Ensuring high quality healthcare services for the people of South Norfolk

Draft Operational Plan 2017-18 and 2018-19

Release: Draft V2
Date: 23/12/16
**Document Control Sheet**

<table>
<thead>
<tr>
<th>Name of document:</th>
<th>Operational Plan 17-19</th>
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<tbody>
<tr>
<td>Version:</td>
<td>2</td>
</tr>
<tr>
<td>Owner:</td>
<td>Jocelyn Pike</td>
</tr>
<tr>
<td>Date of this version:</td>
<td>23rd December 2016</td>
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**Consultation undertaken:**
Operational plan reflect STP submission October 2016.
Operational plan builds on the system-wide Commissioning Intentions issued to providers in October 2016.

**Synopsis and outcomes of Equality and Diversity Impact Assessment:**
Not undertaken at this stage

**Approved by (Committee):**
Version 1 received by GB 22nd November 2016

### Version control

<table>
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<tr>
<th>Revision date</th>
<th>Summary of changes</th>
<th>Author(s)</th>
<th>Version number</th>
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<tr>
<td>24/10/16</td>
<td>Commissioning intentions draft compiled with feedback from CCG officers</td>
<td>Jocelyn Pike</td>
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<tr>
<td>22/11/06</td>
<td>Draft: Version 1 received by GB</td>
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<tr>
<td>22/12/16</td>
<td>Draft: Version 2 amended to capture feedback from NHSE following submission of Version 1.</td>
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### Approvals and submission

This document requires the following approvals or submission timelines: either individual(s), group(s) or board.

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<td>Submission</td>
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<td>21/10/16</td>
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<td>24/11/16</td>
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<tr>
<td>Submission</td>
<td>Financial Op Plan submission</td>
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<td>Submission</td>
<td>Op Plan (narrative) final submission</td>
<td>23/12/16</td>
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Introduction

Background and principles underpinning this document

South Norfolk CCG’s (‘SNCCG’, ‘the CCG’) 2017-19 Operational Plan (‘OP’, ‘the Plan’) builds on the agreed Commissioning intentions for 17/19. They are further developed in the context of the CCG’s financial position, national planning requirements, and the Norfolk and Waveney 5 year Sustainability and Transformation Plan (STP) – ‘In Good Health’.

The OP reflects the expectations of the Planning Guidance for 2017-19. The nine ‘must-do’s are referenced throughout the document and delivery against these is outlined in the relevant sections.

The OP complements the principles and specific actions outlined in the revised Better Care Fund (BCF) plan – technical guidance (when published), and specifically ‘Better Care for South Norfolk’.

Finance

South Norfolk CCG will finish the 2016/17 financial year with a deficit of £8.7m (Subject to Audit). This is in line with the forecast for the year that had previously been agreed with NHS England. The CCG now plans to maintain that deficit by in 2017/18 and to reduce it by £7.3m in 2018/19.

NHS South Norfolk CCG’s recurrent budget will rise from £270.3 m in 2016/17 to £277.5 m in 2017/18, and to £284.5 m in 2018/19. However these increases are more than taken up by increased costs and pressures. These include:

- National Insurance rises
- “Activity growth” – we have a growing and ageing population
- The amount the CCGs must pass to NHS Trusts is rising – final contractual sums are subject to ongoing planning and agreement.
- Costs previously funded non-recurrently by NHS England or from reserves which are now to be paid for from our allocation
- CCGs will be required to fund some patients previously supported by NHS Specialised Commissioning with no additional revenue predicted
- As with previous years CCGs are required to invest in mental health provision commensurate with any uplift they may receive to their baseline allocation

Headline figures for 2017/18 show the CCG achieving an in-year break even position, but in order to deliver that a financial gap of £14.1m needs to be met. As in previous years the CCG must make efficiency savings to contain costs and get back into financial balance. Quality Innovation and Productivity Plans (QIPP) savings of £14.1 m are planned across South Norfolk in 2017/18 to close the gap between our income and expenditure. These savings represent some 5% of total spending and plans are well advanced to deliver service

‘Business as usual’

The CCG acknowledges that the need to make efficiency savings is not new, it is business as usual. The NHS has been making ongoing efficiencies for many years and we have a duty to make public services as cost effective as possible.

In 2016/17 the CCG’s savings target was £13.9m to year end; the CCG is forecasting to achieve £13.1m of savings (Subject to Audit). Going forward the CCG has, as far as possible, looked to combine improvements in quality of care with better financial management – the two can go hand in hand. For example:

- GP Practices in SNCCG used CCG funding via the Over 75s scheme to recruit multi-disciplinary teams to help keep older patients well at home for longer, rather than need hospital care if their conditions worsen.
- Patients placed in nursing homes on long-term packages of care have been helped to return home sooner
• Doctors and prescribing nurses have been encouraged to use less expensive brands of drugs that are just as effective; members of the public are encouraged to order only the medicines they need to reduce waste.

