Recovery & Rehabilitation**

  - Mental Health Rehabilitation Pathways - consider and scope the range of services supporting patient's recovery and rehabilitation through a joint review with SCC.
  - Supported Housing - we will support the shared procurement of the Early Supported Housing contracts with SCC.
  - Tier 4 Children and Adolescent Mental Health Services (CAMHS) - we will support the commissioning of Tier 4 services as required, the responsibility of which is likely to return to CCGs in the future. We will support on-going exploration of opportunities to better integrate local Tier 3 and Tier 4 CAMHS provision.

- **Crisis**

  - 24/7 Crisis Response (including delivery of the Suffolk multi-agency Mental Health Concordat); for adults and children, including review and audit of the current pathway for people with personality disorders (Night Owls Service) and respite beds; more than 50% of people experiencing a first episode of psychosis will be treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral.

  - Police Triage Service; we will implement and mobilise a service that will provide on the spot advice to police officers who are dealing with people with possible mental health problems. This will lead to people receiving appropriate care more quickly, resulting in better outcomes and a reduction in the use of Section 136 and attendance at A&E.
  - Suicide Strategy; we will support the development of the strategy and implementation of recommendations in partnership with Suffolk County Council and Suffolk Constabulary.

- **Children's Emotional Health & Wellbeing**

The Suffolk Children's Emotional Health & Wellbeing Strategy will be refreshed in 2015/16. We will continue to focus as a county-wide system working in partnership to implement the priorities identified in the strategy, and as set out in our Transformation Plan requested by NHS England (to be completed in Autumn 2015).

The key areas of focus will be:

- Single Point of Access; scoping of a single multi-agency point of access for all children's emotional health and wellbeing referrals;
- Children's Eating Disorders; working with NSFT to develop our existing East and West Suffolk Children's Eating Disorder services to ensure the requirements of the August 2015 national commissioning guidance are met (including access and waiting time standards to be implemented from 2017/18);
- Crisis Care; to consider our commissioned response to children in crisis and full link up to the Suffolk Crisis Care Concordat;

- Improving Access to Psychological Therapies (IAPT); roll out the Children and Young People's IAPT programme to ensure that CAMHS commissioned services deliver a choice of evidence-based interventions by 2018. Central monies will also support increased access to training via CYP IAPT for children under five years and for staff working with Autism and Learning Disabilities;
- Perinatal Mental Health; see comment under Maternity Services below.

- **Autism**

  - Ensure that people of all ages have access to earlier assessment and diagnosis for Autism and ASD and are supported to access the services that they need. We will re-model the service in response to the JSNA refresh/evaluation.

- **Dementia**

  - National Drive to increase Dementia diagnosis rate; we will continue to support and promote early diagnosis of Dementia and ensure those diagnosed are appropriately recorded on GP registers.
  - Post Diagnostic Services Model; extension of existing contracts to March 2017 for post diagnostic services to align with SCC contracts. We will work through the Mental Health and Learning Disabilities Joint Commissioning Group with SCC to either align or jointly commission alternative arrangements, from the point of early diagnosis through to advance care planning and end of life care.
  - Dementia Friendly Initiatives; we will work with our 24 practices to promote the establishment of dementia-friendly health and care environments. Our dedicated Care Homes Clinical Support Manager will work with care homes in order to support and facilitate these initiatives.

- **Learning Disabilities**

  - Health Checks and Data Sharing with Social Care; we will continue to focus on improving the care and management of people with Learning Disabilities in primary care and the uptake of health checks.
  - Community Service Model; we will further embed NSFT's new Learning Disabilities service model for adults and children.
  - Awareness Training; we will take every opportunity to improve awareness of Learning Disabilities.

- **Marginalised Vulnerable Adults (MVA)**

This service is currently provided by North Essex Partnership NHS Foundation Trust and is due to expire at the end of July 2016. The service provides support for vulnerable groups and communities, including the homeless, ex-offenders and migrant workers.

