NHS West Suffolk
Clinical Commissioning Group
Integrated Plan
2012/13 – 2014/15
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Glossary
1. Executive Summary

This integrated plan sets out a high level strategy for ensuring delivery of operational, financial and improvement plans, including QIPP (Quality, Innovation, Productivity and Prevention) improvements for the period 2011/12 to 2014/15, by the NHS West Suffolk Clinical Commissioning Group (CCG).

Section 2 provides helpful background for the rest of the report, particularly describing the Joint Suffolk Health and Wellbeing strategy, which is based upon the Joint Strategic Needs Assessment. This strategy informs the CCG’s vision, or in our terms, ‘Ambition’, which is articulated in Section 3.

The CCG has developed its own distinctive ambition and underpinning priorities for 2012-15 to accelerate the delivery of QIPP and provide a local approach for delivery of the Joint Suffolk Health and Wellbeing strategy. At the heart of our Ambition is the view that greater integrated working is the primary vehicle to improve the quality of the local health services. The CCG therefore has the following ambition to **deliver the highest quality health service in West Suffolk through integrated working**.

The term integration means a number of things to a number of people. The way it is conceived in this context is around identifying opportunities for better team working, where this will lead to an improvement in service delivery. The evidence shows us, for example, that there are many opportunities to improve older people’s services through better team working across NHS partners, the voluntary and community sector and with local government. The spirit of our ambition is captured perfectly by principle 5 in the NHS Constitution:

“The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population. The NHS is an integrated system of organisations and services bound together by the principles and values now reflected in the Constitution. The NHS is committed to working jointly with local authorities and a wide range of other private, public and third sector organisations at national and local level to provide and deliver improvements in health and well-being.”

Supporting the delivery of the CCG ambition are six priorities, which are as follows:

- Develop clinical leadership;
- Demonstrate excellence in patient experience and patient engagement;
- Improve the health and care of older people;
- Improve access to mental health services;
- Improve health and wellbeing through partnership working;
- Deliver financial sustainability through quality improvement.
1. Executive Summary

Section 4 covers national and regional priorities and how they feed into our planning.

Section 5 covers our commissioning intentions for 2013/14. These intentions will help to ensure that our QIPP plan is embraced by our providers. They will support the delivery of the QIPP agenda and provide high quality, sustainable and efficient services to the local population.

Section 6 covers QIPP. NHS Suffolk has engaged both of its CCGs in the delivery of QIPP during the past two years, gradually handing over delegated budgetary responsibility so that there is a smooth transition to the new commissioning arrangements in April 2013. The impact of the CCG’s growing leadership of the QIPP agenda has been positive, such as the management of the prescribing budget which is on course to record a surplus for the first time. QIPP is central to all plans – Section 6 cross references our QIPP programmes against the CCG Ambition priorities.

This plan reflects the CCG’s ongoing commitment to the delivery of QIPP. Each area of the CCG’s QIPP Plan is led by a GP. The headline programmes of the plan, the GP lead and the identified QIPP opportunity for 2012/13 are as follows:

<table>
<thead>
<tr>
<th>QIPP programmes</th>
<th>GP Lead</th>
<th>Opportunity (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Ambitions (Prevention)</td>
<td>Dr Tom McGonigle</td>
<td>£ 0.13</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>Dr Emma Derbyshire</td>
<td>£ 2.73</td>
</tr>
<tr>
<td>End of Life</td>
<td>Dr Simon Arthur</td>
<td>£ 0.14</td>
</tr>
<tr>
<td>Planned Care</td>
<td>Dr Jon Ferdinand</td>
<td>£ 2.06</td>
</tr>
<tr>
<td>Planned Care – High Cost Drugs</td>
<td>Dr Emma Derbyshire</td>
<td>£ 0.40</td>
</tr>
<tr>
<td>GP Prescribing</td>
<td>Dr Emma Derbyshire</td>
<td>£ 1.37</td>
</tr>
<tr>
<td>Mental Health</td>
<td>Dr Roz Tandy</td>
<td>£ 0.61</td>
</tr>
<tr>
<td>Children &amp; Young People</td>
<td>Dr Rakesh Raja</td>
<td>£ 0.29</td>
</tr>
<tr>
<td>Cancer</td>
<td>Dr Andrew Yager</td>
<td>£ 0.18</td>
</tr>
<tr>
<td><strong>Total CCG Schemes</strong></td>
<td></td>
<td><strong>£ 7.91</strong></td>
</tr>
</tbody>
</table>

The final three sections cover financial planning, governance & accountability and risk management.
1. Executive Summary

We look forward to working with all partners to deliver this plan over the coming three years.

Yours sincerely

Dr Christopher Browning
Chair – West Suffolk Clinical Commissioning Group
2. Background & Context

2.1 The Local Health System

2.1.1 Local Demographic Profile

The West Suffolk CCG provides healthcare services for around 234,000 people in West Suffolk. In 2012/13 it will spend around £280m each year on commissioning healthcare services for these people. The CCG’s population is registered with 26 West Suffolk practices and is predominantly rural with the population scattered in small towns and villages. Geographically, the area includes the whole of Forest Heath and St. Edmundsbury local authority districts and part of Mid Suffolk and Babergh districts.

The town of Bury St. Edmunds (38,000 residents) is at the centre of the area, which also includes the small towns of Haverhill (24,000), Mildenhall (9,000) and Newmarket (17,000) in the west, Brandon (10,000) in the north and Sudbury (17,000) in the south-east.

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

Figure 2 above shows a population pyramid for the CCG. 16.2% of the CCG’s registered population are under age 15 (England average 17.1%) and 9.0% are age 75 or over (England average 7.5%). 50.5% are female (England average 50.2%).

The age distribution of the population is similar to that of NHS Suffolk but includes a lower proportion of children and young people (up to age 44 years) and a higher proportion of middle-aged and elderly people compared with the resident population of England. The population of West Suffolk is projected to increase by 16-28% between 2008 and 2031. The projected population growth will be accompanied by substantial ageing of the population.

West Suffolk has similar levels of deprivation to NHS Suffolk overall. The areas of highest deprivation are located in parts of the small towns, including areas within Bury St Edmunds, Brandon, Mildenhall, Newmarket and Sudbury as well as the more rural areas which have relatively poor geographical access to services.

Life expectancy at birth for NHS Suffolk in 2007-09 for both males and females was higher than in England as a whole by 2 and 1.5 years respectively. However, there are significant health inequalities in NHS Suffolk with a 5.5 year gap for men and a 4.3 year gap for women in life expectancy between those living in the most and the least deprived areas.

Overall the population of West Suffolk is generally healthy with high life expectancy. Life expectancy at birth for males was 80.2 years and females 84.0 years in West Suffolk compared with 80.3 and 83.7 years respectively in NHS Suffolk. The main causes of death in West Suffolk are similar to England with over three quarters of all deaths caused by cancer, circulatory disease (including coronary heart disease and stroke) and respiratory diseases. Coronary heart disease (CHD) is the most important cause of health inequalities in NHS Suffolk and cancer is the leading cause of premature mortality.

Modeling and analysis of the constituent communities in west Suffolk has been undertaken, in respect of their:

- Age;
- Deprivation;
- Mortality and premature mortality;
- Marginalised vulnerable adults which are divided into:
  - Homeless;
  - Refugee and asylum seekers;
  - Black and minority ethnic communities (BME);
  - Gypsy & Traveller;
  - Ex-offenders.
- Black and minority ethnic communities.
2. Background & Context

A summary demographic profile of the CCG, as produced by the NHS Commissioning Board, is shown at Appendix ‘A’. This is supported by the detailed Public Health Profile of the West Suffolk CCG (Appendix ‘B’).

2.2 Joint Strategic Needs Assessment and Suffolk Health & Wellbeing Strategy

Completing a Joint Strategic Needs Assessment (JSNA) is a statutory requirement of local authorities. JNSA describes a process that identifies current and future health and wellbeing needs in light of existing services, and informs future service planning taking into account evidence of effectiveness. It has enabled the CCG to map and analyse constituent communities and groups.

In Suffolk, there are many components of the JSNA; these include:

- State of Suffolk Report 2011;
- Annual Public Health Reports (latest published September 2012);
- Joint Suffolk Health and Wellbeing strategy (currently in draft form);
- Pharmaceuticals Needs Assessment;
- Clinical Commissioning Groups Profiles;
- Suffolk Observatory.

The information within the JSNA was used to inform the development of the West Suffolk CCG ambitions, priorities and outcomes. The links between the JSNA and CCG ‘Ambition’ are set out in Section 3.

The Suffolk Health and Wellbeing Board are currently developing a strategy for Suffolk. They have agreed on four priority areas, chosen using information from the JSNA. The priorities are as follows:

2.2.1 Suffolk Health and Wellbeing Board Priorities

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

Why?

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

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

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

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

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

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

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

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

**Priority four: People in Suffolk have the opportunity to improve their mental health and wellbeing**

*Why?*
Good mental health is crucial to our overall health and wellbeing. Yet almost half of all adults will experience at least one episode of depression during their lifetime, self-harming in young people is not uncommon and 60% of older adults in acute hospitals have a co-morbid mental health condition.
2. Background & Context

These four priorities help to underpin the CCG’s ‘Ambition’ and QIPP programme and illustrate that the CCG’s planning is based upon the JSNA. Priorities one and two are captured in the CCGs priority to improve health and wellbeing through partnership working and the Healthy Ambitions QIPP programme. Priority three is captured in the CCG’s priority to improve the health and care of older people. Priority four is captured in our priority to improve access to mental health services.

2.3 The Local System Leadership

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

- active involvement of Suffolk County Council leaders in local system-wide meetings and in SHA review meetings (e.g. QIPP, Integrated Care project boards);
- jointly developed work (e.g. CCG and County Council stakeholders have jointly engaged consultancy support through Tricordant to support the development of a strategy for joint commissioning of health and care for older people. This was completed in March 2012 and a full report and action plan submitted to the Health and Wellbeing Board in June 2012. See also 4.3).

Supporting the Health and Wellbeing Board is two other levels of local system leadership, where the CCG’s vision and priorities are developed and then communicated to stakeholders, patients and the public:

There are three levels of local system leadership. These are set out in the structure shown below:
## 2. Background & Context

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>JOINT MEETINGS</th>
<th>ROLE</th>
<th>MEMBERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic</td>
<td>Health &amp; Wellbeing Board</td>
<td>• To set the joint Health &amp; Wellbeing Strategy</td>
<td>• SCC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To promote and influence integrated approaches to deliver the strategy</td>
<td>• District/Borough Councils</td>
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<td></td>
<td></td>
<td></td>
<td>• Health Watch</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• I&amp;ESCCG GP Chair</td>
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<td></td>
<td>• WSCCG GP Chair</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Joint CCG CAO</td>
</tr>
<tr>
<td>Strategic</td>
<td>Ipswich &amp; East and West Suffolk System Leadership Board</td>
<td>• Identify and agree on areas of beneficial joint working</td>
<td>• SCC :</td>
</tr>
<tr>
<td>Delivery</td>
<td></td>
<td>• Agree plans to deliver the joint strategic aims where cross organisational co-operation is required</td>
<td>- CYP Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Scrutinise progress of the joint delivery workstreams and remove blockages to progress</td>
<td>- DPH Director</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• WSH CEO</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• NSFT CEO</td>
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<td></td>
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<td></td>
<td>• SERCO Director</td>
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<td></td>
<td></td>
<td></td>
<td>• I&amp;ESCCG GP Chair</td>
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<td></td>
<td></td>
<td></td>
<td>• WSCCG GP Chair</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Joint CCG CAO</td>
</tr>
<tr>
<td>Operational</td>
<td>Healthy Lifestyles</td>
<td>Integrated Care</td>
<td>Planned Care</td>
</tr>
<tr>
<td>Delivery</td>
<td>End of Life</td>
<td>Mental Health</td>
<td>CYP</td>
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The CCG workstreams drive the local system changes within the overall strategic framework. These workstreams are led by GPs from the CCG Governing Body. Membership of the workstreams is from across the system as appropriate with support from managers from the CCG.
2. Background & Context

Governance, decisions and plans for the workstreams are agreed at the CCG Governing Body, proposals are discussed at the weekly CCG Clinical Executive meetings and all investment decisions over £250k are made by the Governing Body.

The GP leadership of the workstreams as well as key involvement in the System Leadership Board and Health and Wellbeing Board ensures clinical quality is a priority and clinical views are foremost in the system leadership in Suffolk.

2.4 Commissioning and Planning Cycle

At specific times in the year, the CCG will review its medium to long-term strategic plans and set out its annual commissioning and operational plan. We will build into this process an annual programme of patient and public engagement that will give all of our networks the opportunity to understand and contribute to planning decisions.

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

- **May – July**: Publication of refreshed strategic plans and annual commissioning plan. Engagement in specific projects and implementation plans. Early engagement to inform plans for the subsequent year, Joint Strategic Needs Assessment and Health and Wellbeing Strategy.
- **Sept – Jan**: Report back on previous year’s outcomes. Engagement in proposals for the next annual commissioning plan and review of longer term strategy.

Following the success of the ‘Patient Revolution’ event in July (see Section 3.1) we will run two ‘Patient Revolution’ events a year to ensure there is stakeholder input into our commissioning cycle and that the CCG has opportunity to feedback on how previous input was used.

2.4.1 Specific service redesign projects

Throughout the year we will commission programmes, projects, pilot schemes and procurement to develop and implement service improvements. These projects will benefit from the involvement of service users and others. Our chief mechanisms for involving people will be:

- **Our Community Engagement Group**, which is a panel of patients who meet six-weekly to provide feedback on our work and policies; to oversee the delivery of the CCG’s community engagement and the Equality and Diversity agenda; to work with member practices to ensure that information regarding choice is co-ordinated. This group will report to the CCG Executive Committee and will also link with partner organisation engagement groups. It will communicate updates to our public membership;
2. Background & Context

- **Our Health Forum**, which will provide public members with regular updates and opportunities to join service redesign projects;

- **Our three CCG locality groups** across West Suffolk will be developed as the local focus for CCG services and plans derived from a local level with local patient participation groups, district and town councils and parish councils and other local bodies;

- **Our CCG ‘Patient Revolution’ events**. The public have already participated in early work on the development of the CCG Ambition. Over 200 people attended and contributed significantly to establish an agenda of 40 issues which have focused on 6 key themes that are now built into the CCG ambitions;

- **Our road shows**. The CCG has commenced a series of road shows to take their services to local communities on a rolling programme with staff keen to discuss local services with the public. Stakeholders have advised that this can be most accessible by going to the people in a public location. This has commenced with a stand on the Haverhill High Street on 20 and 23 August outside Iceland;

- **Our website** will have a dedicated section on public information and will also have a section for Health Forum and Community Engagement Group members;

- **Our practice visits**. The CCG visits each practice on a monthly basis to keep in touch with local issues and provide a two way channel of communication between patients, GPs and the governing body. The CCG is considering a development programme for surgery staff on a pick and mix basis to support their engagement role as part of the CCG and the development of practice participation groups;

- The CCG has a service which provides primary care support for **Marginalised and Vulnerable Adults** across Suffolk. It has a main static base in Ipswich with ‘spokes’ in the 20% most deprived wards in Suffolk and provides specialist support to all GP practices to enable provision of an accessible, appropriate and responsive service to MVAs. The support is for six marginalised communities:
  - Homeless
  - Refugee and asylum seekers
  - Gypsy and Travellers
  - Other Black Minority and Ethnic (BME) people
  - Migrant workers
  - Ex-offenders

- Our liaison with partners, such as **Suffolk Healthwatch** and the **Foundation Trusts**, who will involve us in their membership engagement.
2. Background & Context

2.4.2 Continuous improvement in service quality and the patient experience

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

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

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

2.4.3 Planning cycle
2. Background & Context

2.5 Provider Landscape

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

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

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

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

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

The CCG is committed to ensuring a clinically and financially sustainable future for the local acute hospital, West Suffolk NHS Foundation Trust, and to ensuring that primary, community and social care services ensure that patients are only treated in a hospital setting when this is the best place to deliver the assessment and treatment the patient needs. A key development for the CCG, in comparison to NHS Suffolk, will be its commissioning relationship with Cambridge University Hospitals NHS Foundation Trust (CUHFT). The CCG will no longer be an associate commissioner for this contract and will take an active role in managing the CUHFT contract jointly with NHS Cambridgeshire and Peterborough CCG.

The provider landscape is going through significant changes with a new independent sector community provider, a radical redesign programme being developed for mental health services, extension of the Allied Health Professionals Social Enterprise services and some new entrants to the provider landscape through Any Qualified Provider (AQP) procurements.

The CCG will continue to actively develop the provider landscape to support improved health outcome, reduced health inequality and ensure clinical sustainability in West Suffolk.
2. Background & Context

2.6 NHS Commissioning Board

The CCG will develop a positive working relationship with the East Anglia Local Area Team of the NHS Commissioning Board to discharge its duty around improving quality and safety in primary care (and support their leadership on commissioning specialised services). In the past year the CCG has supported NHS Midlands and East’s ambition to improve quality and safety in primary care. For example, the CCG has positively embraced the regionally-developed benchmarking toolkit for primary care quality, which focuses on clinical effectiveness and outcomes, patient experience, organisational effectiveness, and patient safety. The CCG is supporting the development of the standards (aligned to priorities within the NHS Outcomes Framework) and the implementation of the toolkit.