• Care homes are being given extra advice to manage patients safely

Delivery this level of service change is very challenging and the CCG will not sidestep the really difficult decisions. The financial position meant that, for example, the CCG has not been able to fund a full roll out of the Admiral Nursing service for patients with Dementia and the spot-purchasing of intermediate care beds has ceased, with limited availability by way of exceptionality. These decisions have been taken in dialogue with patients, support groups and local clinicians.

Looking ahead to 2017/18 and 2018/19 the CCG must continue its programme of efficiencies. Examples of our future plans include:

• Helping the principal acute provider develop its Emergency Department and admissions system to ensure only those people who need specialist hospital care are treated there.

• Continuing to ensure patients with long-term conditions receive appropriate packages of care at the right price.

• Tackling ‘Delayed Transfers of Care’ further – helping people return home from hospital sooner.

• Implementing a referral management service in primary care to activity oversee GP referrals in real-time, and offer choice of provider to patients.

• Further local schemes to help keep older and vulnerable patients safe and well at home.

The 2017/19 plan uses current NHS England business rules to set parameters including the requirement to set aside and not commit 1.0% of our total budget to be kept available for non-recurring cost pressures and 0.5% set aside for contingencies. The South Norfolk CCG plan uses the Office of National Statistics data to project changes in patient activity levels and realistic local assumptions based on historic trends for non-demographic growth.

The plan assumes providers will sign the standard NHSE contract for services, and that they will reach agreement on a “Control Total” with NHS Improvement giving them access to the Sustainability and Transformation Fund (STF). A by-product of accessing STF resources is that contracts will no longer be subject to all the standard contract rules on service delivery and as a result no financial benefit is anticipated from some fines or sanctions.

Business rules and activity planning

Business rules

The CCG acknowledges the requirement to comply with the business rules in order for financial plans to be assured. None compliance will be reflected in the CCGs assurance rating.

In accordance with the planning guidance contract negotiation will be completed by December 2016. The principles by which the CCG has entered into negotiations are:

• The CCG is offering the standard NHS contract for the duration of 2 years

• The CCG remains committed to delivering the best care for its population. This is evidenced, in part, by the achievement of all NHS Constitution targets and so the CCG is unlikely to relax any sanctions or reinvest fines as has been the case in previous years.

• The CCG will apply all contractual levers and business rules, irrespective of agreements or discussions undertaken in previous planning rounds. The only deviation from this principle will be where providers are looking to access STF funding with agreed control totals, and a cessation of fines for specific national standards.

• Any movement away from the application of contractual sanctions will be by mutual negotiation.
• The CCG expects providers to adopt Best Practice Tariffs (BPT). The CCG will not offer top-up or duplicate payments.

Activity Planning

The following principles have been applied to activity planning:

• Start at agreed forecast outturn based on Month 6 freeze activity, reflecting necessary adjustments to cover seasonal variation and incorporating patterns of demand through months 7-12.

Then to make activity adjustments on the following basis:

• Application of growth funding in agreed areas under pressure to buy additional activity (elective and non-elective)
• Add activity for confirmed investments in new services
• Adjust activity for the impact of CCG QIPP and BCF plans
• Adjust activity in line with national productivity metrics e.g. fewer outpatient follow-ups
• Ensure accurate allocation (by commissioner) of specialised activity
• Mandated BPT must be included in activity plans
• Demonstrate agreed changes to Local Pricing Structures

Then to make pricing adjustments on the following basis:

• By ensuring that local prices relating to activity growth reflect actual marginal cost of delivering services
• Applying differential pricing adjustments to tariff (tariff minus) where providers restrict the patient complexity that they treat
• Applying differential pricing adjustments to tariff (tariff plus) where providers are impacted by the above
• Ensuring BPT is certified prior to agreement to BPT payments

Demographic profile

JSNA

As part of the planning for the STP, and in recognition of the agreed planning footprint, a revised Joint Strategic Needs Assessment was commissioned from public health.