The service will be reviewed with the support of a new county-wide Needs Assessment, currently being undertaken with Public Health, and re-commissioned accordingly.

**Children and Young People**

- Paediatric Specialist Community Services:
    - The hosting of this contract has now been awarded to WSFT as lead / coordinating provider as part of the community services procurement. WSCCG will work closely with Ipswich and East Suffolk CCG and Suffolk County Council (SCC) to determine the preferred model of care.
- Long Term Conditions:
    - Having invested into new Community Outreach Paediatric Asthma and Epilepsy Community Nurse posts at WSFT, we will evaluate at Q4 (2015/16) and decide on the future commissioning of these services. We will also consider scoping of other long term conditions that would benefit from specialist nurse input based on national guidance.

**Maternity Services**

- Midwifery Services Review:
    - We will assess and form a local response to the forthcoming NHS England led review of our local Maternity service offer, including perinatal and postnatal pathways.
- Perinatal Mental Health Pathway:
    - We will build on the local Norfolk and Suffolk Foundation Trust and WSFT Perinatal Mental Health pilot in 2015/16, the outcomes from the 2014 NHSE sponsored Sustain project focussing on perinatal service pathways and respond to the expected national commissioning guidance and earmarked investment (late 15/16) for perinatal care.

## 3.5 MEDICINES MANAGEMENT and HIGH COST DRUGS

**The Medicines Management workstream will focus on:**

- Continuing to improve on the review and development of Shared Care Agreements (SCA), where appropriate;
- 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' Clinical Oversight Group (COG);
- Promoting cost effective prescribing and so aligning actual prescribing spends with practice prescribing budgets.

**High Cost Drugs:**

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.

## 3.6 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 'Map of Medicine' to facilitate GPs making referrals consistently in line with local guidelines;
- Developing an approach to co-commissioning with the Area Team which will include local administration of Direct Enhanced Scheme (DES) schemes;
- Reviewing and revising the existing list of contract enhancements - The WSCCG 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 2016/17;
- The PMS Developmental framework will be updated to reflect key objectives for 2016/17.

## 3.7 CONTINUING HEALTHCARE

In 2016/17 the Continuing Healthcare Team will continue the transformation programme commenced in June 2015. It will deliver by the 31st March 2017:

- Improved patient and carer experience
- National framework compliant practice – consistently delivered
- Standardised, lean, processes (internal to the CCG and system-wide)
- Sustainable, motivated and skilled workforce (internal to the CCG and system-wide)
- Assured value from commissioned care packages

These goals will be delivered through improvement to:

- the CCG's CHC provider services (direct patient service provision)
- the CCG's commissioned CHC services (from NHS trusts, care package providers; care package brokers and Commissioning Support Units)
- the CCG's CHC commissioning function (including joint working with Suffolk County Council)

Improvement projects initiated in 2015 will be completed to deliver sustainable business change and the realisation of anticipated benefits. These projects include:

1. CCG's CHC provider services

    a. Process redesign, development of standard operating procedures (SOPs) and delivery of business change for:
        - Fast Track Applications
        - CHC Screening Process
        - CHC Full Consideration Process
        - CHC Eligibility Decision-Making
        - CHC Commissioning a care package process (including PHB process)
        - CHC Review Process

- FNC Eligibility Decision-Making
- FNC Review Process
- Local dispute resolution process

b. Backlog clearance project delivery for:
   - >28 day backlog for full consideration
   - CHC 3 mth and annual review backlog
   - FNC 3 mth and annual review backlog

2. CCG's commissioned CHC services

   a. Stakeholder agreements (in particular from NHS trusts and Suffolk County Council), to the system-wide CHC standard operating procedures and their contribution/role in delivering them.
   b. Contracts with NHS providers of CHC Fast Track, screening and full considerations which include the delivery of the SOPs and process and outcome KPIs. In particular with the community healthcare provider.
   c. The nursing home procurement project.
   d. Contracted brokerage services for PHB facilitation, as required.
   e. Outsourced PUPoC cohort 1 clearance (by NEL CSU)