In order to continue tackling the inappropriate prescribing of antibiotics linked to C.difficile, practices will continue to be monitored monthly using ePACT data. Practices identified as being high prescribers will be audited, challenged, advised on appropriate changes and monitored to minimise risk. This will build on work undertaken in 2011/12 by both Medicines Management and Infection Control and Patient Safety Teams. Scriptswitch will continue to be used as a tool to promote appropriate prescribing of antibiotics and PPIs.

To ensure that the local health system continues to focus on improving the quality of prescribing in other therapeutic areas, audits focused on high risk prescribing including warfarin and diabetes will be carried out at practice level to identify opportunities to improve prescribing protocols. Practices will be expected to use the results of audits to facilitate local discussions around best practice and take action where necessary.

A number of themes are being progressed across the CCG aimed at improving the quality of care for people with diabetes and achieving better outcomes. These include:

- establishing a shared register of patients with diabetes, including all those principally under the care of their General Practitioner, to spot those who have not attended and received elements of care that would reduce complications. Evidence suggests that this is vital for the most effective management of patients;
- commissioning an intermediate tier of care between that currently provided by the hospitals and primary care, to improve care for patients who have more than basic needs but are not sufficiently unwell to attend hospital. In this way, patients currently receiving the main proportion of their care from the General Practitioner will have the benefit of advice from a more specialist source;
- improving the relevance and quality of data with regards to patients with diabetes; in particular, establishing a quality monitoring system shared between hospitals and primary care.

These objectives are being progressed by the Diabetes Integration Project Steering Group. There are five workstreams - one for each of three themes above, together with two further workstreams that provide (i) supporting communications (ii) expertise in finance, procurement, and selection of relevant care settings.
2. Background and Context

The CCG is committed to supporting the commissioning model set out in the NHS Commissioning Board’s ‘Securing excellence in commissioning primary care’, published in June 2012, and the three key areas which are likely to form part of the standard performance reports, namely:

- Health checks for people with learning disabilities;
- Patient satisfaction measured through the GP Patient Survey;
- Influenza immunisation rates (including the new target rate for patients under 65 in the ‘at risk’ group).

The CCG fully supports the proposed model between the CCG and the NHS Commissioning Board and will work closely to ensure that a partnership approach is taken to improving primary care quality and performance and in reducing variability.

3.1 CCG Ambition

3.1.1 How we developed our ‘Ambition’

Since February 2012 the CCG has implemented a programme of stakeholder engagement to develop its own distinctive ambition and underpinning priorities for 2012-15. The process has been inclusive and transparent (as supported by the results of the authorisation stakeholder survey). The clear view that emerged is that greater integrated working is the primary vehicle to improve the quality of the local health services. The CCG therefore has the following ambition to deliver the highest quality health service in West Suffolk through integrated working.

In order to deliver our ambition we have developed with partners the following priorities:

- Develop clinical leadership;
- Demonstrate excellence in patient experience and patient engagement;
- Improve the health and care of older people;
- Improve access to mental health services;
- Improve health and wellbeing through partnership working;
- Deliver financial sustainability through quality improvement.

The CCG’s ‘Ambition’ was developed through a programme of engagement. This programme began at an engagement event for our member practices on 21 February 2012. At this event we made use of innovative ‘Smartspeed’ technology to harvest the ideas of the GPs and Practice Managers. From this raw material, the Governing Body has worked to develop our Ambition, which has been tested in our locality groups and in practice visits. The Ambition has also been shared with our partners through the West Suffolk QIPP Forum that was created by the CCG.

One of the priorities underpinning the ‘Ambition’ is to ‘demonstrate excellence in patient experience and patient engagement’. This was the basis for a ‘Patient Revolution’ event held in Bury St Edmunds on 18 July 2012.

The event was attended by over 200 stakeholders, from the public, NHS, local government, voluntary and community sector, and attracted wide media coverage across Suffolk and East Anglia (e.g. http://www.haverhillecho.co.uk/news/latest-news/healthcare-revolution-for-west-suffolk-1-4080155). The ‘open space’ facilitation allowed delegates to set their own agenda for the event and to run their own discussion groups. This has yielded over 40 areas for the CCG to explore and has underlined the importance of the theme of integrated working:

http://www.westsuffolkcommissioning.co.uk/LinkClick.aspx?fileticket=cv3fQXsfkXA%3d&tabid=3219&mid=6244.

Feedback to stakeholders is also recognised as an essential requirement. The CCG communicated to all stakeholders immediately after the event and will report back to stakeholders in December 2012 progress on taking forward their ideas. Systematic engagement is being taken forward by the new CCG membership scheme and Community Engagement Group, which will ensure that the CCG has regular communication to its stakeholders. These mechanisms will be used to gather information about patient choice to ensure that we convert insights about patient’s choice(s) in practice consultations into plans and decision making. The CCG’s vision and priorities will also be developed and communicated through the system level arrangements described in 2.3.

3.1.2 The ‘Ambition’ Priorities

The following section sets out the six priorities that support the overall Ambition for integrated working. They reflect the JSNA, stakeholder engagement, and evidence / data analysis.

3.2 CCG ‘Ambition’ Priorities

3.2.1 Priority: Develop Clinical Leadership

Rationale: During our engagement process, member practices emphasised the strong tradition of clinical education in West Suffolk and a clear link between the provision of education and quality service delivery. Our member practices believe that we can improve the quality of services for patients and integrated working through increased education, which ideally should be done with clinicians inside and outside of primary care. The CCG would like to become nationally recognised as excelling in providing education and training for local clinicians. We will measure our progress through the number of GP members attending CCG education and training events.

Links with JSNA: Effective clinical leadership in the West Suffolk CCG is essential to the successful delivery of services that meet the needs of the Suffolk population as identified in the JSNA.

Links with NHS Outcomes Framework: The education and training programme will relate to the Outcomes Framework.

Links with the NHS Constitution: Principle 3 (‘The NHS aspires to the highest standards of excellence and professionalism’) and Staff Commitment to provide all staff with personal development.

Outcome measure: Increased uptake of education and training related to commissioning in the West Suffolk GP community. Following a baseline year in 2013/14, there will be a year on year improvement of 25%.

Key Actions:

- Develop a programme of education in West Suffolk (and potentially with neighbouring CCGs) that is organised around QIPP. This would include working closely with the post graduate education lead at West Suffolk NHS Foundation Trust;

- Develop a programme of leadership development for the CCG members and staff and practice staff with the Suffolk Leadership Academy;

- Employ an Education Lead based at the Education Centre of West Suffolk NHS Foundation Trust to co-ordinate the programme above;

- Employ an Academic Adviser to work with local universities to bring world class academic resource to our programme of education and innovation;

- Use our approach to clinical education to recruit GPs to the area;

- Establish a GP interface group with West Suffolk NHS Foundation Trust and support the existing Addenbrooke’s Hospital clinical interface group;

- Implement a similar approach with the Norfolk & Suffolk FT and Community Services through Serco Health. It is important that this programme encompasses wider professional leadership – not just the GPs and hospital consultants;

- Create an education and innovation fund for member practices to bid from. Engage the Suffolk Leadership Academy to tailor its work programme accordingly;

- Through strengthened links with University Campus Suffolk and the Suffolk Leadership Academy, work towards becoming a ‘partner’ who would become a professional adviser to them and a source of potential research material;

- Where possible education and training programmes that are designed by the CCG and delivered in conjunction with the Suffolk Leadership Academy are accredited to a national body such as the Royal College of GPs;

- Embed links through the LETB and local representation will be apparent on the Norfolk & Suffolk Workforce Partnership Group. This will enable primary care to engage with the wider community as well as being able to access appropriate funding via Health Education England. Such funding will enable new ways of working, support leadership development, enable the commissioning of education and training through a number of higher education providers as well as accessing research and development grants to aide innovation;

- Implementation of a ‘passport of training/leadership’ for all GPs with the West Suffolk GP community. This will strengthen and support their continual professional development. Similarly, a programme of development for practice staff to best support their practice engagement activities;

- Year on year participation on the specially designed and commissioned GP coaching programme through the Suffolk Leadership Academy.

3.2.2 Priority: Demonstrate excellence in patient experience and patient engagement

**Rationale:** The CCG has embraced the NHS Midlands and East Ambition around creating a ‘Patient Revolution’ with enthusiasm. The CCG and healthcare providers are required to deliver a transformation across the following three areas that define the ‘patient revolution’:

- **Driving greater co-production** between public and professionals, e.g. through shared decision making and involvement in the management of long term conditions;

- **Delivering greater community participation** between the public and the service, e.g. by involving the public in the future planning and reconfiguration and making even better use of Foundation Trust members; and

- **Improving the customer experience** of patients and carers.

Our governing body has prioritised patient experience and patient engagement. We believe that improving patient experience and engagement is key to improving the health of the West Suffolk population and we will not be an effective commissioner unless we understand the needs and views of our public. We will use the measure of the ‘friends and family’ test (or net promoter score) to measure our progress. In addition we will develop metrics to charter our progress with our Community Engagement Group (CEG).

**Links with JSNA:** Improving patient experience and patient engagement is central to the JSNA for improving the health of the Suffolk population. In addition, self-reported well-being is an indicator in the Public Health Outcomes Framework. Furthermore, the Suffolk Health and Well-being Strategy recognises that the level of engagement of the population in their own health affects NHS expenditure.

**Links with NHS Outcomes Framework:** Domain 4 – Ensure that people have a positive experience of care.

Links with the NHS Constitution: Principle 3 (‘The NHS aspires to the highest standards of excellence and professionalism’) and the Rights around respect, consent and confidentiality; informed choice; involvement in your healthcare and in the NHS; complaint and redress and the responsibility around patient feedback.

Outcome measure: Friends and family test scores for providers within top 10% of the Midlands and East region.

Key Actions:

- **Development of a CCG Communications and Engagement Strategy** and proven evidence of delivery of this;

- **Creating a Customer Services Culture.** Monthly performance data covering patient experience to be presented at the West Suffolk CCG (e.g. Friend and Family Test Net promoter score, local provider survey data, complaints and compliments data, progress of patient experience CQUIN reported quarterly, CQC regulatory unannounced visit reports/compliance). Any exceptions from a trend of improvement to be reported and mitigating actions identified;

- **Use a local patient experience CQUIN for providers** which will focus on provider wide patient/customer care values clarification and communication improvements, as well as the mandated CQUIN linked to the net promoter question. This approach is in line with the Regional Guidance: Implementing the Friends and Family Test which has been embedded within contracting processes and the development of CQUIN for 2012/13;

- Increase providers using **real time patient experience monitoring systems.** This ‘real time’ data to be made available to the public by providers in Board reporting and within clinical settings;

- **Improve co-production.** Patients and staff to be supported and provided with the tools/information to help patients to understand and make **shared decisions** with their clinician about their treatment. To develop a shared decision making culture between patients and their clinicians (including using Patient Decision Aids) where appropriate in partnership with primary and secondary care (including community and mental health services). Monitoring of co-production decision-making within referral rates for key long term conditions as part of QIPP reporting of achievement;

- Hold bi-annual major ‘Patient Revolution’ **stakeholder events** and neighbourhood based roadshows to engage communities; to work with practice participation groups to support their engagement of their patients; to develop staff and PPG members to undertake the engagement role;

- Implement the actions from stakeholder engagement events and to feedback on action taken, including community conversations (adult and children’s events); roadshows and conferences/workshops;

- All major service changes/ commissioning decisions to report on the approach proposed to ensure active engagement of patients and the public within CCG area. Evidence of appropriate patient and public involvement to be a requirement for Governing Body approval of commissioning changes; patients and public to be actively engaged in CCG planning/commissioning cycle;

- Personalisation. Develop the consistent use of patient stories within executive and CCG governing body work; seek advice from CEG about appropriate models;

- Develop Leadership and governing body culture where patient experience and public engagement is everybody’s business: Monitor patient experience through feedback from patients within West Suffolk CCG commissioned services including Quality Improvement walkabouts involving CCG governing body members (programme to be developed – working in partnership with providers);

- Establishment of a Community Engagement Group as a subcommittee of the Governing Body with an independent chairman to advise the Lay Member with the lead responsibility for patient and public engagement. The CEG to review engagement activities and to oversee the programme of engagement proposed to integrate with the development of operational and strategic commissioning plans. Members will act as ambassadors of the CCG engagement programme;

- Development of a Public membership scheme – our Health Forum - to identify members of the public who would like to be kept informed of CCG activity; participate in engagement activities, and select the members of the CEG.

3.2.3 Priority: Improve the health and care of older people

Rationale: Improving the health and care of older people is the most prominent priority that emerged from our engagement programme. The reasons for this are compelling. Almost 1 in 5 (19%) of the current Suffolk population is over the age of 65. By 2020 this number will increase to almost 1 in 4 (24%) with the proportion of over 85’s increasing from 3% to 4%. In West Suffolk people over 65 years comprise 72% of NHS funded care, with the over 65’s accounting for 25% of all accident and emergency attendances, 1 out of 4 calls to ambulance are for falls in the over 65’s and 3 out 4 of the over 85 years being admitted to hospital. Many older people have complex needs or use multiple services.
This growing demand from our over 65 years population will not be met unless we work with the whole health and social system including NHS providers, local authorities, and third sector organisation, to coordinate and improve the continuity. Making care “joined up” has benefits for the whole system as well as the West Suffolk residents and is crucial in considering older people in every aspect of their care pathway.

This priority will be driven by the ‘Joining Up Older People’s Services’ report (June 2012) commissioned jointly with Ipswich & East Suffolk CCG and Suffolk County Council with a focus on prevention and early intervention. A workshop has been held with stakeholders, professional, support staff, and patients to agree the priorities for older people in the light of the report and the contribution of AgeUK’s ‘Voices’ report. The CCG will invest in understanding customer experience as a driver for change across the health and care system.

We will measure progress through an outcome measure on Falls because Falls contribute to approximately 20% of the total urgent care activity in West Suffolk with 1 in 4 calls to ambulance services for falls. The growth in older people over the next 10 years will create an increase in people who fall and people who have fallen and sustain an injury.

Links with JSNA:

*State of Suffolk Report 2011:*

**Part A: A Sustainable Suffolk, ‘Sustainable population growth?’ (pp12-14):**

- The 2009 age structure shows that compared to England, Suffolk has more people aged over 60, pronouncedly in the 60-65 age category. This age category is growing the fastest;
- There are variations within Suffolk. In West Suffolk, Babergh, St. Edmundsbury and Mid Suffolk districts have a shortfall of young adults aged 20-39 and larger proportion in their 50’s than nationally;
- Higher numbers of older people are located in the rural parts of West Suffolk raising sustainability concerns for policies that encourage people to stay in their own homes for as long as possible.

**Part B ‘Being Healthy and Living Well in Suffolk under the theme of Retirement and old age (pp 81-86):**

- Over 65’s accounted for 61% of all unplanned hospital admissions in Suffolk in 2009, and 60% of the total cost of hospital admissions;
- Falls represents the most frequent and serious type of injury for anyone over the age of 65 years. 50% of people over 80 years will fall every year (Department of Health 2001): for Suffolk this could amount to over 7,000 people;
- Hospital admission rates for falls increase with age. In Suffolk, the rates for persons aged 65-74 years, 75-84 years and 85 years and over were respectively over two times, over nine times and over thirty times the rate for persons aged under 65 years;

Annual Public Health Report 2012:

The Indicators – Fall injuries and hip fractures in the over 65s (pp56-57):

- The rate of emergency hospital admissions for fall injuries in the over 65s in Suffolk was 404 admissions per 100,000 population or 4,550 admissions. This was lower than the East of England (425) and England (500) rates;
- St. Edmundsbury experienced a higher rate of admissions (463) compared to Suffolk and the East of England. Babergh, Forest Heath and Mid Suffolk districts experienced lower rates of hospital admissions compared to England;
- The rate of emergency hospital admissions due to fractured neck of femur among 65s and over in Suffolk was 432 admissions per 100,000 population or 886 admissions. This was similar to the rate for the East of England (444) and England (452). The Suffolk admission rates did not vary significantly by districts;
- Those living in the least deprived parts of Suffolk experienced a significantly lower rate of admissions for fractured neck of femur than was expected.

Joint Suffolk Health and Wellbeing strategy:
Priority 3:

- This outcome measure links to priority 3 of the health and wellbeing strategy: ‘Older people in Suffolk have a good quality of life’. There is a particular focus on prevention in the strategy, and falls and injuries in older people will be a measure of success.

West Suffolk CCG Public Health Profile:
Chapter 2 Demography (p9-13):

- The distribution of registered persons in West Suffolk CCG is similar to that of NHS Suffolk but shows lower percentages of children and young people (up to age 44 years) and higher percentages of middle-aged and elderly people compared to the resident population of England;
- In Babergh, Mid Suffolk and St. Edmundsbury, future population change will be accompanied by substantial ageing of the population.