The document entitled: “NHS South Norfolk CCG – Developing an understanding of health and wellbeing, 2016” (Norfolk County Council, February 2016), provides the following information:

Our Population

• South Norfolk CCG has a resident population of approximately 240,000 people. This includes males: 118,300, (49.3%); females: 121,900 (50.7%).
• There are 25 general practices in South Norfolk CCG; practice list sizes range from 3,496 persons to 18,420 persons with an average list size of 9,209 persons.
• South Norfolk has a relatively higher proportion of people aged 55 and above compared to the Norfolk average. The proportion of people aged 20-24 is less than the county average too.
• The largest increase in population between 2014 and 2030 is anticipated to be in the older age bands. This will have an impact on the scale of services required, how those services are delivered and who is going to deliver them.
• 59% of the population are of working age; around the same as the county rate.
• South Norfolk has a similar population structure to Norfolk as a whole.
• Over the next 20 years, South Norfolk CCG is likely to see much larger increases in people over the age of 75 as a proportion of the whole population.
Deprivation

- South Norfolk CCG is the 52nd least deprived CCG in England, out of 209 scored (IMD 2015).
- At 12.8%, the proportion of children in poverty in South Norfolk CCG is lower than that of England (based on IMD 2010). This still means that around 5,228 children in South Norfolk live in poverty.

Life Expectancy

- Life expectancy for both men and women is higher than the England average for people resident in South Norfolk CCG.
- Over the past ten years, death rates from all causes have fallen. The early death rate from heart disease and stroke has improved in South Norfolk and Breckland. They are now similar to the England average in South Norfolk and better than England average in Breckland.

Children and Young People

- The Infant mortality rate (rate of deaths in infants aged under 1 year) is 3.6% and 4.5% respectively in South Norfolk and Breckland respectively. During 2011-2013, there were 34 infant deaths recorded.
- 70.2% of children in reception year are of a healthy weight. However, although this rate is better than county and national averages, it drops to 51.8% by Year 6 (2013-14 data).
- Overall, levels of obese and overweight children in Year R and Year 6 in South Norfolk CCG are average compared to the rest of the county. About 17.2% of Year 6 children are classified as obese and 31% are overweight. (8.2% and 21.6% at reception year).
- Breastfeeding initiation rates in South Norfolk and Breckland is at 83.4% and 76.1% respectively. They are both above the England average (74.3%).
- Levels of teenage pregnancy are lower than county, regional and national averages in South Norfolk and within the inter-quartile range for Breckland. In 2013, this equates to 82 teenage pregnancies.

Working Age

- An estimated 17.4% of adults smoke and 21.8% are obese. In Breckland its 18.9% and 22.8% respectively.
- In South Norfolk and Breckland smoking contributes about 3100 hospital admissions per year at a cost of about £6 million and about 400 deaths per year
- In South Norfolk, 43% of adults are not achieving the recommended 150 minutes physical activity per week.
- The proportion of mothers who smoke during pregnancy in South Norfolk is 13.9% at South Norfolk and 14.1% at Breckland (2014-15). This is significantly different from the national average.
- There were 783 admissions to hospital for an alcohol related condition in South Norfolk and (596 per 100,000) and 888 admissions in in Breckland (653 per 100,000).
- 5.7% of people in South Norfolk are diagnosed with diabetes, which is similar to the England average, and in Breckland this is significantly higher at 7.1% (2014-15).

Older People

- The estimates for mid-2013 show that the population of South Norfolk is similar to Norfolk as a whole, with 23% of the population aged 65 and over compared with 23% in Norfolk.
- Estimates show in Norwich, 1,941 people have been diagnosed with Dementia. This is a significant increase in the detection rates compared to recent years and equates to 0.8% of total population. This equates to 1,955 diagnosed above age 65 and equates to 3.76% of 65+ population.
• The potential high cost of falls and frequency that they occur highlights the importance of prevention. The Excess winter death rates for South Norfolk & Breckland are within the interquartile range nationally.

Value as a guiding principle

The OP technical guidance and the STP looks to evidence based, value based commissioning. In addition to the benchmarking evidence as outlined, and the local needs assessment being undertaken, the CCG will use NHS Right Care and similar tools to both plan and evaluate service delivery.


The Commissioning for Value packs sent to CCGs in January outlined headline opportunities for the CCG to investigate across the following areas:

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Spend</th>
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</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>Cancer</td>
</tr>
<tr>
<td>Circulation</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Gastro-intestinal</td>
</tr>
<tr>
<td>Maternity</td>
<td>Circulation</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Neurological</td>
</tr>
</tbody>
</table>

A majority of the profiling and subsequent opportunities has also been identified in the benchmarking work undertaken locally. This is good news for South Norfolk as it proves the CCG is already prioritising in the correct areas.

However the pack has offered additional areas for investigation and this is welcomed and reflected in the work programme for the next 2 years.

SNCCG Improvement and Assessment Framework

In 2016, NHS England published a revised assurance framework for CCGs. Using this new Improvement and Assessment Framework (IAF), CCGs receive an overall rating of outstanding, good, requires improvement, or inadequate. In July 2016 the CCG received the result of its annual assessment by NHS England, which rated South Norfolk CCG as ‘Requires Improvement’

Key Areas of Strength / Areas of Good Practice

Appointed a new Chair, Chief Officer, and Head of Primary Care, resulting in the leadership team being almost complete, as well as a strong PMO function being established.