3. CCG's CHC commissioning function

   a. Value review of care package costs.
   b. Contracts in place for all care package provision
   c. A commissioning strategy for future CHC services (including alignment with emergent delivery models for the assessment and case management of people in the community with long term complex care needs)
   d. An implemented new operating model for a sustainable CCG CHC service (processes, organisation, technology & accommodation, information)

## 4. PUBLIC/PATIENT ENGAGEMENT

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

- Continue to support the Five Year Forward View principles, particularly with a view to enabling whole system change and financial sustainability. There will be heavy involvement in Connect Sudbury – the early adopter site for a part of the delivery of the Health and Care Review 2014;
- Focus on under 18s and economic migrants to build better involvement and information giving and receiving;
- Increase our use of social media content and reach, to widen digital participation also ensuring this feedback and intelligence becomes more central to our work so that people can get good answers to their questions about commissioning and health;
- Develop our website, making sure those who visit get the best possible experience and can feedback to the organisation;
- Continue to specifically support areas of work, such as the development of the Children's Mental Health Services, in partnership with Suffolk County Council.

## 5. PATIENT SAFETY & QUALITY

### 5.1 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, where provider quality reporting is explicit.

The CCG will work with local Maternity services to ensure the recommendations of the Report of the Morecambe Bay Investigation and National Midwifery Review are considered and where appropriate implemented in local maternity services.

The CCG will work with regulators and providers to ensure relevant and appropriate recommendations as a result of the Savile report are implemented.

The CCG has a statutory obligation to ensure that staff and arrangements are in place to meet the Adult Safeguarding and the Special Educational Needs and Disabilities (SEND) Reforms, and in 2015/16 the CCG received external non-recurrent funding from NHSE for this purpose.

In order to ensure continued funding for the SEND reforms in 2016/17, the CCG will restructure its funding commitment to the Multi Agency Safeguarding Hub (MASH) to meet our statutory obligations to fund the Designate Safeguarding Professionals (CYP) Adult Safeguarding Professionals (Adult) and SEND (CYP) Clinical Officer. The MASH service is currently funded solely by the three CCGs locally (West Suffolk Clinical Commissioning Group, Ipswich and East Suffolk Clinical Commissioning Group, Great Yarmouth and Waveney Clinical Commissioning Group), and accordingly, with effect from 01 April 2016, will require funding from all members of the Safeguarding Board – namely the three CCGs, IHT, WSFT, NSFT, SCH. This will bring the funding of the Board in line with the approach in other localities.

### 5.2 QUALITY/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, response to serious case reviews and the application of the mental capacity act to address parity of esteem objectives.

The CCG is committed to improving support for people with care needs and their carers and will continue to deliver the national objectives set out by NHS England 'Better Care for Carers'.

## 6. PROMOTING HEALTHY OUTCOMES

The CCG works closely with its partners in Suffolk County Council Public Health Department. The following is an update on Public Health's Commissioning Intentions which the CCG will review in the period leading up to 2016/17:

- Commit to embedding Making Every Contract Count (MECC) within contracts and service provision;
- Commit to developing a workplace health programme within our own and partner organisations;
- Support the proposal that some of Public Health (PH) grant should be used to create a wider PH network to support primary prevention and decrease health inequalities within local authorities, with an agreed Memorandum of Understanding (MOU) to ensure the terms of the ring fenced grant are met;
- Consider the co-commissioning of some lifestyle services as part of the Healthy Lifestyle Service procurement;
- Agree to the development of an evidence based prevention strategy for Suffolk with robust partnership contribution and strong system wide governance arrangements.

The aim of Prevention in the system is to improve population health by limiting 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.