Links with NHS Outcomes Framework: All five domains.

Links with the NHS Constitution: Principle 5 (‘The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.’) and the Rights around quality of care and environment.

**Outcome measure:** Reduction in falls and injuries emergency non-elective admission to be within the best 10% of the Midlands and East region.

**Key Actions:**

Implement the recommendations of the ‘Joining Up Older People’s Services’ report (June 2012) for West Suffolk and the Voices reports from AgeUK these include:

- **Intermediate Care** - To develop a pull based hospital accelerated discharge process, based on the new community model, informed by the North East Essex Accelerated Discharge Team model. This model providing assessment and discharge planning for inpatients in the North East Essex acute and community hospitals. The core purpose of the team is to ensure that patients are supported to return to independent living by offering appropriate therapeutic support during their inpatient stay and by the provision of appropriate post discharge support services, including reablement;

- **Community Development and primary prevention** - To connect the community development and primary prevention agenda better into the work of Integrated Care Teams through the mechanism of the Neighbourhood Partnership Networks;

- **Integrated Crisis response service (ICRS)** - An ICRS is an integrated health and social care intervention in response to a health or social care crisis, allowing a person to be supported and treated at home safely and avoids an unnecessary admission to hospital or residential care. It seeks to maintain and/or help the person regain their maximum independence and to support carers, as a crisis can threaten the stability of care and support arrangements;

- **Care home commissioning and market shaping** - To develop a joint plan with Suffolk County Council to proactively commission for outcomes and quality standards in both the residential and nursing home sectors;

- **Whole-system geriatrics and comprehensive geriatric assessment** - There is robust evidence to support multidimensional assessment and multi-agency management of older people through comprehensive geriatric assessment leading to better outcomes, including reduced readmissions, reduced long term care, greater satisfaction and lower costs. Identifying individuals at risk, preventative measures and early interventions, with support in the community to reduce crises and attendance at Emergency Departments can be achieved through integrated approaches which include specialist Geriatric support and leadership. Benefits include prevention of incipient crisis and End of Life Care, plus potential (if sufficient staff in the multi-disciplinary team [MDT]) to support care homes;

- **Investment in Assistive Technology** – To market-shape the local assistive technology offer which includes telehealth and builds on the existing local telecare framework. Such support systems will be integral to the self-care offer;

- **Improved Continence management** - Evidence-based clinical pathways (including timely assessment, education and support and interventions) can deliver cost benefit. An integrated pathway approach would have similar characteristics to the integrated falls pathway, spanning primary prevention, early intervention, maintenance and review;

- **Improved Dementia Care** - There are opportunities for maximising both the impact of these initiatives and of the resources available through greater collaboration and integration. For example, exploring the opportunities for joint commissioning of dementia services so that the community based dementia services, acute and third sector organisations are genuinely integrated both in terms of multi-disciplinary teams working to a seamless, holistic pathway. This would need to be underpinned by participating in the Norfolk and Suffolk Dementia Alliance dementia friendly communities programme and continuing our workforce and development programmes. Such an approach would also enable an alignment with admission prevention services so that those patients who present in crisis with both physical and mental health needs and whose pose the greatest service and resource challenges, can be supported by community-based interventions and avoid the additional risks that hospitalisation brings for these patients. There is emerging evidence from the most successful hospital avoidance services that those with mental health specialists or a close alignment with specialist services can achieve significant efficiencies through preventing patients with mental health needs being admitted to acute hospitals and running the risk of lengthy and delayed stays in hospital;

- **Falls** - Continue the development of the integrated falls service as a jointly provided service between health and social care for older people who are at risk of falling or who have fallen. This will include health promotion initiatives designed to reduce the risk factors for osteoporosis and falls in the general population, using the single assessment process and community equipment services to promote older people’s safety and independence, developing a falls service, and providing support for older people who have fallen;

- **System Leadership** – Development of a Suffolk System Leadership Board, to engage key stakeholders within the West Suffolk local health economy to support improvements in care and outcomes for patients and the public, and explore joint commissioning;

- **Neighbourhood Partnership Networks** – Improve patient care and experience through the creation of Neighbourhood partnership networks bringing together health and social care providers, third sector, and the public to deliver seamless and integrated care.

In addition, we will continue the pioneering patient safety work in Suffolk around the NHS Midlands and East ambition to eliminate avoidable pressure ulcers. Avoidable pressure ulcers are a key indicator of the quality of nursing care. Elimination of avoidable Grade Two, Three and Four pressure ulcers is being used as an outcome measure for nursing which includes: hydration, nutrition, pressure area management, medication management and individualised care for patients in acute and community providers.

The NHS in Suffolk has piloted the NHS Trust wide data collection using the Patient Safety Thermometer since November 2011. This has allowed for the identification of any issues in data collection and to inform the regional data collection work. This data will be accessed from the Quality Observatory and validated by the CCG. The on-going collection of this census data is incentivised through the national CQUIN scheme. The CCG intends to build on the local CQUIN from 2010/11 to include not only the national data collection CQUIN to further incentivise the reduction of avoidable pressure sores within Suffolk, but also additional further stretch targets for the reduction.

The achievement of this elimination goal will be supported by monthly monitoring of the adequacy of assessment, prevention and treatment activities within provider organisations, including Quality Improvement Visits as well as data submission. The provision of this data is a contractual requirement.

The implementation programme will include a series of intensive support visits to review progress and facilitate intervention as appropriate. It is planned to procure a programme to engage staff and embed the clinical protocols and care bundles that have recently been completed by the expert working group. This will support a commitment approach to the ambition in parallel to monitoring compliance.

The third strand of the implementation programme is to build a communications plan that promotes the key messages of the ambition to the public at large and highlights the trends in numbers reported at the current time.

3.2.4 Priority: Improve access to mental health services

Rationale: Improving access to mental health services is a theme that emerged strongly both from GP members and the public. Whilst there have been areas of mental health delivery which have been of a high standard in West Suffolk there have also been examples of insufficient service capacity, gaps in provision for the needs of the local population and poor communication and barriers between service providers. This has been evident particularly for children and young people’s mental health provision, and for people with primary mental health needs.

For instance, the criteria for acceptance into the Improving Access to Psychological Therapies Service means that many people who need psychological support are not eligible for the service and yet there have been no other options for them. The increasing numbers of older people and the projected rising demographic of people with dementia from 4,755 in 2010 to 7,955 in 2025 means that we also need to ensure that mental health provision is adapted to and sufficient for their specific needs.

We will measure our progress with an outcome measure which will allow us to demonstrate whether more people are able to benefit from improved primary mental provision. The outcome measure reflects the measure for population coverage for Improving Access to Psychological Therapies Services (IAPT). IAPT services are expected to offer interventions to 15% of local population needs and progress against this target is reported quarterly by all services in the East of England.

This means that we can benchmark our progress against primary mental health provision in the region. We believe that the extended range of therapeutic interventions we are commissioning will offer support to a greater number of the population and demonstrate that we are enhancing the IAPT target.

**Links with JSNA:**

*State of Suffolk Report 2011:* Depression is one of the most common chronic health conditions experienced by Suffolk residents. 13.4% of residents, or 64,989 people experienced depression in 2009.

*Joint Suffolk Health and Wellbeing strategy:* This outcome measure links to priority 4 of the health and wellbeing strategy: ‘People in Suffolk have the opportunity to improve their mental health and wellbeing’. There is a particular focus on the provision of high quality services that are equally accessible for all.

**Links with NHS Outcomes Framework:** Domains 2 (‘Enhancing quality of like for people with long term conditions’) and 4 (‘Ensuring that people have a positive experience of care’).

**Links with the NHS Constitution:** Principle 3 (‘The NHS aspires to the highest standards of excellence and professionalism’) and the Rights around access to health services.

**Outcome measure:** To be in the top 10% of the Midlands and East region for the proportion of people who have depression and/or anxiety disorders that receive primary psychological therapies against the level of population need.

**Key Actions:**

- We will seek the views of GPs and Primary Care providers on mental health services to understand their views and check that mental health services deliver what they need for their patients;

- The approach for Child and Adolescent Mental Health Services will focus on early intervention and prevention. Pathways will be developed which will facilitate timely and easy access to the service and allow smooth transition into other services including into adult mental health services for those who need them;

- We will commission new age inclusive Eating Disorder and remodelled Autism Services;

- The newly commissioned Suffolk Integrated Wellbeing Service will be delivered by Norfolk and Suffolk Mental Health Trust who will sub-contract to local third sector providers offering a wide range of therapeutic interventions. These including Improving Access to Psychological Therapies, counselling, psycho-educational workshops, group therapies, befriending, peer-led support groups, employment support. It will facilitate smooth access to and from other specialist and secondary mental health services. The service is for all the local population aged thirteen and above and will also focus on older people and family carers. The service also commissions community development workers to make sure that it is responsive to local marginalised communities. The service offers self-referral to facilitate easy access and will ensure by pro-active onward referral that no one is bounced back to their GP with a request that they are then referred to another mental health service;

- We are modelling an approach to offer psychological support for people with COPD which will be delivered by the Wellbeing Service. We will extend this model to other long term physical health conditions;

- We work with Norfolk and Suffolk Mental Health Foundation Trust to ensure that mental health provision is integrated with wider health programmes, in particular the Integrated Care Programme with a shared vision of admission prevention and shared procedures and policies for the care of individuals;

- We will continue to focus on improving the provision of dementia care including shared workforce training and development across providers, embedding our dementia intensive support service within our admission prevention work and remodelling dementia services to meet rising demand.

3.2.5 Priority: Improve health and wellbeing through partnership working

Rationale: A clear message from our engagement programme is that the CCG will need to work in an integrated fashion with partners to ensure that in West Suffolk people live healthier lives and that the differences in life expectancy between our communities decrease. The CCG is a member of the Health and Wellbeing Board and is committed to supporting the delivery of Suffolk’s Health and Wellbeing Board’s strategy. The CCG will focus particularly on two of the four priorities of the Health and Wellbeing Board’s strategy:

- Ensuring Every child in Suffolk has the best start in life;

- Ensuring older people in Suffolk have a good quality of life.

This is reflected in the two outcome measures that we have chosen to measure our progress: one in the area of health improvement (breastfeeding) and the other related to health inequalities (cardiovascular mortality). The rationale for these outcome measures are as follows:

- The prevalence of breastfeeding in Suffolk is low compared with regional and national averages and the benefits of breastfeeding to the infant are well established;

- Within Suffolk, as in other parts of the country, an inequality exists in mortality rates due to circulatory disease in the under 75s between people living in the 20% most deprived areas of the County compared to the remaining 80%.

Links with JSNA:

**State of Suffolk Report 2011:**
*Part B ‘Being Healthy and Living Well in Suffolk (p62)*:

- Suffolk has lower levels of breast feeding at birth compared to national averages;
- 64% of babies were breastfed at birth. However, only 44% of babies have some breast milk at 6-8 weeks [2010/11].

**Annual Public Health Report 2012:**
*The Indicators – Breastfeeding (pp14-15):*

- In 2009-10, 72.1% of mothers in Suffolk initiated breastfeeding; this was lower than the East of England and England averages;
- Breastfeeding initiation is similar across all local authority districts in West Suffolk and across Suffolk as a whole;
- The latest data on breastfeeding prevalence at 6-8 week check: 52% of babies were totally or partially breastfed. This has increased and is higher than regional (47.7%) and national (49.1%) averages [Q1 2011/12];
- Socioeconomic inequalities in breastfeeding exist; mothers classified in higher occupations are much more likely to breastfeed than mothers classified in lower occupations and in lower socioeconomic groups.

**Joint Suffolk Health and Wellbeing strategy:**
*Priority 1:*

- This outcome measure links to priority 1 of the health and wellbeing strategy: ‘Every child in Suffolk has the best start in life’. Breast feeding rates will be a measure of success in relation to this priority.
State of Suffolk Report 2011:
Part B ‘Being Healthy and Living Well in Suffolk (pp44-47):

- Inequalities exist between different groups and geographical areas in Suffolk. In 2005-09 life expectancy among males living in the most deprived parts of Suffolk was on average 5.3 years less than males living in the least deprived areas. The gap for females was 4.4 years;
- Cardiovascular disease is the biggest contributor to inequalities in life expectancy between those living in the most and least deprived areas in Suffolk. CVD accounted for 30% of the gap (1.3 years) for men and 29% (0.6 years) women;
- Inequalities in premature death due to coronary heart disease are getting wider. The risk of dying prematurely from coronary heart disease in the most deprived parts of Suffolk compared to rest of the population has risen over the last 10 years from 18% to 40% for males and from 18% to 70% for females;
- Coronary heart disease is one of the most common chronic conditions experienced by Suffolk residents. In 2009, 3.7% of residents, or 22,754 people experienced coronary heart disease. It is estimated that this number will increase by 25% by 2020;
- In 2009, circulatory disease accounted for 23% of deaths in people under the age of 75 in Suffolk.

Joint Suffolk Health and Wellbeing strategy:
Priority 3:
- This outcome measure links to priority 3 of the health and wellbeing strategy: ‘Older people in Suffolk have a good quality of life’. There is a particular focus on prevention in the strategy, and premature mortality from cardiovascular diseases is a measure of success.

West Suffolk CCG Public Health Profile:
Executive Summary (p5):
- Life expectancy in West Suffolk is 80.2 years for males and 84 years for females. Premature mortality in West Suffolk is associated with deprivation;
- The main causes of death in West Suffolk are cancers, circulatory disease and respiratory disease.

Chapter 3 – Deprivation (pp15-20):
- In West Suffolk, areas of highest deprivation relative to NHS Suffolk are located in parts of the small towns in the areas of Bury St. Edmunds, Brandon, Haverhill, Mildenhall, Newmarket and Sudbury, and in rural areas which have relatively poor geographical access to services.

Chapter 4 – Mortality (pp21-26):
- 36% of all deaths in West Suffolk are caused by circulatory disease.

Chapter 6 – Cardiovascular disease (pp31-34):

- The QOF unadjusted prevalence estimates of cardiovascular disease in West Suffolk are: CHD 3.5%, stroke/TIA 1.8%, hypertension 14.2%, heart failure 0.9%;
- Modelled prevalence estimates from the Association of Public Health Observatories (APHO) suggest that prevalence of cardiovascular diseases in NHS Suffolk may be higher: CHD 3.5%, stroke 2.2%, hypertension 26.5%;
- The age standardised premature (<75) mortality rate due to circulatory disease in West Suffolk (2007/09) is 53.1 per 100,000. This is less than the Suffolk average (55.9) and the national average (70.5).

Links with NHS Outcomes Framework: Domain 1 ‘Preventing people from dying prematurely’, 2 ‘Enhancing quality of life for people with long-term conditions’, 3 ‘Helping people to recover from episodes of ill health or following injury’.

Links with the NHS Constitution: Principle 5 (‘The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population’).

Outcome measures:

Breast feeding prevalence at 6 to 8 weeks to be within the top 10% of the Midlands and East region.

To achieve a 33% reduction by 2015 in the difference in mortality due to circulatory disease (including ischaemic heart disease and stroke) in people under 75 years between the 20% most deprived Lower Super Output Areas (LSOAs) in our CCG, compared to the other 80%.

Key Actions:

- Embed reduction in inequalities in all decision-making processes – a form of health inequality proofing of all our commissioning decisions and the impact of decisions on health inequalities;
- Reduce mortality from cardiovascular disease and cancer, and reduce inequalities between social groups by targeted primary and secondary prevention. Primary prevention activities include those aimed at improving the populations’ health via healthy living, such as weight management, physical activity and smoking cessation services. High quality primary care services are essential for effective secondary prevention of chronic disease, via management of conditions such as high cholesterol, hypertension and diabetes;
- Reduce infant mortality and reduce inequalities between social groups through evidence based interventions For example, significant work is currently underway with the aim of promoting breastfeeding, especially in deprived groups;

- Improve the coverage of screening and immunisations across all age groups and all areas with particular attention to deprived areas. An example of work that will be undertaken is the examination of colorectal screening uptake patterns by deprivation in West Suffolk in order to identify and address any existing inequalities;

- Promote community development in deprived communities to improve health & wellbeing. An example of community development underway in West Suffolk is the health trainers, provided by Livewell Suffolk, the local healthy living provider. Health trainers provide healthy lifestyle information, signposting to local services, practice advice and guidance in relation to lifestyle changes, and support to setting and achieving goals around healthy eating, weight management, physical activity, smoking cessation, reducing alcohol intake and reducing stress;

- Promote active healthy living by offering targeted wellbeing services. Livewell Suffolk provides a range of health and wellbeing services, including those aimed at enabling people to improve their lifestyles by stopping smoking, losing weight, improving their diet and becoming more physically active. The CCG will develop close links with “Live Well” and ensure that constituent member practices take up the services offered by this provider. The CCG also will explore options to explore to utilize the expertise and services of Livewell by expanding the coverage and the scope of the services.