Been able to agree all three main contracts before 25 April 2016.

Achieved QIPP delivery greater than the £5.57m planned position with delivery 18% above plan.

Delivered the NHS Continuing Healthcare trajectory.

 Undertaken good work in turning the CCG around during 2015/16, resulting in the CCG being in stronger position than at the Annual Assurance meeting for 2014/15.

Key Areas of Challenge

Achievement of the planned £14.1m QIPP target following requirements being met in 2015/16 and delivery of in-year surplus by 2017/18.
Ongoing work on the transition from joint commissioning in 2016/17 to fully delegated by April 2017.
Focus is needed on the issues in developing primary care, including predicted population growth.
Improved performance against the IAPT and Dementia standards at NSFT
Ongoing work with partner CCGs to ensure recovery of performance of constitutional standards at the NNUH.

The framework also includes six clinical priority areas:

- Cancer
- Dementia
- Diabetes
- Learning disability
- Maternity
- Mental health

The CCG received the following ratings:

<table>
<thead>
<tr>
<th>Clinical Priority Area</th>
<th>Overall Rating</th>
<th>Indicator Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>57.90%</td>
<td>Needs Improvement</td>
</tr>
<tr>
<td></td>
<td>77.00%</td>
<td>of people with an urgent GP referral having first definitive treatment for cancer within 62 days of referral</td>
</tr>
<tr>
<td></td>
<td>70.50%</td>
<td>of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis</td>
</tr>
<tr>
<td></td>
<td>92.20%</td>
<td>of responses which were positive to the question &quot;Overall, how would you rate your care?&quot;</td>
</tr>
<tr>
<td>Dementia</td>
<td>55.10%</td>
<td>Needs Improvement</td>
</tr>
<tr>
<td></td>
<td>78.90%</td>
<td>Estimated diagnosis rate for people with dementia</td>
</tr>
<tr>
<td>Diabetes</td>
<td>36.50%</td>
<td>Greatest need for improvement</td>
</tr>
<tr>
<td></td>
<td>68.00%</td>
<td>of people with diabetes diagnosed for less than a year who attended a structured education course</td>
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<tr>
<td></td>
<td>0.20%</td>
<td>of GP practices that participated in the National Diabetes Audit</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>55</td>
<td>Needs Improvement</td>
</tr>
<tr>
<td></td>
<td>52%</td>
<td>Rate of inpatients per million GP registered adult population for each Transforming Care Partnership. CCGs are then assigned the score of the TCP they belong to</td>
</tr>
<tr>
<td></td>
<td>10.40%</td>
<td>of people with a learning disability who are on the GP register and receiving an annual health check during the year. Measured as a percentage of the CCG’s registered learning disability population</td>
</tr>
<tr>
<td>Maternity</td>
<td>81.8</td>
<td>Needs Improvement</td>
</tr>
<tr>
<td></td>
<td>62.7</td>
<td>The score out of 100 for women’s experience of maternity services based on the 2015 CQC National Maternity Services Survey</td>
</tr>
<tr>
<td></td>
<td>5.1</td>
<td>The rate of stillbirths and deaths within 28 days of birth per 1,000 live births and stillbirths, reported at CCG of residence level by calendar year</td>
</tr>
<tr>
<td></td>
<td>10.40%</td>
<td>of women who were smokers at the time of delivery</td>
</tr>
<tr>
<td>Mental Health</td>
<td>47.70%</td>
<td>Performing well</td>
</tr>
<tr>
<td></td>
<td>100.00%</td>
<td>of people who were initially assessed as “at caseness”, attended at least two treatment contacts, are coded as discharged, and are assessed as moving to recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>treatment with a NICE-recommended package of care and treated within 2 weeks of referral</td>
</tr>
</tbody>
</table>
Mental Health

In addition to the above, the CCG also received further ratings in respect of mental health provision to inform the ambition and priority areas for 17-19.

<table>
<thead>
<tr>
<th>NHS SOUTH NORFOLK CCG</th>
<th>Percentage compliance with a self-assessed list of minimum service expectations for Children and Young People's Mental Health, weighted to reflect preparedness for transformation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYPMH</td>
<td>65%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crisis Care</th>
<th>Percentage compliance with a self-assessed list of minimum service expectations for Crisis Care, weighted to reflect preparedness for transformation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>OAPs</td>
<td>Percentage compliance with a self-assessed list of minimum service expectations for Out of Area Placements, weighted to reflect preparedness for transformation.</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tbody>
</table>

During 2017/18 and 2018/19, the CCG will continue to focus on maintaining and improving performance against the measures set out in the framework.