A Suffolk Prevention Strategy will be informed by the 2015 Annual Public Health report and will go to the Health and Wellbeing Board for ratification in January 2016. Key aspects are listed below

- All staff who have face to face contact with patients complete Making Every Contact Count training (45 min e-learning – 3 x 15 min modules – and a 1 hour workshop);

- Improve referral pathways to LiveWell Suffolk for patients who require support for; Tobacco use harm reduction and smoking cessation; adult weight management for obese patients; child weight management for children who are overweight or obese;

- Develop a workplace health and wellbeing programme for staff and volunteers;

- Emphasise self-care to all patients using CCG commissioned services;

- Ensure Secondary Prevention is systematic by working with general practices to increase referral rates to DESMOND and elective surgery rehabilitation services;

- Implement all recommendations set out in NICE guidance about Vitamin D in at risk groups. In particular ensure all bounty packs given to pregnant women via antenatal clinics contain a Healthy Start registration form and a leaflet about local suppliers of Healthy Start vitamins;

- Ensure smoking at time of delivery data is recorded accurately at antenatal visits. Any pregnant smoker identified either by a CO reading or by self-report must be referred to LiveWell Suffolk for stop smoking support - CO monitoring for mothers attending for first visit and referral to stop smoking services is recommended by NICE guidance PH26;

- Improve the number of Women whose smoking status at time of delivery was not known to no more than 3% as per England average Currently 5.1%

**References and Links:**

Vitamin D: increasing supplement use among at risk groups
http://www.nice.org.uk/guidance/ph56/chapter/1-recommendations

Link to MECC e-learning http://www.suffolkcpd.co.uk/ Registration along with the first part of the training can be located by searching for 'MECC' or by looking under event code M15001 for part one.

NICE guidance PH26 http://www.nice.org.uk/guidance/PH26

## 7. COMMISSIONING FOR SUSTAINABILITY

All services commissioned by the following principles:

- Ensuring our clinical pathway designs address prevention, quality, innovation productivity and integration.
- Delivering our duties under the Social Value Act of 2012 and embedding social value and community assets in our procurement practice.
- Fully utilising contractual levers to ensure sustainable practice within commissioned services.
- The CCG will expect that all providers report on performance against their Sustainable Development Management Plans (SDMS) as part of monthly quality boards.

To enable a sustainable commissioning approach, the principles of sustainable development should be considered throughout the commissioning cycle and procurement process. For instance, as part of designing service specifications and invitation to tender documents, commissioners should use local benchmarking data to establish indicators against which providers can be judged. This might include data on emissions or energy usage at an estate or patient level. Additionally, working with local stakeholder groups, the social impacts of any service can be established and specified in measurable ways. This should include the use of existing community assets, focusing on local employment skills and resources and additional impacts beyond the immediate scope of the service being commission.

## 8. MARKET REVIEWS

A number of procurements have been undertaken by the CCG during 2016/17 and there continues to be a flow of tenders to be released.

- Services for procurement include:

| Service | Likely tender start* | Service Implementation Date* |
|---|---|---|
| Primary Care Mental Health | Summer 2015 | July 2016 |
| Care Homes – joint procurement with Suffolk County Council | Autumn 2015 | Spring 2016 |
| Marginalised & Vulnerable Adults | Spring 2016 | Early 2017 |

* These dates are subject to the CCG's Governing Body approval

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

- Ophthalmology
- Community Services
- NHS 111 & Out of Hours
- Respiratory
- Cardiology
- Gastroenterology
- Musculoskeletal
- Dermatology
- Vasectomy
- Lymphoedema
- Minor Surgery

## 9. COMMISSIONING AND CONTRACTING PRINICIPLES IN 16/17

### 9.1 APPLICATION OF STANDARD CONTRACT

**Application of standard contract:**

CCG will commission all healthcare services, via the Standard NHS Contract where applicable and as such all providers will be expected to comply with its standard nationally mandated terms. Where these commissioning intentions result in any significant changes to the terms of our contracts, we will apply reasonable notice periods to providers in line with contractual requirements