3.2.6 Priority: Delivery financial sustainability through quality improvement

Rationale: A clear message from all parties in our engagement programme is that it is essential that financial sustainability is secured in order to be able to deliver the highest quality services and to be able to invest in future developments. This sustainability needs to be across the health and care economy and be supportive of the integrated plans, which is why the overall ambition around integrated working is so important.

The detail of this priority is outlined at length in Section 6 on QIPP and Section 5 on Commissioning Intentions.

Links with JSNA: In order to deliver effective, high quality health services that meet the needs of the Suffolk population as identified in the JSNA, the West Suffolk CCG recognises that it will need to establish and maintain financial sustainability.

Links with NHS Outcomes Framework: All domains.

Links with the NHS Constitution: Principle 6 (‘The NHS is committed to providing the best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources’).

Outcome measure:

- Ongoing financial balance for the health and care economy of West Suffolk with agreed investment/disinvestment plans to reflect health needs of the population from the delivery of system surpluses;

Key Actions:

- Delivery of West Suffolk QIPP Plan (see Section 6);
- Clear commissioning intentions which correlate with Commissioner QIPP and Provider Cost Improvement Plans (CIP) - see Section 5;
- Governing body review of expenditure prioritisation;
- Five year financial planning with all stakeholders;
- Approved financial recovery plans for challenged Providers;
- Project management approach to service redesign and financial consequences;
- Focus on activity levels to understand cost base and drivers;
- A triangulated financial plan with workforce and activity so that the strategy and its impact can be understood and measured by all concerned.
4. National & Regional Priorities 2012/13

4.1 NHS Constitution

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

All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this Constitution in their decisions and actions.

The NHS West Suffolk CCG has embraced the seven principles that underpin the NHS Constitution:

- The NHS provides a comprehensive service, available to all;
- Access to NHS services is based on clinical need, not an individual’s ability to pay;
- The NHS aspires to the highest standards of excellence and professionalism;
- NHS services must reflect the needs and preferences of patients, their families and their carers;
- The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population;
- The NHS is committed to providing best value for taxpayers’ money and the most effective, fair and sustainable use of finite resources;
- The NHS is accountable to the public, communities and patients that it serves.

The CCG has aligned its priorities (as set out on Section 3) to these principles.

4.2 National Frameworks and Strategies

The National Outcomes Framework 2012/13, together with the Adult Social Care and Public Health Outcomes Frameworks together support the Government’s desire to improve integration of services.

The **NHS Outcomes Framework** is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on:
4. National & Regional Priorities 2012/13

<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>Preventing people from dying prematurely;</td>
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<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions;</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill health or following injury;</td>
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<tr>
<td>Domain 4</td>
<td>Ensuring that people have a positive experience of care; and</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in a safe environment; and protecting them from avoidable harm.</td>
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</table>

Delivery of each Domain will be measured through twelve overarching performance indicators (supported by 27 ‘improvement’ measures) which, in themselves, will be used to hold the NHS Commissioning Board to account, and for the Board to hold CCGs to account for effective commissioning and promoting improvements in quality and outcomes they are achieving for the local population. These are detailed at Appendix ‘C’.

The **NHS Operating Framework** 2012/13 supports delivery of the Outcomes Framework by setting out the planning, performance and financial requirements for NHS organisations in 2012/13 and the basis on which they will be held to account. The current NHS reforms set out a clear strategic vision around transforming service delivery so that it is focused on better outcomes for patients with real decisions increasingly being taken by patients and their GPs and services being held to account by them.

To improve services for patients, four key themes have been identified for all NHS organisations during 2012/13:

- putting patients at the centre of decision making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care;
- completion of the last year of transition to the new system, building the capacity of emerging clinical commissioning groups (CCGs) and supporting the establishment of Health and Wellbeing Boards so that they become key drivers of improvement across the NHS;
- increasing the pace on delivery of the quality, innovation, productivity and prevention (QIPP) challenge; and maintaining a strong grip on service and financial performance, including ensuring that the NHS Constitution right to treatment within 18 weeks is met.
4. National & Regional Priorities 2012/13

The Midlands & East SHA Regional Commissioning Framework 2012/13 also sets out a series of priorities that articulate the regional aspiration of making a difference to patients during 2012/13 despite the challenges being faced. The 5 SHA cluster priorities are:

- Eliminating avoidable pressure ulcers;
- Making every contact count;
- Significantly improve quality and safety in Primary Care;
- Ensuring radically strengthened partnership between the NHS and Local Government;
- Create a revolution in patient and customer experience.

The CCG has embraced these ambitions as part of its ambition for greater integrated working.

4.3 NHS Operating Framework 2012/13

The NHS Operating Framework 2012/13 sets out the planning, performance and financial requirements for NHS organisations in 2012/13. The current NHS reforms set out a clear strategic vision around transforming service delivery so that it is focused on better outcomes for patients and better quality of services provided.

The NHS Operating Framework sets out a number of key areas that require particular attention during 2012/13 to provide the bedrock for a health service driven by patients and clinicians. The local health system’s arrangements to embrace these areas are detailed below:

4.3.1 Dementia and care of older people

Caring for patients with dignity and respect is a priority for the CCG. Building on the Care Quality Commission’s report ‘Dignity and Nutrition for Older People’, the NHS in Suffolk and Suffolk County Council have jointly recognised the need to maintain and improve the commissioning of services for older people.

This is set against a background where the elderly population is growing and budgets are under increasing pressure. In order to continue to deliver high quality care, the CCG has worked to improve joint working and to maximize the efficient use of resources through the development of a joint strategy for older people’s services in Suffolk with a joint commissioning plan.
4. National & Regional Priorities 2012/13

The outcomes for this work are:

- a clear understanding of the current service and spend;
- the development of a joint strategy that meets the needs of older people;
- the development of a joint commissioning plan to invest in, and deliver, the strategy.

It is essential that this work is developed in a co-productive and inclusive way with stakeholders from all sectors of the local health economy, including older people themselves.

Running concurrently with the piece of work, is the development of neighbourhood teams. These multi-agency teams will offer and provide integrated care with an emphasis on prevention, early intervention, rehabilitation and reablement.

Joint working is also in place with Suffolk County Council on the Suffolk Dementia Strategy which forms an integral part of the strategy outlined above, and will also enhance the pathway of care for people with dementia through the following:

- 2012/13 contracts with providers are compliant with recommendations of the Royal College of Psychiatrists National Audit of Dementia Care in General Hospitals 2011;
- 2012/13 contracts with providers are standardised for the use of ICT 10 coding of people with dementia to support recognition and management across the care pathway;
- workforce development programme with dedicated trainers are based in acute hospital trusts and community health services and open to all healthcare providers to raise awareness of dementia leading to improved care of patients;
- roll out of dementia pathway template for GP clinical systems to support referral to memory services and care of people with dementia and their carers;
- revised specification and dedicated reablement funding to increase capacity of Memory Assessment Services;
- increased percentage of people with dementia on Quality Outcomes Framework (QOF) registers from 38% to 60%;
- improved support programme for people with dementia and their carers to maintain their health and wellbeing. This includes caring with confidence training, building networks of support and targeted support for people from Black Minority Ethnic (BME) communities;
- tender for Dementia Advisors using reablement funding;
- continued roll out of anti-psychotic medications prescribing guidelines;
- reablement funding for Dementia Intensive Support Teams to reduce inappropriate hospital admissions and readmissions, reduce length of stay and help facilitate people to return to their own homes.
4. National & Regional Priorities 2012/13

4.3.2 Carers

Carers play a vital role in the local health system and local organisations will continue to support them during 2012/13 in that role.

A Joint Needs Assessment (JNA) of carers informed the ‘Suffolk multi-agency Carers strategy’ which has been approved by both the NHS in Suffolk and Suffolk County Council. The strategy is underpinned by an action plan that all agencies have agreed. The action plan for 2012/13 was signed off by the CCG and Suffolk County Council in May 2012 and has been implemented.

In 2011/12, the NHS in Suffolk spent £1.7m on carers’ breaks which included £360k that was transferred to Suffolk County Council. Additionally, the NHS Suffolk spent £63k on the core funding for organisations that support carers.

A multi-agency review of carers services and breaks in 2010/11 informed the development of direct payments and personalised budgets for carers. This has led to carers being able to use their allocations for a more diverse range of activities that allow them a break from their caring role. An analysis of the types and number of breaks the current funding is providing within this new arrangement will be published on the NHS Suffolk website (http://www.suffolk.nhs.uk/) in October 2012, along with the carers plan for 2012/13.

4.3.3 Health Visitors and Family Nurse Partnerships

The Government has committed to increasing the number Health Visitors by 2015. Locally, robust plans are in place to increase the Suffolk Health Visiting establishment from 70 to 115 by March 2015 in line with ‘A Call to Action’, which will ensure improved support for families through the delivery of the Healthy Child Programme and the Family Nurse Partnership programme, and provide improved outcomes for the most vulnerable first time teenage mothers and their children.

Within the Children, Young People & Maternity QIPP programme specific projects for 2012/13 and beyond include:

- New Health Visitor investment in line with ‘A Call to Action’ and further development of the Suffolk County Council Integrated Services New Operating Model (NOM). Plans incorporate the development of a ‘Family Nurse Partnership’ (FNP) Scheme in 2012/13 to target first time teenage mothers and their children;
- New Health Visitor investment will support development of a county wide enuresis service.

In September 2012, the first cohort of 20 newly qualified Health Visitors were deployed across Suffolk in line with deprivation and vulnerability indices. This work is being undertaken in conjunction with Public Health and the CCG. The next cohort of student Health Visitor has commenced training, and are due to complete this in September 2013. This will result in an additional 45 health visitors being in post by September 2013 - ahead of 2015 target.
4. National & Regional Priorities 2012/13

In addition to this Suffolk County Council has allocated Clinical Practice Teacher (CPT) capacity for these students, in addition to supporting the newly qualified. This has involved the use of ‘long arm’ allocation of CPTs supported by experienced practitioners who undertake close supervision of students and newly qualified staff. The students will also receive safeguarding supervision. To plan for future requirements, Suffolk County Council has also identified individuals for future CPT training.

The target for additional Health Visitors will be achieved and monitored through the contracting mechanisms and performance monitoring framework. The CCG is assured that clinical teaching and supervision will remain of a high standard and in line with NHS Midlands and East recommendations.

4.4 Other Priorities

4.4.1 Major Trauma

The regional requirements specify that:

- 100% of organisations within each trauma network will have implemented integrated trauma systems with formally adopted policies, procedures and protocols;
- 100% of major trauma patients will receive tranexamic acid within 3 hours.

The CCG has ensured that specifications within the West Suffolk NHS Foundation Trust contract reflect the following principles:

- Trauma Centre designation, according to the Trauma Network Major Trauma Centre and Trauma Unit Standards;
- Implementation of Network policies for:
  - Sending patients in a timely manner to the Major Trauma Centre or Trauma Units;
  - Receiving patients back from a Major Trauma Centre or Trauma Unit;
  - Submission of quality data to the Trauma and Audit Research Network;
  - Information sharing arrangements with the Trauma Network.
4. National & Regional Priorities 2012/13

- Formal adoption and continued collaboration in the review and development of Trauma Network protocols for clinical procedures and operations, including:
  - First hour bundle of care;
  - Administration of Tranexamic acid;
  - Time to CT and rapid image transfer.

In addition, the specifications within the ambulance contract will reflect the implementation of:

- Trauma Triage Tool;
- Administration of Tranexamic Acid;
- 45 minute primary transfer.

The CCG will continue to work proactively and progressively with the Specialised Commissioning Groups (SCGs) regarding the commissioning of the Trauma Networks and associated services.

4.4.2 Stroke Care

The CCG will continue to work alongside Ipswich and East Suffolk CCG to support a combined response to the NHS Midlands and East led Stroke Review. The review addresses care along the entire stroke pathway, from Primary Prevention, through Acute and Hyper Acute Services, Early Supported Discharge and Long-term care, to End of Life care. The CCG will use the Review Process to ensure that the future model for Stroke Services in West Suffolk is clinically and financially sustainable, developed based on the 2012 Stroke Specification, and with a view to the best possible patient outcomes for stroke patients across all of West Suffolk; in the meantime, it will continue to work with providers and commissioning partners to drive continuous improvements within stroke services across the pathway.

In particular the CCG will work with Ipswich and East Suffolk CCG, and local providers to develop a robust business case to maintain a Hyper-Acute Stroke Unit within West Suffolk NHS Foundation Trust, and to develop a new Early Supported Discharge service covering the whole of Suffolk by the end of 2013-14. Detailed plans will be developed to address workforce (and other) deficits identified by the review, and further recommendations arising from the review will be addressed as they arise.
4. National & Regional Priorities 2012/13

4.3 Pathology

The regional special projects team is developing and implementing plans to achieve the Carter (2008) recommendations for transforming pathology services in the East of England which focus on eight key areas for improvement:

- Quality;
- Communication;
- User responsiveness and information transparency;
- Consolidation;
- Workforce reform;
- Tariffs / benchmarking;
- Commissioning guidance;
- Innovation.

The Full Business Case for the reconfiguration of community requested pathology services in the East of England will be presented to the CCG in Autumn 2012. Contract completion is planned for April 2013.

4.4 ‘111’

The ‘111’ service is a national single point of access for unscheduled care that sits alongside GP surgeries and the 999 ambulance service. It works cooperatively with both of these, and will be available 24 hours 7 days a week, free to call from a landline or mobile phones. The NHS 111 service helps patients find the most appropriate service to them based on distance, medical needs as well as what is available at that time and place.

The four core principles and the context for each are:

- **Initial Assessment**: Calls are answered in 60 seconds and completion of a clinical assessment on the first call without the need for a call back. If the caller only requires Health information (i.e. where is my nearest pharmacy) this will be given directly without launching the clinical support software;

- **Clinical Assessment**: If required at any time during the call, the call handler can transfer calls to a clinician ("warm transfer") seated in the same facility for further assessment immediately;
4. National & Regional Priorities 2012/13

- **Information Transfer**: The call details and NHS Pathways assessment are sent electronically to the patients GP, and service provider selected as most appropriate e.g. OOH, (avoiding the need for callers being re-triaged);

- **Real Emergencies**: if the caller needs an ambulance (from NHS Pathways disposition) a message will be immediately sent into the ambulance stack as if the caller had dialled 999 in the first place.

**Suffolk 111 Programme**: Suffolk has established a 111 Programme Board and operational team with the SRO as Tracy Dowling and joint Clinical leads being Dr Billy McKee (Ipswich and East Suffolk CCG) and Dr Simon Arthur (West Suffolk CCG). The board includes stakeholder membership from Community Services, Acute providers, Mental Health Trust, Suffolk CC and Patient groups. The programme team reports bi-weekly and the board reviews progress monthly.

The service will "go live" to the public in Suffolk on Feb 19th 2013. In late January the service will 'soft launch' when all OOH calls will be handled by 111. The NHS 111 service will replace NHS Direct (0845 46 47) telephone service, which will cease taking calls on 31 March 2013.

The Suffolk NHS 111 Clinical Governance Group is charged with improving the patient journey as a whole by improving patient safety, improving patient experience, avoiding duplication and identifying the inevitable gaps and opportunities that we all know exist.

4.5 Innovation Review

The CCG has reviewed “Innovation, Health and Wealth, *Accelerating Adoption and Diffusion in the NHS*" which sets out a delivery agenda for spreading innovation at pace and scale throughout the NHS. A summary has been disseminated to all QIPP programme leads. The report sets out a number of High Impact Changes that can be started immediately:

- building the actions set out in the report into the planning processes for 2012/13;
- planning in local areas to deliver the High Impact Innovations as set out in the report;
- developing a clear plan to improve the uptake of NICE technology appraisals; and
- working together to develop local plans for the formation of Academic Health Science Networks.

The key recommendations, in particular those relating to high impact innovations, NICE Technology Appraisals (TA) implementation, innovation and procurement have been embedded in the contracts with the relevant providers. The CCG will use CQUIN to accelerate the delivery of these changes.
4. National & Regional Priorities 2012/13

Through CQUIN negotiations the CCG is looking to move face to face outpatient follow ups to an electronic (web, text or telephone) solution, where appropriate. This is scheduled to take place during 2012/13.

NHS Innovations identifies Telehealth as one of the six High Impact contributors to service transformation and redesign; offering solutions to the challenges facing the modern NHS – rising demand, limited resources, and an increasingly aged population with multiple long term conditions and mental health problems. Our vision is to integrate telehealth concepts and systems into the proposed Integrated Care model to:

- allow care to be delivered closer to home,
- to empower people to take greater care and responsibility for their health and care,
- to improve patient safety and protect face-to-face services.

In doing so we would seek to collaborate with Social Care where possible on joint delivery of technological solutions and services in a way that puts the patient before the technology.

Through CQUIN negotiations, the CCG is also looking to make progress on the ‘Child in a Chair in a Day’ challenge. This has been developed with the current provider (SCH) so that the system will be ideally placed to progress further when the new provider (Serco) takes on the service.