Programme Management Office (PMO)

PMO Purpose

The purpose of the PMO is to support the delivery of the QIPP Programme by providing information to enable oversight, scrutiny and challenge. The PMO provides full traceability from strategic plans to the investment in delivering new capabilities and the realisation of benefits. Project delivery and governance is supported via the PMO through the implementation of agreed standardised processes.

Performance Measures

Project Managers use standard templates throughout the lifecycle of a project and report to the PMO about project progress on a weekly basis using a Highlight Report.

Principles Guidance determines the RAG (Red, Amber, Green) rating to be applied to each of the criteria on the highlight report: Project Team, Project Plan, Stakeholder & Engagement, Milestones, Key Performance Indicators, Risk, Benefits Realised, Quality and Equality Impact Assessment and Overall Current RAG Status.
Project Managers must apply the Principles Guidance when selecting the RAG status for each of the criteria in the highlight report. The PMO checks the selected RAG status against the Principles Guidance. This ensures consistent performance measures and provides assurance about reporting.

The PMO is responsible for producing the QIPP Programme Dashboard. The dashboard provides an overview of every project within the QIPP Programme and enables the PMO to report on the overall health of the QIPP Programme.

**QIPP Programme Board**

The QIPP Programme Board, Chaired by the Chief Officer, meets monthly to scrutinise the health of the Programme and approve Project Initiation Documents and Project Workbooks. The QIPP Programme Dashboard is presented for review and scrutiny. A further deep dive meeting is held with the Turnaround Director, Chief Finance Officer and Project Manager when determined necessary for a Red RAG rated project.

**PMO Reporting**

The PMO produces a monthly report on the overall health of the QIPP Programme. This report provides commentary on any Red RAG rated projects. The report is presented at QIPP Programme Board, Finance and Performance Committee and Council of M

Further detail on specific QIPP schemes, risk assessment and PID templates, and the PMO process can be found in the additional submissions to NHSE; namely QIPP scheme summary, and the finance and activity return.

**7 day working**

The OP reflects the ambition of both the Five Year Forward View, the GP Five Year Forward View, and the Five Year Forward View for Mental Health in relation to 7 day working. The STP as a minimum is required to set out local ambitions to deliver 7 day services. In particular improving access and better integrating 111, minor injuries, urgent care and out of hours GP services. In addition, improving access to primary care at weekends and evenings. And, implementing the 4 priority clinical standards for hospital services every day of the week.

**Acute services**

The principal provider of Acute provision NNUH is participating in the regular self-assessments of its provision against the 10 clinical standards identified by NHS England with the results of the next assessment being due to Commissioners in November 2016.

The results of the most recent self-assessment demonstrate that job planning does make provision for consultant led ward rounds every day of the week in the majority of surveyed departments (76%). An average of 30% of patients are assessed by a suitable consultant within 14 hours of arrival, and there is documented evidence that 17% of patients are made aware of their diagnosis, management plan, and prognosis within 48 hours of arrival. There is no significant difference in weekend performance. An average of 5% of patients can access consultant directed diagnostic testing within 1 hour for patients with critical needs, and 2% within 12 hours for patients with urgent needs. Patients do have access to consultant directed interventions 7 days a week in all departments. An average of 34% of patients on AMU, ASU, ITU and other high dependency areas are seen and reviewed twice daily. ITU achieves 100%. Only ASU has a significant reduction over the weekend. Once transferred to a general ward from an acute areas, an average of 15% of patients were reviewed as part of a consultant delivered ward round at least once every 24 hours. There was a significant reduction over the weekend. 10% of patients were made aware of review done by consultants in high dependency areas and made aware of status and changes to their management plans.

These results appear to show that NNUH falls short of achieving equivalent levels of 7 day service for acute patients compared to other acute trusts in England and in our region despite making relatively good provision
for 7 days per week care in terms of consultant ward rounds in most specialities, and 100% availability of consultant led interventions 7 days per week.

This survey exercise was performed independently of the clinical teams by the coding department using only information that could be gained from the medical notes of each patient. The survey was performed in a highly diligent manner with full submission of data for 282 patients so that for instance a ward round would only be labelled as compliant with the standards if the consultants name was clearly legible and if the time was clearly recorded. For future surveys (beginning in September) individual divisions will ensure clinical input so that the results we record accurately reflect the extent of the seven day service we provide. For some standards cross-referencing with other professionals notes and other systems (e.g. RIS) will be required.

**Mental health services**

The mental health taskforce strategy proposes that people facing a crisis should have access to mental health care 7 days a week and 24 hrs. a day.