The CCG has numerous health service contracts spanning the NHS and independent/private and charitable sector and each of these contracts has an expiry date. The terms of the NHS constitution and the requirement to comply with procurement law means that all expired contracts should be scrutinised by the CCG in order to determine whether services and subsequently contracts are to be decommissioned, tendered or extended. In 2016/17 a number of key contracts will require renewal. Many of the contracts are Suffolk wide with Ipswich and East Suffolk CCG. Should the CCG decide on a different direction of travel there will need to be a mutually agreeable solution on whether there will be a divergence and contracts split.

### 9.2 LEAD COMMISSIONING ARRANGEMENTS - OTHER LOCAL/NATIONAL INITIATIVES

**Lead Commissioning Arrangements:**

The CCG anticipates working closely with Ipswich and East Suffolk CCG and Cambridge and Peterborough CCG, as well as other CCGs, in particular to ensure a coherent approach to commissioning is maintained. CCG intends to continue with the lead commissioning arrangements agreed in 2015/16 for major contracts. 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.

Where relevant to patients in the wet of Suffolk, the CCG will seek to enter into associate agreements with other CCGs outside of Suffolk that 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 2016/17 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.

**Other national and local initiatives:**

The CCG will implement the 2016/17 National Operating Framework (and any other appropriate national mandatory Guidance) when issued by NHS England. The Operating Plan and national Guidance 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 financial allocations and provides a clear framework for the negotiation of all provider contracts.

## 9.3 ACTIVITY AND PRICING

The CCG will use benchmarking to indicate services which are being delivered differently from comparators, with a view to agreeing changes to:

i) delivery of the service
ii) recording of the service or
iii) payment for the service.

The CCG will undertake the following, dependant of type of provider and contract type:

- Review of local tariffs
- Clinical and Coding Audits in line with Section 15.8 of the contract.
- Evaluation of the Clinical Decision Unit (CDU) and Acute Medical Unit (AMU) at West Suffolk Foundation Trust (WSFT);
- Evaluation of the impact of WSFT decision to commission additional beds at Davers Court and Glastonbury Court (or similar) to ensure the commissioning of additional beds are at a cost neutral position to the CCG as agreed.
- Review of Emergency Pathway including review of any changes to the global conversion rate at WSFT and recording of short stay non elective admissions versus outpatient or appropriate ambulatory care tariff/ward attender;
- Evaluation of funding streams outside of contract;
- Evaluation of virtual clinics;
- Review day case procedures expected to be undertaken as outpatient procedures by speciality and specify commissioning levels. Require compliance with national guidance over recording of day cases versus outpatient procedures;
- Review of block elements in the contract and potentially move to alternative payment options where appropriate;
- Review requirement for additional investment in HASU at WSFT.
- Review of new to follow up ratios at WSFT.
- Continue to explore the possibility of a block contract with WSFT linked with the ICO (Integrated Care Organisation)

- The current structure for Safeguarding Boards in relation to Adults and Children in Suffolk is that all commissioner level structures are funded on a tripartite basis – Police, Local Authority and Health. However, it is a requirement for all full members to fund the Boards – this includes the Acute Trusts, SCH, NSFT and the NHSE Sub Region. The same applies to the Multi Agency Safeguarding Hub (MASH) which covers both Children and Adults**.** The CCG intends to recharge the full members with their share of costs.

Where appropriate, the provider will be required to be compliant with 2016/17 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.