Contractual clauses have been introduced into the 2012/13 contract with West Suffolk NHS Foundation Trust outlining the expectations for provider involvement in developing local plans for the formation of Academic Health Science Networks, and to ensure their active participation in the Networks thereafter.
5. Commissioning Intentions 2013/14

5.1 Commissioning Intentions

From April 2013, the West Suffolk CCG will take on responsibility for commissioning the vast majority of healthcare services for the West of Suffolk. There will be a continuation and heightening of the challenge to maintain or improve the quality of services, whilst increasing productivity and encouraging innovation and prevention strategies.

The following section sets out the CCG’s commissioning intentions for 2013/14 and beyond, which will support the delivery of the QIPP agenda and provide high quality, sustainable and efficient services to the local population.

5.1.1 Approach to developing Commissioning Intentions 2013-14

The issue of the ‘Commissioning Intentions’ letter signals the start of the contract round for the following year. It is issued to providers from commissioners six months in advance of the new contract year. Its primary purpose is to:

- set out the clinical vision of the CCG for 2013-14;
- describe the key service changes or reviews anticipated to give providers informal notice of likely service change;
- describe to providers and potential providers opportunities which may arise in 2013-14.

In order to create a comprehensive letter, all levels of the CCG have been engaged in the process - from member practices to the Governing Body, thereby ensuring that all areas of clinical service commissioning are covered.

The final ‘Commissioning Intentions’ letter is triangulated with the CCG’s ‘Ambition’, Joint Strategic Needs Assessment (JSNA) and views drawn from CCG patient and public engagement.

The compilation of the letter has been coordinated by the Chief Contract Officer’s team in close collaboration with the Chief Operating Officer and Chief Redesign Officer. It is signed by the CCG Chair and Accountable Officer.

5.1.2 CCG ‘Ambition’ Priorities

The CCG aims to deliver the highest quality health service in West Suffolk through integrated working. The CCG will deliver this ambition by 2016 through the following priorities (detailed in Section 3):
5. Commissioning Intentions 2013/14

- Develop clinical leadership;
- Demonstrate excellence in patient experience and patient engagement;
- Improve the health and care of older people;
- Improve access to mental health services;
- Improve health and wellbeing through partnership working;
- Deliver financial sustainability through quality improvement.

The commissioning intentions which will support delivery of these priorities are set out below:

5.1.3 Prevention

The Prevention Programme aims to improve the health and well-being of the population of West Suffolk. Through agreeing performance indicators or incentive schemes the programme will:

- Enhance post natal care in order to support mothers and increase prevalence of breast feeding;
- Reduce the number of women smoking at time of delivery;
- Reduce obesity in pregnancy – at both Suffolk acute hospitals in Suffolk;
- Extend Making Every Contact Count so all opportunities are taken to give positive health messages.

5.1.4 Integrated Care

During 2013/14 the Integrated Care Programme will work in partnership with all our Suffolk health and care partners to implement the recommendations of the Joining Up Older Peoples Services review. The CCG will:

- develop a system wide partnership Board to coordinate strategic development and provide system leadership around agreed priorities;
- establish a delivery group that will lead on the detailed implementation of priorities;
- develop an integrated approach to a planned discharge pathway out of hospital by developing a ‘pull’ based accelerated discharge process. Where necessary this will access appropriate reablement or rehabilitation services that limit the need for on-going care and delay or avoid placement into a residential care home or re-entry to hospital;
- implement a model of integrated neighbourhood teams that connect community and primary care;
- adopt a systematic approach to admission prevention that links up case management and risk stratification and enables a more proactive preventative response for people that if left alone are likely to tip into crisis at some future point. The CCG will implement an integrated crises response service across health and care services;
5. Commissioning Intentions 2013/14

- develop a system of care support;
- develop whole system comprehensive geriatric assessment through interface geriatrics;
- implement risk stratification and self-care including telehealth and telecare;
- develop an integrated continence pathway;
- promote a more comprehensive package of support for family carers, recognising that family carers often neglect their own health, and to work with Adult and Community Services to provide advice, support and services that will assist families to remain together & living independently;
- consider how to improve the delivery of a range of services to people that abuse substances that results in a more effective co-ordinated approach and reduced impact on the acute service;
- ensure that care homes deliver advance care plans.

The Integrated Care Programme will:

- review COPD pathways in view of new guidance on discharge care bundles and NHS Network’s COPD commissioning toolkit;
- work with third sector organisations to develop a carer passport;
- explore incentive schemes to encourage providers to work with and support carers;
- require stage 2 falls assessments are undertaken for all patients who make contact with a service following a fall and ensure the patient is referred to the appropriate service;
- work with Cambridge University Hospitals Trust to ensure their fragility fracture liaison service links with other West Suffolk based services.

During 2013/14 the Programme there will be a continued focus on stroke:

- work with our local partners to commission an early supported discharge service to support the drive to reduce length of stay in the acute trust following a stroke and produce better long term outcomes for people, increased independence and self-management;
- ensure all stroke survivors receive 6 and 12 monthly post stroke reviews;
- continue to support the local delivery and development of the hyper acute and acute stroke pathway, Trans Ischaemic Attack (TIA) prevention and management, telemedicine and thrombolysis;
- work towards ensuring our local acute trusts provide 24/7 consultant on call and weekend ward rounds.

The CCG will work with Suffolk County Council to develop a proactive joint approach to care home commissioning and market shaping developing joint standards for health and social care to enable preventive care, dignity and safeguarding across:
5. Commissioning Intentions 2013/14

- Very Sheltered Housing;
- Home care;
- Residential home care;
- Nursing home care.

5.1.5 End of Life

The End of Life Programme aims to develop and improve palliative and End of Life care services for all patients (regardless of diagnosis) enabling them to be cared for in their place of choice. Services will be supplied by trained and competent providers (specialist and generalist) who work collaboratively with other End of Life Care providers to deliver the best possible services for patients, families/carers.

Specific intentions for 2013/14 include:

- the delivery of timely, coordinated and consistent palliative and end of life care, including signposting to bereavement services as per the agreed Suffolk End of Life Pathway;
- development of the means of identifying patients who have palliative and end of life care needs, supported by a relevant prognostic tool, in a timely manner particularly in hospitals and other institutional settings. This will include providing multi-professional education and training, the use of End of Life ‘tools’ and the use of the yellow folders;
- continued development of a robust and dynamic system that enables information sharing across all agencies involved in the care of EoL patients. There will be continued piloting and extension of the use of the Electronic Palliative Care Coordinating System/EoL register across Suffolk;
- explore with the Hospice commissioning a rapid response at night service.

5.1.6 Planned Care

In 2013/14 the Planned Care Programme will undertake work in the following priority areas.

Musculoskeletal/Orthopaedic/Rheumatology/Pain:

- continue the implementation of the osteo-arthritis hip pathway to improve access to non-surgical and/or community based interventions;
- introduce the osteo-arthritis knee pathway to improve access to non-surgical and/or community based interventions;
- introduce the shoulder pathway to improve access to non-surgical and/or community based interventions;
5. Commissioning Intentions 2013/14

- review pain services and pathways both acute/community, to include a post implementation review and refinement of the Back and Neck services (BANS);
- review of bone density and Dual Energy X-ray Absorptiometry (DEXA) scan pathways;
- review of musculoskeletal physiotherapy commissioned pathways including improvements in access and a review of practice based physiotherapy pilots;
- review spinal pathway to develop a new threshold policy and pathway for spinal surgery;
- renegotiate the price for carpal tunnel surgery in our acute providers with a view to matching the tariff of the recently tendered service.

General Surgery/Gastroenterology:
- establish a community endoscopy service at Thetford;
- review the local bariatric surgery pathway for levels 1-3 into the specialist commissioned service commissioned by the National Commissioning Board.

Dermatology
- implement a new dermatology service configuration in Suffolk, to develop a model for increased community-based provision;
- introduce restricted criteria for consultant to consultant referral between dermatology and plastics. The coding of current procedures may change specialty as a result.

Ear, Nose and Throat
- review Ear, Nose and Throat (ENT) pathways with a view to establishing a pre-falls (dizziness) clinic in the community, community audiology screening sessions, a review of the hearing aid follow up process and a pathway for sinusitis and polyps. The role of intermediate clinics for ENT will be reviewed;
- to introduce micro suction ENT services in the community within 2012/13 but with the full year impact in 2013/14;
- review and develop audiology services in a primary/community setting.

Diabetes
- to review community based service options for patients with diabetes. A tiered approach to care utilising local expertise and skill mix to provide more care in primary care settings will be explored. A specific focus will be made on repatriation of patients from Addenbrookes and a review of pathway options into West Suffolk NHS Foundation Trust.
5. Commissioning Intentions 2013/14

Other areas for consideration in 2013/14 will be:

Cardiology
- increase the community based options for cardiology services.

Oral Surgery
- consider options in sustaining Oral and Maxillofacial Surgery (OMFS) provision for the local population residing within Suffolk;
- review provision of sedation/general anaesthetic services in the community;
- extend primary care minor oral surgery to under 18s.

Ophthalmology
- extend the ophthalmology referral refinement schemes to include phase 3 Children’s Eye care services;
- review the existing cataract pathways into existing providers, explore potential for market contestability.

Gynaecology
- review the possibility of establishing gynaecology community services including endometrial biopsies, heavy menstrual bleed pathway and specialist coil fitting for menorrhagia on a locality basis. An intermediate level service may be tendered to cover a range of community level services;
- in support of the gynaecological pathways, develop a community physiotherapy led continence service to support a reduction in outpatients and provide wide spread local access to a service that is currently limited or unavailable;
- ensure that capacity is optimal to address the new screening programmes e.g. gynaecology March 2013.

Diagnostics
- facilitate the wider use of 24 hour ambulatory blood pressure monitoring in primary care;
- review direct access diagnostics and outpatient pathways to ensure optimal mix. Increase the range of community based options for diagnostics in line with national expectations;
- consider direct access MRI for ENT pathways under protocol and review the possibility of implementation of MRI direct access for musculoskeletal pathways, including anterior knee, mechanical knee and backs for all practices;
- investigate the suitability of a direct access scans for ‘lumps in the neck’ and the thyroid clinic;
- introduce a community doppler service for leg ulcer assessment and follow ups for a planned monitoring service and to risk assess patients proactively.
5. Commissioning Intentions 2013/14

General

- continue to promote and implement joint working on enhanced recovery and accelerated discharge programmes in agreed specialties or pathways, to reduce average length of stay;
- outpatient procedure (OP) rationalisation - review of work conducted as OP procedure – some items of work may need to have local tariff agreed or premium to outpatient department rather than attract a separate procedure tariff;
- embed the Community Management Service (CMS) and roll-out to more specialties;
- ensure that all appropriate services are offered by Providers, either directly or indirectly to be available via Choose & Book. Robust contractual measures will continue to be applied to maximise the usage of Choose and Book;
- review, expand and monitor threshold policies;
- review consultant to consultant referrals to ensure compliance with exceptions and work with the GP liaison group to review pathways included as exceptions;
- build on the CQUIN digital by default to ensure better use of skill mix and local pricing to deliver outpatient alternatives;
- continue to develop discharge summaries to include a section on ‘information given to the patient or representative’, ‘follow up actions for the patient’, ‘follow up actions for hospital’ and ‘follow up actions for the primary health care team’.

In relation to screening programmes, commissioners will:

- seek to commission virtual outpatient clinics for consultant review of diabetic retinopathy images with a view to reducing the levels of unnecessary onward referral;
- commission adequate endoscopy clinic and colonoscopy capacity to meet the requirements of bowel cancer screening including the age extended (70 – 75) cohort. Providers will ensure they maintain Joint Advisory Group (JAG) and Global Rating Scale (GRS) standards and also implement Quality Assurance recommendations where these have been identified. Providers of bowel cancer screening should ensure only JAG accredited endoscopists perform colonoscopies created through the screening programme and that these endoscopists meet the minimum numbers required to maintain JAG accreditation;
- work with providers to ensure there is a clinical pathway for the management and surveillance of high risk breast cancer women once DH guidance has been issued;
- commission adequate colposcopy clinics to meet the requirement of year 2 cervical screening programme (HPV);
- ensure providers report on antenatal KPIs as set out by the relevant national programmes;
- seek to develop a county wide single Newborn Hearing Screening service across Suffolk during 13/14. Providers should work with commissioners in agreeing a common clinical pathway in line with Newborn Hearing Screening Programme (NHSP) requirements. With respect to Newborn Bloodspot screening providers are to ensure all elements of the national standards are met. Providers should also ensure that they report on all newborn screening KPI’s;
- require providers meet all Vascular Society of Great Britain and Ireland (VSGBI) guidelines with respect to all major vascular procedures including those identified through Abdominal Aortic Aneurysm (AAA) screening.
5. Commissioning Intentions 2013/14

5.1.7 Planned Care (High Cost Drugs)

The high cost drugs programme aims to ensure there is a consistent, evidenced-based, cost-effective commissioning programme for the implementation of all high cost drugs and NICE approved technologies across the CCG. The high cost drugs programme will cover the following areas:

High cost Drugs and/or PbR excluded drugs validation:

- work directly with providers to ensure a series of robust terms relating to high cost drugs are incorporated into the contracts;
- maintain systems for the facilitation of appropriate payment and checking of all high cost drugs invoicing including cancer regimens commissioned by the Anglia Cancer Network and special projects for the commissioning of Non-NICE business cases for example Botulinum Toxin.

Post verification Audit of NICE TAs:

- continue to develop a proforma based system which supports the commissioning of all NICE TA’s and IFRs and transfer this to the web-based Blueteq system which will facilitate reconciliation of invoices for high cost drugs;
- further develop monthly reporting systems which monitor NICE implementation in line with DH proposed NICE compliance regimen and Innovation Scorecard.

Proactive management of the pathway for the introduction and maintenance of high cost drugs/new drugs and indications across the CCG system:

- ensure there are robust and appropriate systems in place for managing the introduction of high cost drugs in both primary and secondary care. This includes consideration of business cases, commissioning of pathways and ensuring transparent funding flows through service variations;
- support appropriate mechanisms for the introduction of all new drugs and indications. This includes robust “horizon scanning” as part of the commissioning round and implementing the updated guidance on the operation and maintenance of Area Prescribing Committees;
- continue to develop and ensure that providers utilise ‘homecare’ arrangements for appropriate cohorts of patients.
5. Commissioning Intentions 2013/14

5.1.8 Prescribing

The CCG intends to build on the solid foundations and achievements of 2012/13 in ensuring on-going clinically appropriate and cost effective prescribing. Key initiatives will be:

Implementation of cost effective prescribing initiatives:

- support prescribers in following the guidance provided in the NHS Suffolk “Analgesics in Primary Care Guidance (not palliative care)” document. Morphine to be prescribed ahead of alternative potent opiates;
- promote adherence to BTS/SIGN guidance and prescribe inhaled corticosteroids and combination inhalers cost effectively;
- prescribe cost effective gonadorelin analogues for prostate cancer;
- prescribe isophane insulin ahead of glargine and detemir.

Implementation of a care home/elderly strategy:

- to work holistically with all stakeholders to improve the clinical outcomes for the elderly/patients in care homes;
- use the patient passport to reduce A&E attendance and admissions longer than 3 days;
- carry out medication reviews to enhance the effectiveness of prescribing and reduce waste;
- support proactive management of patients with dementia to reduce antipsychotic prescribing;
- consider the introduction of a service to manage cellulitis in the community.

CCG preferred drugs:

- continue to work across the health system to identify, agree and implement the appropriate use of preferred drugs;
- ensure the preferred drugs list includes NICE Technical Appraisal approved drugs;
- to review the Suffolk antibiotic formulary and monitor adherence.

Area Prescribing Committee (APC):

- participate in APC discussions and influence decisions on the traffic light classification of new drugs;
- adhere to the traffic light decisions made by the APC and Clinical Priorities Group.
5. Commissioning Intentions 2013/14

The New Medicines Service (NMS):

- to work across the health system to implement appropriate referrals to the NMS.

5.1.9 Mental Health

The CCG Ambition for Mental Health is:

- that mental health provision will be open and accessible to all people who need it regardless of their age and the diagnosis and severity of their mental health condition. No mental health service user should need to be returned to their GP for onward referral for another mental health service;
- to commission mental health and learning disability services which are integrated with the wider health and social system and which support the recognition that people’s mental health should be seen as part of their overall physical and mental wellbeing. This will apply to all people regardless of their age including those marginalised from society.

In 2013/14 the Mental Health Programme will undertake the following work.

Child and Adolescent Mental Health Services (see also CYP programme):
- embed and reinforce improvements made in 2012/13 to ensure services are comprehensive and needs led, free of barriers and responsive to service users and referrers;
- net promoter scores implemented for patients and professionals.