Specifically STPs are encouraged to focus on 24/7 community-based crisis resolution and home treatment teams for both adults, and children and young people. A 7 day crisis response service with a multi-agency suicide prevention plan. And a 24/7 urgent and emergency mental health response for people attending A&E or admitted as inpatients.

To date the principal provider of mental health services in Norfolk, Norfolk and Suffolk Foundation Trust (NSFT) providing the following services over 7 days:

- Adult acute inpatient services
- Older people acute inpatient services
- Dementia Intensive Support Unit
- Crisis Resolution Home Treatment teams
- Dementia Intensive Support Teams
- Psychiatric Liaison at the Norfolk and Norwich University Hospital Foundation Trust (NNUHFT)
- Police control room team

In addition, and as part of successful bid into the CAMHS Transformation Fund the following services are also now extended to cover 7 day working from 16/17 onwards:

- Crisis Support services to under 18s
- A weekend liaison service for under 18s (at NNUHFT)

As part of 17/19 contract negotiations discussions are ongoing to extend community services to provide full 7 day cover.

Delivery of 7 day working across existing service lines listed is managed through standard contract performance meetings held monthly with NSFT. Any outstanding areas still being negotiated such as community services, will either require further work via the SDIP or an agreed long-stop date.

In addition to the services outlined above there are 2 helplines available to service users 24 hours a day/ 7 days a week.

1. IAPT helpline for registered service users of the IAPT service (now known as the primary care mental health service). This covers clusters 1-4.
2. MIND crisis helpline for any individual who presents with mild to moderate anxiety and depression. There is no requirement to be registered with, or known to, existing mental health services.

**Out of hospital services**

The principal provider of community services, Norfolk Community Health and Care NHS Trust (NCHC) completed the following actions as part of 2016-17 SDIP:

- Mapping of current services provided on a 7 day basis by CCG was completed
- Joint scoping exercise to identify whether benefit in increasing 7 day coverage was completed
- Depending on outcome of scoping; to develop business case for inclusion in 17/18 commissioning intentions – by end September 2016 plans for further development on a service by service basis
included in commissioning intentions 2016-17 and in contract negotiations for 2017-19: developments based on benefit to acute and primary care sectors and to support patient choice e.g. there is a plan for further roll out of evening and weekend appointments for community MSK-Physio

- Explore opportunities for community provider to support achievement of priority clinical standard 5: access to diagnostics – by end September 2016 - this didn’t have a timescale in the contract and wasn’t included in final SDOP report by NCH&C - Tim do you know or shall I check it with NCH&C?
- Quarterly discussion at NCHC SPRG to understand impact on community services with the move to 7 day acute provision. Final report to SPRG in October 2016

Working with primary care in South Norfolk throughout 16/17 will be pivotal in ensuring they are able to match the challenge of 7 day working alongside the other providers listed. The CCG welcomed the move to co-commissioning of primary care with NHSE with effect from April 2016. Allowing CCG greater oversight and input into key decisions such as estates and workforce planning. It has also allowed for far more influential involvement in planning applications and subsequent decisions taken.

The Primary Care section outlines a number of commissioning intentions which over the course of 17/18 will allow practices to embrace 7 day working in accordance with the timelines and milestones set. Specifically implementation of GPFV Improving access programme and Priority 3 of the 2017-19 NHS S Operational Plan,

This includes the development of a primary care strategy to 2021 which should identify the workforce footprint required with a commitment to work across practices and with HEE and academic bodies to attract and retain critical and skilled staff.

The bi-monthly Joint Committee meetings held with NHSE and the CCG will oversee delivery and subsequent roll out.

**Planning for Winter 2017/18**

The CCG, in conjunction with other local NHS and social care partners, will build on the planning undertaken for Winter 2015/16 and 2016/17 by developing the central Norfolk System Winter Resilience Plan further for 2017/18. The development of this plan will be led by the central A&E Delivery Board. This is anticipated to include key mitigation in relation to the following service areas:

- Acute hospital capacity
- Delayed Transfer of Care – Norfolk and Norwich University Hospital NHS Foundation Trust
- Delayed Transfer of Care – Norfolk Community Health and Care NHS Trust
- Social Care (including housing & wider Local Government)
- Ambulance Service
- Primary and Community Services
- Mental Health and Learning Disabilities
- Escalations and Communications
Quality

Quality Assurance.

South Norfolk CCG’s Quality Team will continue to work with all providers to identify areas for improvement and support them in the development and implementation of plans and strategies to make sustained improvements. As co-ordinating commissioner for mental health we will lead specifically on this area on behalf of all CCG’s within the local STP footprint.

The Quality Team will continue to use contractual levers such as CQUINs and increasingly Quality Outcome Frameworks to incentivise continual improvement. Quality schedules and quality scrutiny panels will be utilised to ensure that providers have robust mortality and morbidity review processes in place and comply with requirements to publish avoidable mortality rates, acting as a critical friend confirming and challenging information and monitoring completion of improvement action plans.