## 9.4 PERFORMANCE DATA/INFORMATION

For all contracts the CCG intends the following:

- Providers will be required to submit all information within formats agreed with the CCG. In order to improve standardisation of information between providers the CCG may review, change, and agree with providers, new formats in order to easier understand activity and performance;
- Continued on-going compliance with the reporting requirements of UNIFY 2, SSNAP, Open Exeter, SUS, and any other national or locally mandated datasets. This includes compliance with the required format, schedules for delivery of data, and definitions as set out in the Health & Social Care Information centre (HSCIC) 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 required 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;
- Continued 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.
- Providers transact their information flows in compliance with all requirements in accordance with Information Governance as set out by Information Commissioner's Office.
- To work with provider reporting on eReferral service as that functionality becomes available
- In addition, 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 WSCCG through the DSCRO;

- Where statutory reporting is required to UNIFY2, eReferral service, Omnibus, Open Exeter and other statutory reporting, the provider should ensure that they are N3 compliant;

- Compliance with ISN 0149 where completion of NHS Numbers is a mandatory requirement.

## 9.5 INFORMATICS STRATEGY

Healthcare is 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 record sharing capability – the **Suffolk Shared Care Record**;
- Ensuring informed patient consent and information governance is central to this programme and overcoming obstacles that prevent progress;
- Developing a network of integrated and accessible public services infrastructure
- Developing a pan-system strategy for 'Improving Population Health & Wellbeing by the use of Information, Intelligence and Innovation' – **IPHWi**[3]

In particular we will be working with all providers to progress the Suffolk roadmap against the National Information Board 'Personalised Health & Care 2020'

To show our commitment to information sharing for improved healthcare, we will move our Continuing Health Care team to SystmOne, and will evaluate how this opportunity connects and supports the wider health and care system.

Underpinning our Informatics Strategy is the need for fit for purpose IT Service Management. We intend to progress our redesigned IT services by focusing on high quality service provision, innovative utilisation of technologies, and best value for the public purse.

## 9.6 CONTRACTUAL QUALITY REQUIREMENTS

**Contractual Quality Requirements**:

We will aim for a consistent approach to local Quality Requirements for all our providers as far as possible, but acknowledge that some variation may be necessary to reflect individual circumstances. These will be discussed and agreed as part of the usual contract negotiation process with changes introduced to reflect any key focus areas or new performance/quality issues that have come to light during 2015/16, as appropriate. We do not intend to commission any local Quality Requirements in 2016/17 or going forwards which are a lesser requirement than those currently commissioned and will be looking to secure further improvements to ensure the best outcomes are delivered for patients within our catchment area and beyond.

Where performance against Quality Requirements have been managed via a Remedial Action Plan (RAP) during 2015/16 and this plan has not been completed (e.g. Milestones run on into 2016/17) we expect all conditions of the RAP (including any contractual penalties) to be carried over into the 2016/17 contract via the Service Development and Improvement Plan.

## 9.7 COMMISSIONING FOR QUALITY AND INNOVATION

**Commissioning for Quality and Innovation (CQUIN):**

In the event that CQUIN continues as a mechanism to support quality and innovation, all proposals must be linked to clear, measurable outcomes to be eligible for award; quality incentives must demonstrate improved outcomes to demonstrate success. Funding shall be awarded against full compliance.

We would like to engage with providers at an early stage on the design of CQUIN schemes for 2016/17 and will be pleased to receive suggestions on appropriate initiatives for consideration by the end of December to ensure timely discussions. The CCG will be ultimately responsible for award and as per the guidance, reserves the right not to award local schemes in the absence of measurable improvements that demonstrate improvements in-line with the value of the Scheme.

## 10. 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 this will ease 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.

## 11. CONCLUSION

2016/17 presents the west Suffolk health system with a series of significant challenges not least maintaining and improving quality in the face of ever tighter budgets and demand pressures relating to on-going demographic changes. It is critical in this year that commissioners and providers work together to integrate care wherever possible thereby eliminating waste, improving communication and improving patient experience. System partners have agreed that they wish to pursue working towards an Integrated Care Organisation (ICO) to deliver the new health and care model. This is likely to require a different approach to the alignment of rewards to the achievement of system objectives and may require a radically different approach to payment and contracting approaches.

We look forward to working with you to meet these challenges