Dementia:
- remodel services to ensure the predicted rises in the number of people with dementia are treated appropriately. This will include reviewing the capacity of memory services as increased emphasis is placed on early detection and diagnosis both within primary care and in acute hospitals;
- support people with dementia to live well in their local communities taking account of all their physical, mental and social needs to deliver patient-centred care in partnership with all providers including psychiatric liaison with Hospitals and Community Services;
- work with prescribing leads to support the continued reduction in anti-psychotic prescribing;
- accelerate the implementation of the dementia strategy to ensure effective early diagnosis and support.
5. Commissioning Intentions 2013/14

Well-being:
- ensure a swift, early response, offering the lowest level of intervention appropriate to peoples’ needs in order to minimise the onset of mental illness, reduce deterioration, overcome stigma and promote recovery;
- the newly commissioned Wellbeing Service dynamically changing in line with its specification during the contract term, in order to adapt its provision to meet the needs of the local population;
- offering of interventions for people with long term conditions such as COPD. Through early intervention we wish to see a reduction in the numbers needing secondary mental health care and unplanned admissions into inpatient and out of area placements;
- increased options to support patients’ progression back to their lives in their local communities reflected in a reduction in in-patient bed occupancy and length of stay.

Norfolk and Suffolk Foundation Trust – Radical Service Redesign
- ensure that the new ways of working result in increased community activity and reduced inpatient activity;
- pathways will be aligned with Payment by Results clusters and there will be no further costs to commissioners over the agreed costs for care packages;
- single point of access with net promoter scores implemented for patients and professionals;
- management the out of area placement programme, with agreement on the share of any resource savings.

Psychological Liaison Services
- meet the mental health needs of people in all departments of acute hospitals by facilitating best practice and optimising cost effective services through the continued enhancement of psychological liaison services. This will include people with substance misuse, crises, delirium/dementia and long term conditions and medically unexplained symptoms presentations. The Mental Health Programme seeks a 70% reduction in readmissions and 40% diversion from A&E.

Eating Disorder Service
- age inclusive Eating Disorder Service new pathways implemented bringing together the successful SEEDs model and Children’s Eating Disorders Services and include the best elements from the most successful regional eating disorders service;
- a percentage target set for reducing out of area placements.

Adult learning disability service
- procure a new Community and In-patient Adult Learning Disability Service in line with national best practice by September 2014.
5. Commissioning Intentions 2013/14

Autism:
- procure by July 2013 a NICE compliant autism service for adults which will be fully integrated as part of an age inclusive comprehensive pathway for people with autism.

Expectant mothers:
- explore commissioning of services for pregnant women beyond interventions when they are actively psychotic or suicidal.

Overall expectation:
- a 10% shift from inpatient to community services;
- 95% bed occupancy;
- Memory Assessment waiting times to remain within target 10 weeks.

5.1.10 Children and Young People and Maternity

The priorities below have been developed in consultation with the Regional Child Health and Well Being Group and Suffolk County Council as a significant local stakeholder.

Engagement with Children, Young People and their families:
- providers to demonstrate how they have listened to the voice of children and young people and how this will improve their health outcomes.

Development of a patient pathway approach:
- develop a patient pathway approach, which sets out questions that those using health services may ask for each pathway step, and a broader life course approach, which helps identify indicators important at particular life stage(s) such as from conception through pregnancy to birth, the early years, mid-childhood, to teenagers and young adults;
- further develop pathways in the same way as 2012/13 paediatric asthma pathway which may arise as a result of initiatives such as the Community Management System (CMS) referral development work underway with hospitals.

Looked After Children and Young People and inequalities in outcomes:
- deliver sufficient clinical expertise and leadership for looked after children, including a designated doctor and nurse;
- implement a tariff for the statutory health assessment of looked after children to promote the health and wellbeing of looked after children placed out of their local area;
5. Commissioning Intentions 2013/14

- specifically recognise care leavers in early adulthood (18–25), as well as looked after children, including a requirement that children in care health teams include a focus on this group.

Integration and Partnership (commissioning and provision):
- join up services and commissioning so: children, young people and parents will not have to keep repeating their information; records are not lost or duplicated; individuals and their needs do not fall between gaps; resources are focused on the same goals.

Children’s Universal Services (Health Visiting, School Nursing)\(^1\)
- build on the integration of children’s community health universal services with Suffolk County Council as part of the creation of a Section 75 partnership agreement;
- realise the benefits of integrated working and improving the working relationships between local authority (social work teams, children’s centres and early years) with health services and third sector organisations;
- build on the work completed in the Department of Health pilot ‘Project 4’ which developed a commissioning tool for Health Visiting;
- implement the 8 evidence based care pathways as developed in Project 4 work namely; Antenatal, Early Childhood Development, Infant Mental Health, Nutritional Healthy Start, Parental Mental Health and Wellbeing, Parenting Support, Vulnerable Families and Safeguarding;
- deliver 45 additional health visitors in Suffolk by the end of March 2015 and deploy them in agreed areas of need;
- establish a Family Nurse Partnership (FNP) scheme in Suffolk by April 2013 (initially in Ipswich);
- meet the needs of vulnerable groups, including those in need of safeguarding as identified in the JSNA.

Reducing avoidable secondary care activity:
- review the effectiveness of the acute led Paediatric Consultant GP Telephone Advice line initiative;
- review of paediatric urgent care/A&E pathway. Implementation of actions from regional peer led review undertaken in December 2011;
- development of Community Management System (CMS). Working with primary and secondary care to further develop referral pathways for advice and guidance;
- Paediatric Diabetes Best Practice Tariff. Continued review to ensure enhanced service is delivered to the 330 young people with diabetes (County wide). To include assessment of reducing unplanned diabetic related hospital admissions as patients better manage their blood glucose levels;

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\(^1\) *It should be noted that Health Visiting and School Nursing services are currently commissioned on a County wide basis covering West Suffolk CCG and Ipswich and East CCG. On 01.04.13, Commissioning of Health Visiting is due to transfer to the NHS CB and School Nursing to Suffolk County Council.*
5. Commissioning Intentions 2013/14

- Educational Resources for Children and Families on Common Childhood Illnesses. Develop a booklet for families with Children (0-5 years) with advice on management of common childhood illnesses designed to empower families to use services appropriately and avoid unnecessary hospital activity.

Child and Adolescent Mental Health Services (CAMHS) (see also Mental Health section)
- refresh the joint strategic needs assessment and existing Suffolk CAMHS strategy;
- respond to the views of CCGs and other stakeholders;
- improve access and understanding of CAMHS services across the County;
- reduce tier 4 placements and improve timeliness of responses to emergency and urgent mental health issues through the tier based service model of early intervention and prevention approaches;
- ensure the single point of access is seamless and develops relationships with the Integrated Services Access Team. Review of the referral criteria for specialist CAMHS services;
- ensure the jointly commissioned (with Suffolk County Council) Primary Mental Health Workers (PMHW’s) service develops further to support lower tier emotional health and well-being needs across the county, CCGs and Suffolk County Council view the PMHW service as vital in terms of supporting primary care and other universal services with training and support as well as playing a key role in client referral pathway management;
- ensure clarity is established with the respective roles of primary care and Norfolk and Suffolk Foundation Trust concerning the responsibility for prescribing and diagnostic work up and management;
- ensure Norfolk and Suffolk Foundation Trust will respond accordingly to the thematic review of issues which is currently underway;
- review of the Norfolk and Suffolk Foundation Trust Learning Disability CAMHS service considering the service delivered by Lothingland and its relationship with Suffolk County Council provided LD Nursing service. An option to tender will be considered;
- develop and commission a county wide age inclusive eating disorders service. Currently an East CYP and county wide adult service are in place.

Children’s Specialist Community Services (Community Paediatricians, Paediatric Therapies etc.):
- providers to continue to support and fully engage in joint agency working and pathway development as appropriate;
- deliver against key outcomes and targets including 18 week referral to treatment times;
- providers to review all services and ensure close working relationships between universal and specialist children’s services;
- Children’s Specialist Community Services have a key role to prevent admission to acute trusts and ensure joint working with all providers to promote early supported discharge;
- integrated pathways will be developed and jointly commissioned for Speech and Language Therapy and Autism services.
5. Commissioning Intentions 2013/14

Suffolk Family Focus (Troubled Families Programme):
- support the initiative and provide core universal and specialist health services support where need is identified for clients;
- Providers to adopt a family focus approach to assessment and provision of services (in accordance with the Adults and Children’s Services Coordination ACCORD protocol (currently under review) whereby the client/patient and their wider holistic needs are addressed.

Responding to the Green Paper on Special Educational Needs (SEN) and Disability:
- include parents in the assessment process and introduce a legal right, by 2014, to give them control of funding for the support their child needs;
- replace statements with a single assessment process and a combined education, health and care plan so that health and social services are included in the package of support, along with education;
- replace the existing complicated School Action and School Action Plus system with a simpler new school-based category to help teachers focus on raising attainment;
- overhaul teacher training and professional development to better help pupils with special educational needs and to raise their attainment;
- inject greater independence from local authorities in assessments by looking at how voluntary groups might coordinate the package of support.

Maternity:
- address issues of maternal obesity, maternal age (both teenagers and older mothers), smoking during pregnancy, breastfeeding, low birth weight, maternal mental health and screening for infectious diseases;
- continuing the implementation of choice about maternity care. Commissioners will seek assurance that there is: evidence of access to all types of intrapartum care: homebirth, midwife led environments (freestanding or alongside units), obstetric led environments; evidence of a range of models of antenatal and postnatal care including individual and group sessions, in and out of hours availability; promotion of normal birth through reduced caesarean section rates;
- implement payment by results guidance relating to maternity service pathway bundles. Providers will need to be able to estimate the proportions of women falling into each of the case mix categories and commissioners will compare this against national benchmarks and local data on needs and demographics. Commissioners will require providers to engage with the process of calculating local case mix proportions using the national templates.

Autism Services:
- joined up approach to commissioning services for both children and adults with autism (development of single strategy 0-25 years) developed in partnership with Suffolk County Council. This will include clear transition arrangements;
5. Commissioning Intentions 2013/14

5.1.11 Cancer

The Cancer Programme will commission cancer services to improve outcomes for patients with cancer. All cancer services will be compliant with the relevant Improving Outcomes Guidance (IOG), including pathology testing of haematological malignancy, liver metastases, cancer of unknown primary and psychological support services, with compliance measured via the Cancer Peer Review process against the Manual for Cancer Services. Performance against the Cancer Waiting Times Operating Standards will be achieved.

The Cancer Programme will undertake the following work streams:

Primary Care Cancer Nurse Pilots
- support for cancer patients will be provided within the community in order to meet their assessed survivorship and rehabilitation needs;
- new models of follow up for cancer patients will be implemented based on risk stratification, with an associated reduction in hospital follow ups achieved;
- each patient completing an acute phase of treatment for cancer will be offered an individualised plan for follow up, including access to a supported self-management programme (and have their needs holistically assessed), an end of treatment care plan agreed, and an end of treatment summary provided.

Cancer Services:
- cancer bed days reduced by the continuation of services, such as the acute oncology service, working to prevent emergency cancer admissions and by ensuring enhanced recovery programmes are offered to all eligible patients;
- earlier diagnosis of cancer will be supported by improving access to appropriate diagnostic tests, including colonoscopy as the primary diagnostic test for lower GI cancer, and the role of diagnostics within the two week wait pathway will be examined;
- the prescription of chemotherapy via an e-prescription system will be explored and will be in line with the relevant tumour specific Anglia Cancer Network agreed chemotherapy regimens and algorithms;
- information needs of patients will be engaged via the use of information prescriptions to ensure patients are able to access up to date information about their cancer and its treatment and that providers are able to evidence that this information has been offered;
- cancer services will actively engage with relevant User groups to enhance service design and patient experience;
- Head and Neck cancer patients will be able to access IOG compliant rehabilitation services;
- Teenage and Young adult cancer patients (aged 16-24) will be treated in specialised designated hospitals and benefit from age appropriate care;
- All children with cancer should have access to psychological support, rehabilitation and community nursing if require.
5. Commissioning Intentions 2013/14

5.1.12 Corporate

Estates managed by NHS Suffolk will transfer to NHS Property Services Limited. There will be a continued drive to increase utilisation of the estate and where appropriate rationalise the number of buildings.

5.1.13 Quality, Innovation Productivity and Prevention (QIPP)

QIPP remains one of West Suffolk CCG’s key priorities for 2013/14. There is a continuing need for new ideas that will help to sustain the financial health of the Suffolk health economy whilst maintaining or improving quality. Providers with ideas relating to changes in commissioning that will help fulfill this agenda are invited to share their ideas with West Suffolk CCG.

5.1.14 Market reviews

In addition to tenders which are as the result of the above strategic initiatives, the following is a list of services which are due be reviewed or tendered in the next two years:

<table>
<thead>
<tr>
<th>Service</th>
<th>Date of review and potential tender</th>
<th>If tendered, earliest date for change in provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmic Triage</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>Primary Care Minor Oral Surgery Triage</td>
<td>2012/13</td>
<td>2013/14</td>
</tr>
<tr>
<td>Musculoskeletal Physiotherapy</td>
<td>2013/14</td>
<td>2014/15</td>
</tr>
<tr>
<td>Patient Transport Clinical Assessment and Advice</td>
<td>2013/14</td>
<td>2014/15</td>
</tr>
</tbody>
</table>

5.1.15 Activity levels

The CCG will:

- review block services with a view to transfer to cost and volume;
- review maternity 1:1 care in labour – review funding in relation to tariff;
- move maternity screening (block) to tariff;
- include the Newmarket transfer from SCH (and any other community services) into the West Suffolk Hospital Foundation Trust contract;
5. Commissioning Intentions 2013/14

- require drug injections (subcutaneous, intramuscular, joints) to be outpatient procedures and not day case (only IV infusions funded as day case, where necessary);
- require compliance with national guidance over recording of day cases versus outpatient procedures;
- require compliance with 2013/14 payment by results guidance and national data definitions;
- investigate the coding of a number of operations being coded as daycase to ensure they are correctly coded and not in fact being undertaken in an outpatient setting;
- review the pricing of non-consultant led Outpatient and diagnostic tests.

5.1.16 Lead Commissioning Arrangements

The CCG anticipates working closely with Ipswich and East Suffolk CCG in particular to ensure a coherent approach to commissioning is maintained. It is expected that all contracts that have historically been hosted by NHS Suffolk will now be hosted by one of the Suffolk CCG’s with an associate agreement with the other where relevant. As with current multilateral contracts there may be variations to the schedules within those contracts to reflect the differing priorities of each group and a separation of the budget elements to each CCG.

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

A specific review of the Cambridge University Hospitals Foundation Trust commissioning arrangements has been undertaken. Joint commissioning is being progressed with NHS Cambridgeshire and Peterborough CCG.

5.1.17 Other national and local initiatives

The commissioner will take further action to ensure the recommendations of Innovation, Health and Wealth are implemented, specifically:
- exploring whether levels of oesophageal Doppler monitoring are optimized;
- that the child in a chair in a day initiative for children’s wheelchairs is fully considered and implemented.

5.1.18 Performance Data / information

From 2013/14 there will be a requirement to provide local data sets to support 111 referrals or a locally agreed method of identifying 111 referrals through the commissioning data sets.
5. Commissioning Intentions 2013/14

5.1.19 Notice Periods

West Suffolk CCG will apply reasonable notice periods in line with contractual requirements where significant change is anticipated.

5.1.20 Public Involvement

West Suffolk CCG is committed to involving the public and patients in planning of and decisions about change and it expects its providers to continue to fulfill their obligations in this respect.
6. QIPP

6.1 QIPP

QIPP stands for Quality, Innovation, Productivity and Prevention. QIPP emphasises the focus the CCG, local healthcare organisations and the NHS as a whole has on improving quality of care while making efficiency savings for reinvestment in a time of financial restriction. The challenge for the CCG is to achieve the systematic adoption and spread of innovation and improvement at pace and scale. It is therefore essential that good practice, improvement, innovative ways of working and new technologies are identified and adopted locally. These changes will be delivered through a number of discrete QIPP programmes as set out below.

6.2 QIPP Challenge

The original system ‘challenge’ was estimated in 2011 and formed part of the System QIPP Plan published in October 2011 for the system. The ‘challenge’ figure has now been updated and apportioned to the CCG as set out below.