The CCG will continue to work collaboratively with the CQC to share intelligence in relation to the quality of commissioned services and will support providers in the development and implementation of action plans in response to CQC inspection findings aimed at improving the quality and safety of services.

Themes from completed inspections will be shared with providers that are yet to be inspected to enable learning, adoption of good practice and proactive management of risk areas. For those providers who are deemed ‘inadequate’ or in ‘special measures’ immediate action will be taken to ensure that there is a safe environment for patients whilst improvements are being made.

Contracts will be managed accordingly where improvements cannot or are not achieved.

Management of incidents

A range of safety data including safety thermometer, incident reporting, claims and complaints to facilitate benchmarking and peer review to support the identification and sharing of best practice will be used. The team will also continue to monitor root cause analysis to further improve the learning from incidents and ability to identify and implement harm reduction strategies.

Robust methods of feedback will continue to be developed, particularly in primary care through our local Quality Issue Reports, to facilitate learning from incidents and encourage increased reporting by demonstrating the positive impact that this can have on improvement.

The team will ensure that mechanisms for staff and patients/carers to raise concerns about the quality or safety of services are accessible and effective ensuring that appropriate action is taken in response to concerns and that this intelligence is triangulated with other sources of information to provide a comprehensive picture of the quality of services being delivered. It will ensure that providers have appropriate systems and processes in place to support patients, their families and carers, as well as staff who have been involved in incidents and will monitor compliance with the duty of candour.

In addition, the team will continue to work to reduce harm in nursing and residential care across South Norfolk. Working with primary care and key providers, the CCG has developed a new model(s) to support care homes through education and clinical support; this model will draw on best practice and successes from around the country and will include elements of education for untrained staff, and additional staff in the community (e.g., nursing, emergency care practitioners, geriatricians, GP’s with Special Interests or pharmacists) with the ability to diagnose and prescribe, and further community-based support around therapies and advice.

CQUINS

The CQUIN scheme will enable providers to earn up to 2.5% of annual contract value if they deliver objectives set out in the scheme.

For 2017/8 and 2018/9 1.5% of the 2.5% will be linked to delivery of nationally identified indicators. For acute and community services, the proposed national indicators cover six areas; there are five in mental health, and two each in ambulance services, NHS 111 and care homes.

The national indicators include:
- NHS staff health and wellbeing
- Proactive and safe discharge
- Reducing 999 conveyance
- NHS 111 referrals to A&E and 999
- Reducing the impact of serious infections
- Wound care
- Improving services for people with mental health needs who present to A&E
- Physical health for people with severe mental illness
- Transition for children and young people with mental health needs
- E-referrals
- Preventing ill health from risky behaviours

The remaining 1% will be assigned to support providers locally. 0.5% will be available subject to full provider engagement and commitment to the STP process.

**Quality Premium**

The Quality Premium (QP) scheme provides a mechanism for rewarding Clinical Commissioning Groups (CCGs) for improvements in the quality of the services we commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services.

As in previous years, we will retain a focus on the fundamentals of everyday commissioning. These include delivery of the NHS Constitution commitments on Referral to Treatment (RTT) Times, A&E, ambulance and cancer waiting times; adhering to quality regulatory standards, and delivering financial balance.

This is a two year Quality Premium scheme. The QP paid to CCGs in 2018/19 and 2019/20 reflects the quality of the health services commissioned by them in 2017/18 and 2018/19. The QP award will be based on measures that cover a combination of national and local priorities, and on delivery of the gateway tests, as described below.

There are five national measures and in total these are worth 85% of the QP. These are as follows:

- Early Cancer Diagnosis 17%
- GP Access and Experience 17%
- Continuing Healthcare 17%
- Mental Health 17%
- Bloodstream Infections 17%

As per the National Guidance the CCG can select one local indicator which will be worth 15% of the QP. The indicator has been selected using the RightCare suite of indicators – as set out in the Commissioning for Value packs, and focuses on an area of unwarranted variation locally which offers the potential for us to drive improvement. The local indicator for 2017/2019 is Diabetes.

The level of improvement needed to trigger the reward will be agreed locally between the CCG and NHS England regional team, ensuring that this is robust and offers a stretching ambition. We will develop and submit our locally agreed indicator definition and level of improvement (as agreed with the Regional Team) early in 2017 via UNIFY.

**Improving Quality in Organisations**

As Commissioners we will actively monitor quality of care in all our providers and seek assurance that Quality Improvement Plans are developed and implemented. Were an organisation is in special measures we will work with that organisation and other regulators such as Monitor and CQC to implement and monitor Recovery Action Plans.
We will use contracts including outcomes and quality standards to actively assure ourselves that providers have both the capacity and capability to meet the requirements of any Quality Improvement Plan.