The following table shows the CCG challenge and how it is met by savings resulting from the provider efficiency in contracts and the QIPP schemes detailed in Section 6:

<table>
<thead>
<tr>
<th>Table 1 Total CCG Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>West Suffolk CCG</strong></td>
</tr>
<tr>
<td>CCGTable</td>
</tr>
<tr>
<td>CCG Challenge (a)</td>
</tr>
<tr>
<td>Price Efficiency (b)</td>
</tr>
<tr>
<td>CCG Disinvestments (c)</td>
</tr>
<tr>
<td>CCG QIPP Schemes (d)</td>
</tr>
<tr>
<td>Total CCG Savings (b + c + d)</td>
</tr>
</tbody>
</table>

6.3 QIPP Productivity Opportunities

The CCG has identified potential productivity opportunities of £7.9m from CCG-led (Commissioner) QIPP programmes for 2012/13 as set out in the table below. The CCG QIPP plans that underpin delivery of that opportunity are set out in Section 6.4 below and detailed in Appendix ‘D’.
6. QIPP

### Table 2 Total CCG Productivity Opportunities

<table>
<thead>
<tr>
<th>QIPP programmes</th>
<th>Opportunity 2012/13 (£m)</th>
<th>Opportunity 2013/14 (£m)</th>
<th>Opportunity 2014/15 (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Ambitions (Prevention)</td>
<td>£ 0.13</td>
<td>£ 0.12</td>
<td>£ 0.10</td>
</tr>
<tr>
<td>Integrated Care Transformation</td>
<td>£ 2.73</td>
<td>£ 2.76</td>
<td>£ 2.39</td>
</tr>
<tr>
<td>End of Life (<em>included in ICT from 13/14</em>)</td>
<td>£ 0.14</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Planned Care</td>
<td>£ 2.06</td>
<td>£ 2.76</td>
<td>£ 2.39</td>
</tr>
<tr>
<td>High Cost Drugs (<em>included in Planned Care from 13/14</em>)</td>
<td>£ 0.40</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>GP Prescribing</td>
<td>£ 1.37</td>
<td>£ 0.48</td>
<td>£ 0.42</td>
</tr>
<tr>
<td>Mental Health</td>
<td>£ 0.61</td>
<td>£ 1.12</td>
<td>£ 0.97</td>
</tr>
<tr>
<td>Children &amp; Young People</td>
<td>£ 0.29</td>
<td>£ 1.60</td>
<td>£ 1.39</td>
</tr>
<tr>
<td>Cancer</td>
<td>£ 0.18</td>
<td>£ 0.16</td>
<td>£ 0.14</td>
</tr>
<tr>
<td><strong>Total CCG Schemes</strong></td>
<td><strong>£ 7.91</strong></td>
<td><strong>£ 9.00</strong></td>
<td><strong>£ 7.80</strong></td>
</tr>
</tbody>
</table>

* QIPP opportunities for 2013/14 and 2014/15 are initial estimates only. The planning work to establish detailed QIPP initiatives and revised opportunity through to 2014/15 will be undertaken during Dec. 2012 to Feb. 2013 as part of the annual planning process cycle.

### 6.4 QIPP Programmes

There are eight QIPP programmes across Suffolk which are led by CCGs. CCG leads assumed the clinical leadership and responsibility for QIPP schemes during 2011/12. This will continue during 2012/13 and beyond. The aligned clinical leadership of QIPP plans and contract negotiations ensures that the activity assumptions arising from QIPP workstreams are fully reflected in commissioning plans.

Each QIPP programme for 2012/13 is set out below (section 6.4.1) and outlines its objectives in terms of the improved outcomes for patients, financial savings, and the expected improvements in quality of services. Each programme is supported by a suite of Key Performance Indicators (KPIs).
6. QIPP

QIPP programmes will continue to be developed throughout 2013/14 and beyond as part of the annual planning process and their will span a number of years. The CCG has phased the delivery of some QIPP schemes through to 2014/15, providing the headroom shown in Table 1 above. The key milestones for delivering some of these schemes are set out in Appendix ‘E1’, and form part of the monthly submission to the NHS Midlands & East SHA.

The planning work to establish the detailed QIPP schemes to support delivery of future years’ ‘opportunity’ will be undertaken during Dec. 2012 to Feb. 2013 as part of the annual planning process cycle.

The CCG will continue to jointly work with NHS Ipswich and East Suffolk CCG and neighbouring CCGs to develop further QIPP schemes where there are identified health benefits to patients, and opportunities for efficiency savings and investment. The CCG is currently working together with the Ipswich and East CCG on the following projects:

- Winter planning;
- Stroke review;
- Development of case management;
- Development of Interface geriatrics.

The NHS Commissioning Board has provided a range of measures to highlight variation in activity levels between CCGs and growth in activity over time (Appendix ‘E’ – Activity, Spend and Outcome Profile). This information allows CCGs to compare their performance with others and to identify where they appear to be an outlier. This information will be considered when setting future QIPP programmes and priorities.
6. QIPP

6.4.1 Healthy Ambitions (Prevention)

(Supporting CCG Priority 5 – Improve health and wellbeing through partnership working).

Objectives:
To improve health and reduce health inequalities. Emphasis will be placed on reducing smoking and alcohol consumption, decreasing obesity, increasing breastfeeding initiation rates improving cardiovascular morbidity and mortality (through NHS health checks) and increasing long acting reversible contraception (LARC) in line with NICE guidance. The programme will ensure high quality screening programmes are offered to the population and that screening and immunisation coverage protects the population’s health. Action will decrease the burden of ill health on the local NHS, particularly the impact of long term conditions. The effect will be cumulative with increased savings longer term (5-10 years).

Key projects:
- Reducing the prevalence of smoking;
- Increase the rate of breastfeeding;
- Successful transition to newly commissioned integrated Healthy Lifestyle service which has already demonstrated additional value for money and quality;
- Implement NHS Health Check programme;
- Reducing harm due to drug and alcohol misuse;
- Implement and embed cervical, Abdominal Aortic Aneurysm (AAA) screening and diabetic retinopathy screening programmes.
- Improving Sexual Health;
- Decreasing future health burden through improved lifestyle – for example increasing the number of children with successful outcome accessing child weight management services and increasing the number of adults with BMI>30 (or >25 with co-morbidities) with successful outcome accessing adult weight management services;

Quality Opportunities:
- To decrease health inequalities by ensuring lifestyle services and health checks reach the deprived and high risk communities within the CCG area and more adults access the health trainer service;
- Ensure screening programmes meet/exceed national quality criteria;
- Financial savings of £0.08m through prevention of acute admissions from reduction in numbers smoking;
- Financial savings of £0.04m through increased LARC prescribing.

Financial Savings:
- Number of smoking quitters (target: 1,696);
- To offer 14,655 eligible people an NHS Health Checks, and to ensure uptake of 8,793 is achieved);
- To increase the uptake of LARC 1% (to 13.4%) within Primary Care from 2011/12.

Key Performance Indicators 2012/13:
- Productivity Opportunity identified for 2012/13: £0.13m
6. QIPP

6.4.2 Integrated Care Transformation (exc. children)

(Supporting CCG Priority 3 – Improve the health and care of older people).

Objectives:
The Integrated Care programmes primary objective is to ensure that the health and care system delivers the right health care, at the right time and in the right place. The focus of the QIPP programme will be on improving the quality of care for people through the implementation of integrated and flexible primary and secondary health and care services which promote the wider development of community-based alternatives to hospital admissions. The programme also focuses on improving the quality of care and management of those patients with long-term conditions.

Key projects:
- Expand the EAU service at West Suffolk NHS Foundation Trust;
- Increase Admission Prevention Service (APS) impact, capacity and resilience;
- Single point of Access for clinicians to health services;
- Implement an integrated approach to prevention and management of falls/fragility fractures;
- Pathway development for 4 ambulatory care sensitive conditions;
- Risk stratification - identify people at medium to high risk of health deterioration and hospital admission within the next 12 months;
- Improve management of long-term conditions in primary/community care for Heart Failure, COPD, Diabetes and Cardiac Rehab.;
- Develop and establish the specialist provision including interface geriatrics to manage condition specific and care of elderly demand;
- Embed Multi-disciplinary team reviews of patients at risk of admission;
- Implement Early Supported Discharge for stroke patients;
- Implement national ‘111’ programme;
- Identifying more people with dementia using the QOF registers;
- Implement Memory Service and Intensive Support Teams for Dementia patients;
- Implementation of case management via integrated neighbourhood community teams;
- Further develop self-management/self-care at home/in community;

Quality Opportunities:
- Reduced hospital admissions and management of more patients in the community;
- Extend the range of APS provision to ensure admission prevention is embedded into core business;
- Reduction in readmission rates;
- Improved assessment and management of falls and fragility fractures;

Productivity Opportunity identified for 2012/13: £2.73m
6. QIPP

- Improving care homes/community hospital outcomes/experiences;
- Improved quality of GP and community care for dementia sufferers and the elderly;
- Case management approach to support frail and elderly;
- Improved patient support for self-management and self-care through assistive technology, personal health plans etc.;
- Reduced pressure sores/ulcers for patients;
- Improved services and workforce support for dementia patients;
- Reduced inappropriate antipsychotic prescribing for people with dementia to improve quality of life;
- Optimal management of long-term conditions in primary/community care for Heart Failure, COPD and Diabetes;
- Cardiac rehabilitation services delivered in accordance with Department of Health (DH) specification and NICE activity levels;
- Streamlined access to community and clinical services.

Financial Savings:
- The following projects have the potential to yield savings as detailed:
  - Long Term Conditions (LTC) - Supporting people by preventing deterioration in health, including pathway refinement and improvement (£0.9m);
  - Pathway development for 4 ambulatory care sensitive condition pathways (£0.2m);
  - Dementia pathway improvements (£0.1m);
  - Admission Prevention - Expand the Emergency Assessment Unit (EAU) at West Suffolk hospital (£0.9m);
  - Managing falls & fragility fractures (£0.4m);
  - Renegotiation of ambulance contract (£0.2m);

Key Performance Indicators:
- Reduce the total number of emergency non-elective admissions (Adult only) by 1,241 (exc. LTC, Heart Failure, COPD, falls);
- Reduce falls fragility fractures-related emergency non-elective admissions by 94;
- Reduce emergency non-elective admissions for ACSC conditions by 78 (9.2%).
6. QIPP

### 6.4.3 End of Life (integrated within ICT programme at 6.3.2)

(Supporting CCG Priority 3 – Improve the health and care of older people; and CCG Priority 2 – Demonstrate Excellence to patient experience and patient engagement).

**Objectives:**
To develop and provide the best possible services for palliative and end of life care patients, allowing them to be cared for in the place of their choice.

**Key projects:**
- To implement the Suffolk End of Life Pathway across health and social care providers to deliver improved choices for people, their families and carers.

**Quality Opportunities:**
- Improved identification of patients in last year of life;
- Improved access to community services to meet needs of patients and their family carers;
- Implement End of Life register across county;
- Maintain workforce education and training programmes; including Advanced Care Plans (ACP) for people with Dementia;
- Develop and support model for bereaved services for care providers;
- Patients cared for in place of preferred choice.

**Financial Savings:**
- Reduction in acute emergency admissions for those in last year of life and associated ambulance call outs.

**Key Performance Indicators:**
- To achieve a 88 (1%) reduction in ‘last year of life’ emergency admissions to acute care from 2011/12 baseline;
- To achieve 49.9% of deaths in usual place of residence by March 2013 (to support Suffolk-wide achievement of 52%).

---

Productivity Opportunity identified for 2012/13: £0.14m
6. QIPP

6.4.4 Planned Care (inc. High cost drugs)

(Supporting CCG Priority 2 – Demonstrate Excellence to patient experience and patient engagement; and CCG Priority 6 – Delivery of financial sustainability through quality improvement).

Objectives:
To reduce planned non-specialist acute activity and expenditure, whilst also maintaining waiting time standards, the NHS constitution, and a positive patient experience. To adopt a system-wide approach to the prioritisation and funding of cost-effective medicines.

Key projects:
- Carpal Tunnel pathway;
- Primary Care Minor Oral Surgery;
- Referral and Demand Management – CMS project;
- Reducing variation and managing activity;
- New elective pathway reviews;
- Critical Care;
- High cost drugs/PbR excluded drugs validation;
- Post verification Audit of NICE TAs;
- Secondary care savings Agreements;
- T&O demand management – OA hip pathway, knees, shoulders;
- Ophthalmology referral refinement scheme;
- Clinical Thresholds policy impact;
- Acute Activity Management;
- Alternatives to Outpatient appointments;
- Appropriate utilisation of Homecare;
- Pathway management for introduction of high cost drugs;
- Individual Funding Requests.

Quality Opportunities:
- Achievement of waiting times targets;
- Positive impact on patient experience/satisfaction, PROMS;
- Improved outcomes for patients;

- Review of low priority procedures and thresholds;
- Transfer of Outpatient procedures into a community setting;
- Improved cost-effectiveness of high cost drug prescribing;
- Patients receiving conservative care in primary care setting;
- Improved access to non-surgical treatments & surgery avoidance;
- Increased number of patients’ whose on-going care can be managed by GPs or community-based healthcare professional;
- Improved access to services; and reduce waiting times;
- Reduced hospital length of stay;
- Increase VTE risk-assessments to reduce Pulmonary Embolism.

Financial Savings:
- Further pathway changes for Carpal Tunnel has the potential to provide savings of approximately £0.06m;
- T&O demand management; across the three pathways it is anticipated the full year savings will be £0.35m;
6. QIPP

- Savings from pathway changes in Minor Oral Surgery and Ophthalmology are expected to be around £0.12m;
- Referral and demand management projects have the potential to provide savings of £0.88m;
- New elective pathway reviews are expected to yield savings of around £0.22m;
- Robust management and appropriate high cost drugs prescribing is expected to save approximately £2.06m.

**Key Performance Indicators:**
- To achieve a reduction of 69 (25%) Carpal Tunnel procedures from 2012/13 baseline;
- To achieve a 26 (10%) reduction on OA hip procedures from 2012/13 baseline;
- To achieve a 96 (15%) reduction on knee procedures from the baseline;
- To achieve a 27 (15%) reduction on shoulder procedures from the baseline;
- To achieve a 1,775 (25%) reduction in first outpatients Ophthalmology appointments from the baseline;
- To achieve a reduction in first outpatients OP Dermatology appointments in 2012/13 from baseline.
- Referral & demand management – to achieve an overall reduction of 7,323 (10%) in 1st OP & follow-up appointments from baseline throughout rollout of CMS.
6. QIPP

6.4.5 Prescribing

(Supporting CCG Priority 6 – Delivery of financial sustainability through quality improvement).

Objectives:
To implement safe, quality changes in prescribing which release a £1.37m reduction in spend from the 2011/12 baseline.

Key projects:
- Reduce inappropriate prescribing of Ezetimibe & rosuvastatin;
- Complex medication reviews;
- Switch patients from branded to generic medicines;
- Reduce cost of blood glucose testing kits;
- Patients needing oxygen referred to West Suffolk COPD service;
- Reduce cost of combination inhalers;
- Dietetics;
- High cost drugs.

Quality Opportunities:
- Optimisation of medication for complex patients;
- Reduced transitions in key therapeutic areas;
- Improved safety for patients at risk of severe allergic reactions;
- Optimisation of asthma inhalers including education;
- Improved medication ordering systems and availability of homely remedies;
- Patients’ transition to food as opposed to sip feeds;
- Improved adherence to the Pain Ladder;
- Adherence to NICE guidelines for statin prescribing;
- Improved self-care for minor ailments;
- Continued referral of patients requiring home oxygen to specialist service.

Financial Savings:
- Medication reviews has the potential to provide savings of approximately £1.1m;
- Review of drugs currently included in high cost drugs could save £0.1m;
- High cost drugs: This has the potential to provide savings of approximately £0.1m.

Key Performance Indicators:
- To achieve a £1.37m reduction in the GP prescribing spend by the end of 2012/13 as compared with 2011/12.
6. QIPP

6.4.6 Mental Health and LD

(Supporting CCG Priority 4 – Improve access to mental health services; and CCG Priority 6 – Delivery of financial sustainability through quality improvement).

Objectives:
To maintain or increase the quality of mental health learning disability services and to reduce the unit cost of services by reducing waste and increasing productivity.

Key projects:
- Procurement of Wellbeing Approach;
- Review of Community Mental Health Team (CMHT) provision;
- Development of Mental Health Payment by Results;
- Reduction in activity in secondary MH services;
- Repatriation of service users in out of county provision;
- Reduce level of provision of inpatient services for older people.

Quality Opportunities:
- Improved clinical outcomes and patient experience;
- Improved mental health and well-being;
- Improved primary mental health care;
- Equity of access to evidence based interventions;
- Monitoring Mental Health safety and risk management processes;
- Patients treated closer to home.

Financial Savings:
- Increase in number of people accessing primary psychological therapies through the procurement of Wellbeing Approach could save £0.2m;
- Continuation of repatriation programme could achieve £0.3m savings;
- Other contractual savings could achieve savings of £0.2m.

Key Performance Indicators:
- To reduce the monthly spend on people in out of area placements (county-wide) by £280k through delivery of budget spend;
- To increase the number of people accessing primary psychological therapies to 13% in 2012/13 and to 15% (by 2014/15) in accordance with SHA trajectory.

Productivity Opportunity identified for 2012/13: £0.61m
6. QIPP

6.4.7 Children, Young People & Maternity

(Supporting CCG Priority 4 – Improve access to mental health services; and CCG Priority 5 – Improve health and wellbeing through partnership working).

Objectives:
To reduce acute activity and out of county placements by commissioning integrated pathways and service models across primary, community (including Local Authority services) and secondary care including self-care.

Key projects:
- Reduce Paediatric non-elective admissions with a LOS < 6 hours for West CCG GP practices;
- Improve Asthma care;
- Mental Health: Invest to save scheme to focus on clients with eating disorders;
- Improving Paediatric Diabetes Management.

Quality Opportunities:
- Reduction in avoidable paediatric non-elective admissions and planned care;
- Improve paediatric diabetes management in community setting;
- Improved Asthma pathway leading to earlier diagnosis and improved management of condition in the community;
- Improved community support for children and young people;
- Increased number of children receiving early community mental health intervention;
- Early targeting of vulnerable children to CAMHS and lower tier services. Reduction in higher Tier 4 more expensive treatment.

Financial Savings:
- Improved Paediatric Diabetes management could achieve £11k savings;
- Rollout of the Asthma pathway has the potential to yield savings of £15k.

Key Performance Indicators:
- Reduce number of paediatric emergency admissions for Asthma by 36 admissions from baseline;
- To reduce the number of paediatric emergency admissions for Diabetes by 12 admissions from baseline;
- To reduce the number of <6 hours paediatric non-elective admissions (with no procedure) by 383 admissions (30%) from baseline.

Productivity Opportunity identified for 2012/13: £0.29m
6. QIPP

6.4.8 Cancer

(Supporting CCG Priority 5 – Improve health and wellbeing through partnership working).

Objectives:
To improve cancer outcomes by ensuring cancers are diagnosed promptly, services are compliant with Improving Outcomes Guidance and care is delivered in the most appropriate setting.

Key projects:
- Increase support available to cancer patients in primary/community setting;
- Operationalise the Local Awareness & Early Diagnosis Initiative;
- Implement individualised model of follow up care;
- Implement IOG compliant services for specified services.

Quality Opportunities:
- Reduction in the number of emergency admissions to acute setting;
- End of treatment summaries and care plans issued to patients after radiotherapy and chemotherapy;
- Improved early diagnosis of cancers;
- Improved outcomes for cancer patients.

Financial Savings:
- Reductions in acute emergency admissions has the potential to save £0.1m;
- Reductions in the number of clinical & medical oncology follow-up appointments could save £0.1m.

Key Performance Indicators:
- To reduce the number of emergency admissions for cancer by 26 (1.5%) from baseline;
- Reduce the number of clinical and medical oncology appointments by 661 (17%) from baseline.

Productivity Opportunity identified for 2012/13: £0.18m
6. QIPP

6.5 QIPP Monitoring and Tracking

Detailed project plans, timetables and progress trackers record and monitor progress for each of the programmes throughout the year.

Regular monitoring and progress (through the Programme Management Office) of the QIPP schemes will continue to be a fundamental part of the CCG responsibility and they will be accountable to the NHS Suffolk Board for its delivery until March 2013.

Progress reports are provided to both the CCG Executive Team and NHS Suffolk Executive Management Team (until April 2013). This is supported by monthly scrutiny of QIPP delivery by the CCG Governing Body. A copy of the QIPP milestone tracker and QIPP Key Performance Indicators (KPI) schedules are attached at Appendix ‘D’ and Appendix ‘F’ respectively. This is supported by scrutiny of QIPP delivery by the CCG Governing Body.

Where a QIPP programme is not on track to meet the plan for 2012/13, the Programme Management Office will work with the CCG Executive Team to ensure there is a clear and time limited resolution path to recover. Currently QIPP progress is on track to deliver for 2012/13.
7. Financial Plans

7.1 Financial Plans 2012/13

7.1.1 Background and Approach

The Department of Health issued ‘Baseline spending estimates for the new NHS and Public Health Architecture’ in February 2012. This set out high level estimates for how resources would be deployed under the commissioning architecture proposed in the Health and Social Care Bill. Actual allocations have been based on the configuration of CCGs and on the balance of funding for nationally and locally commissioned services.

7.1.2 CCG Financial Plan 2012/13

The West Suffolk CCG has a robust and detailed financial plan that delivers financial balance, together with any other requirements set by the NHS Commissioning Board.

The financial and activity plans for 2012/13 are aligned to commissioning plans and have been built up from the detailed QIPP schemes being led by the CCG. The overarching assumptions and the financial plans themselves were previously discussed and agreed at CCG committee meetings.

The Financial plan for 2012/13 for the CCG is set out below.

The plan includes a transformational fund of £7.2m which has been set following agreement of key SLA values and confirmation of affordability.

The financial plan is highly dependent on delivery of the QIPP projects outlined in Section 6, totaling £7.9m.
## 7. Financial Plans

### West Suffolk CCG

#### Summarised Financial Plan 2012/13

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<thead>
<tr>
<th></th>
<th>Forecast</th>
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<td>Out of Hours GP</td>
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<tr>
<td>2% Transformational - Other resource</td>
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</table>
7. Financial Plans

7.1.3 Transformation Funding

The proposed areas for use of the £7.2m Transformation Funding held by the CCG is as follows:

![Table showing proposed allocation of Transformation Funding 2012-13](image-url)
7. Financial Plans

7.1.4 Monitoring Delivery of the Financial Plan

Delivery of the financial plan is dependent on delivery of the QIPP savings set out above. Detailed QIPP work plans have been developed, supported by a suite of Key Performance Indicator trajectories. These have been aligned to the financial plan.

The CCG fully appreciated the importance of QIPP delivery and continuing financial balance. Close monthly monitoring and review of progress is carried out by CCG Governing Body on a monthly basis. This includes detailed scrutiny of the financial position, trends and variances from plan in levels of acute activity, and delivery of QIPP KPIs and key milestones. The NHS Suffolk Executive Management Team and Board will continue to receive the same monthly updates until April 2013.

7.2 Activity Projections 2012/13

Acute activity projections have been built up in two stages:

i) Development of a ‘do nothing’ scenario. The latest actual data (October 2010 to September 2011) has been adjusted to take account of known contracting and accounting changes to produce a consistent set of baseline data for 2012/13 planning. Demographic and residual growth assumptions were applied to the baseline data to develop the “do nothing” scenario, provisional values are as follows:

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<th>Age group</th>
<th>Demographic growth</th>
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<td>0-19</td>
<td>0.4%</td>
</tr>
<tr>
<td>20-64</td>
<td>0.2%</td>
</tr>
<tr>
<td>65+</td>
<td>4.5%</td>
</tr>
<tr>
<td>All ages</td>
<td>1.1%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Residual growth</th>
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</thead>
<tbody>
<tr>
<td>Outpatients</td>
</tr>
<tr>
<td>Inpatients</td>
</tr>
<tr>
<td>A&amp;E</td>
</tr>
<tr>
<td>Average</td>
</tr>
</tbody>
</table>

ii) Layering on of the QIPP programmes as set out in Section 6 of this document.

The resulting activity plans for the CCG are set out below:
Work will shortly commence in the preparation of activity forecasts and plans for 2013/14 and beyond as part of the annual planning process cycle. The variation in activity levels between CCGs and growth in activity over time as reported in Appendix ‘E’ – Activity, Spend & Outcome Profile will be considered when setting plans, and will inform the commissioning intentions and planning processes for 2013/14 and beyond.
8. Governance & Accountability

8.1 Governance

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

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

8.1.1 Governance arrangements

The CCG Governing Body meets bi-monthly from January 2013 and has prime responsibility for the scrutiny and approval of strategic and operational plans. The governing body is supported by a weekly Executive meeting and bi-monthly GP locality meetings, where decisions are delegated as appropriate. In addition, the West Suffolk Community Engagement Group will provide scrutiny of strategic and operational plans from a community perspective. All investment decisions over £250,000 have to be made by the governing body.

8.1.2 QIPP Programme Management Office (PMO) arrangements

A Programme Management Office (PMO) approach to tracking delivery of the individual QIPP programmes has been established within the CCG. Delivery is tracked through a quantitative assessment of delivery of a suite of agreed Key Performance Indicators (covering both activity levels and financial spend), and a qualitative assessment of delivery against key milestones.

A weekly progress report is presented to the CCG Executive, detailing current issues (together with any risks and mitigations) and an assessment of whether individual projects are on track to deliver within agreed timescales. Monthly reports of overall progress and Exception Reports are presented to the CCG Governing Bodies alongside financial and acute activity information. This provides assurances around delivery and also provides an opportunity for risks and key issues to be highlighted at an early stage and remedial actions to be discussed and agreed.

8.1.3 CCG QIPP Forum

The CCG hosts a monthly executive level QIPP forum for local providers and government to discuss strategic issues relating to QIPP. This forum therefore discusses issues such as Winter Planning, commissioning intentions, transformation funding, etc.
8. Governance & Accountability

8.1.4 Performance Delivery

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

- performance against key national and local targets;
- key clinical quality and patient safety issue;
- delivery of QIPP;
- financial performance;
- analysis of acute activity.

The Report provides the CCG Executive with a detailed ‘early warning’ system across the performance landscape, highlighting those areas where performance delivery is not in accordance with agreed targets or trajectories. The Report also outlines the mitigating actions being undertaken to address the issues.

A summary of the Report is subsequently presented to the CCG Governing Body on a monthly basis, providing a further level of scrutiny and accountability. An example Integrated Performance Report is attached at Appendix ‘G’.
9. Risks

9.1 Governing Body Assurance Framework (GBAF)

9.1.1 Overview

The Governing Body Assurance Framework (GBAF) provides the CCG with a simple but comprehensive method for the effective and focused management of risk. Through the GBAF, the CCG Governing Body and NHS Suffolk Board gain assurance that risks are being appropriately managed throughout the organisation.

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

The GBAF should be seen as a working document and will be updated regularly by the Executive Management Team, monitored by the Audit Committee and reported to the NHS Suffolk Board on a quarterly basis. The BAF is linked to the corporate Risk Register, the content of which is also provided for review by the relevant sub-committees of the Board. A flow chart setting out how risks are identified and managed is set out overleaf.

In order to ensure consistency in the risk assessment process, the likelihood and consequences of all risks on the Risk Register are assessed against the National Patient Safety Agency (NPSA) 5X5 risk matrix and those scoring 15 and above migrate to the BAF and thereby inform the Trust Board agenda.

The NPSA 5X5 risk matrix and subsequent red, amber, green (RAG) score identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action, and determines whether risks are to be accepted on the basis of the colour bandings and risk ratings. In terms of evaluation of effectiveness, the RAG rating system is also used to present how well the agreed controls are operating.

The GBAF for the CCG is shown in Appendix ‘H’.

The governance arrangements for the management of risk (up until April 2013) are as follows:
UNTIL APRIL 2013, RISKS IDENTIFIED THROUGH:

- Work Stream Risk Assessments
- External Assessment & Audit + Guidance & Alerts
- Serious Incidents, Complaints, Public Health & Quality Issues
- Public & Stakeholder Engagement
- Business & Service Delivery Plans

NHS Suffolk Executive Directors Own & Manage Risks & the Executive Management Team Reviews the Risk Register/GBAF

Clinical Risks Overseen by the Clinical Senate

Governing Body Assurance Framework

Overview & Scrutiny by the Audit Committee

Assurance to Board

Finance & Performance Risks Overseen by the EMT & Shadow CCGs
9. Risks

The governance arrangements for the management of risk after April 2013 are as follows. This is further detailed in the Integrated Risk Management Strategy and Organisational Framework 2013 – 2016 at Appendix ‘I’.
## 10. Appendices:

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
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<tbody>
<tr>
<td>Appendix A:</td>
<td>NHS Commissioning Board: CCG Demographic Profile</td>
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<td>Appendix B:</td>
<td>Public Health profile of the West Suffolk CCG</td>
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<td>Appendix C:</td>
<td>NHS Outcomes Framework 2012-13 Summary – Domains and Indicators</td>
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<td>Appendix D:</td>
<td>West Suffolk CCG Detailed QIPP Plans 2012/13</td>
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<td>Appendix E:</td>
<td>Activity, Spend and Outcome Profile: West Suffolk CCG</td>
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<td>Appendix E1:</td>
<td>Suffolk Milestones Sept 12</td>
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<td>Appendix F:</td>
<td>QIPP Key Performance Indicators 2012/13</td>
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<td>Appendix G:</td>
<td>West Suffolk CCG: Governing Body: Integrated Performance Report</td>
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<td>Appendix H:</td>
<td>West Suffolk CCG: Governing Body Assurance Framework (GBAF)</td>
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### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAA</td>
<td>Abdominal Aortic Aneurysm</td>
</tr>
<tr>
<td>A &amp; E</td>
<td>Accident &amp; Emergency</td>
</tr>
<tr>
<td>ACCORD</td>
<td>Adults and Children's Services Coordination</td>
</tr>
<tr>
<td>ACSC</td>
<td>Ambulatory care sensitive conditions</td>
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<tr>
<td>ACP</td>
<td>Advanced care plan</td>
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<tr>
<td>APC</td>
<td>Area Prescribing Committee</td>
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<td>APS</td>
<td>Admission Prevention Service</td>
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<td>BAF</td>
<td>Board Assurance Framework</td>
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<td>BANS</td>
<td>Back and Neck Services</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>BME</td>
<td>Black and Minority Ethnic</td>
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<td>Clinical Commissioning Group</td>
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<td>Comprehensive Geriatric Assessment</td>
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<td>Do not attempt Cardio-Pulmonary Resuscitation</td>
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<td>HCD</td>
<td>High cost drugs</td>
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<td>IAPT</td>
<td>Access to Psychological Therapies Service</td>
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<tr>
<td>ICRS</td>
<td>Integrated Care Record Service</td>
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<tr>
<td>ICT</td>
<td>Integrated Care Transformation</td>
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<tr>
<td>IFR</td>
<td>Individual Funding Requests</td>
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<tr>
<td>IHT</td>
<td>Ipswich Hospital</td>
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<tr>
<td>IOG</td>
<td>Improving Outcomes Guidance</td>
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<tr>
<td>JAG</td>
<td>Joint Advisory Group</td>
</tr>
<tr>
<td>JNA</td>
<td>Joint Needs Assessment</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
</tr>
<tr>
<td>LARC</td>
<td>Long Acting Reversible Contraception</td>
</tr>
<tr>
<td>LD</td>
<td>Learning Disabilities</td>
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<tr>
<td>LES</td>
<td>Local Enhanced Service</td>
</tr>
<tr>
<td>LETB</td>
<td>Local Education Training Board</td>
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<tr>
<td>LOS</td>
<td>Length of stay</td>
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<td>LSOA</td>
<td>Lower Super Output Areas</td>
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<tr>
<td>LTC</td>
<td>Long Term Conditions</td>
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<tr>
<td>MDT</td>
<td>Multi - Disciplinary Team</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic Resonance Imaging</td>
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<tr>
<td>NCB</td>
<td>National Commissioning Board</td>
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<tr>
<td>NHS</td>
<td>National Health Service</td>
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## Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>NHSP</td>
<td>New-born Bloodspot Screening Providers</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health &amp; Clinical Excellence</td>
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<tr>
<td>NMS</td>
<td>New Medicines Service</td>
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<td>NOM</td>
<td>New Operating Model</td>
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<tr>
<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<tr>
<td>NSFT</td>
<td>Norfolk and Suffolk Foundation Trust</td>
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<tr>
<td>OA HIP</td>
<td>Osteoarthritis of the Hip</td>
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<tr>
<td>OMFS</td>
<td>Oral and Maxillofacial Surgery</td>
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<tr>
<td>OOH</td>
<td>Out of hours</td>
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<td>OP</td>
<td>Outpatient Procedure</td>
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<td>PBR</td>
<td>Payment by results</td>
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<td>PH</td>
<td>Public Health</td>
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<tr>
<td>PMHW</td>
<td>Primary Mental Health Workers</td>
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<tr>
<td>PMO</td>
<td>Programme Management Office</td>
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<td>PPI</td>
<td>Proton Pump Inhibitor</td>
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<tr>
<td>PROMS</td>
<td>Patient Reported Outcome Measures</td>
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<tr>
<td>QIPP</td>
<td>Quality, Innovation, Productivity, Prevention</td>
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<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<tr>
<td>RAF</td>
<td>Royal Air Force</td>
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<tr>
<td>RAG</td>
<td>Red, Amber, Green</td>
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<tr>
<td>SCC</td>
<td>Suffolk County Council</td>
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<tr>
<td>SCG</td>
<td>Specialised Commissioning Group</td>
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<td>SCH</td>
<td>Suffolk Community Healthcare</td>
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<td>SEEDS</td>
<td>Suffolk East Eating Disorder Services</td>
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<td>SEN</td>
<td>Special Educational Needs</td>
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<td>SHA</td>
<td>Strategic Health Authority</td>
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<tr>
<td>SRO</td>
<td>Senior responsible officer</td>
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<tr>
<td>T&amp;O</td>
<td>Trauma &amp; Orthopaedics</td>
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<tr>
<td>TA</td>
<td>Technology Appraisals</td>
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<td>TCS</td>
<td>Transforming Community Services</td>
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<td>TIA</td>
<td>Transient Ischemic Attack</td>
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<td>USAF</td>
<td>United States Air Force</td>
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<tr>
<td>VSGBI</td>
<td>Vascular Society of Great Britain and Ireland</td>
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<td>VTE</td>
<td>Venous Thromboembolism</td>
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<tr>
<td>WSH</td>
<td>West Suffolk NHS Foundation Trust</td>
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