We will monitor providers’ quality and outcomes closely, and where problems arise that pose a threat to quality, we will use appropriate commissioning and contractual levers to bring about improvements. As Commissioners we recognise that we have a contribution to make in addressing poor performance and poor quality especially where these are driven by the configuration of local services or the setting of local prices in contracts.

**National Quality Boards**

As Commissioners we will actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract. We will use contracts including outcomes and quality standards to actively assure ourselves that providers have sufficient nursing, midwifery and care staffing capacity and capability to meet these.

We will monitor providers' quality and outcomes closely, and where problems with staff capacity and capability pose a threat to quality, we will use appropriate commissioning and contractual levers to bring about improvements. As Commissioners we recognise that we have a contribution to make in addressing staffing-related quality issues, where these are driven by the configuration of local services or the setting of local prices in contracts.

**Review of Deaths**

SNCCG recognises the importance of the learning to be gained through the review of deaths and as such we will work with our partners in NHS England in participating in the annual publication of findings from reviews of deaths including the annual publication of avoidable death rates, and any actions we have to take to reduce deaths related to problems in healthcare locally.

We will work collaboratively with NHSE to resource and roll out the Learning Disabilities Mortality Review (LeDeR) Programme. This will help to identify the potentially avoidable contributory factors related to deaths of people with learning disabilities; identify variation and best practice in preventing premature mortality of people with learning disabilities and support the development of local action plans to make any necessary changes to health and social care service delivery for people with learning disabilities and/or autism.
Sustainability and Transformation Plan – 2016-2021: ‘In Good Health’

The 2017-19 OP compliments the Sustainability and Transformation Plan (‘STP’) 16/17-2021. The OP allows the CCG to take immediate actions as required whilst also starting the process of transformation and innovation. As such the Plan acts as Years 2 and 3 of the STP.

Recognition is given to the STPs status by way of it being the forum for accessing the Sustainability and Transformation Fund, and real-term growth in CCG allocations from 17/18 onwards.

The agreed planning footprint (‘the planning footprint’) in Norfolk consists of: South Norfolk CCG, Norwich CCG, North Norfolk CCG, Gt. Yarmouth and Waveney CCG, West Norfolk CCG, Norfolk Community Health and Care NHS Trust, Norfolk and Suffolk Foundation Trust, Norfolk and Norwich University Hospital NHS Foundation Trust, Queen Elizabeth Kings Lynn NHS Foundation Trust, James Paget University Hospital NHS Foundation Trust, Norfolk County Council.

Five Guiding Principles of the Norfolk & Waveney STP – ‘In Good Health’

1. Preventing illness and promoting wellbeing
Norfolk and Waveney residents will be enabled to live healthy lives for as long as possible, through a spectrum of support: from targeting lifestyle risk factors (e.g. alcohol, obesity) to secondary prevention preventing unnecessary escalation to higher acuity care settings. Strong community services aligned with local authorities and the third sector support independence and increase resilience.

2. Care closer to home
People are supported to live with maximum independence, with improved access to primary and secondary care, and supported by thriving links to the third sector. Enhanced community care delivers the right care at the right time in the right place, reducing demand on acute and residential services. End of Life care is structured to allow patients to die in their place of choice. A system-wide children’s strategy will improve service provision for children and young people.

3. Integrated working across physical, social and mental health
Integrated working across all system interfaces is co-ordinated to deliver holistic care with reduced duplication and gaps in care, and improved patient experience and outcomes. Services recognise the importance of social care and mental health parity of esteem.

4. Sustainable acute sector
Acute services will be configured to be sustainable under future demand pressures through increased provider collaboration. Out of hospital services will reduce demand at the front door, and assist discharge processes to maintain capacity within the acute system.

5. Cost-effective services
Delivered within the finances available – providers and commissioners will work together to realise CIP and QIPP savings, release organisational efficiencies, and remove perverse incentive structures.

Implement agreed STP milestones, so that the Norfolk and Waveney STP is on track for full achievement by 2020/21.

Achieve agreed trajectories against the STP core metrics set for 2017-19.

Include clear and credible milestones

Areas of key impact
Norfolk and Waveney STP work streams have identified areas where they can best positively impact the health and care outcomes of our population and these align along the following system priorities:

- Sustainable physical and mental health, social care and prevention services out of hospital
• Reducing acute activity, including A&E attendances, non-elective (NEL) admissions and inpatient length of stay (LoS) by establishing integrated locality or place based teams responsible for physical, mental and social care
• Improved management of planned care to meet national waiting time standards, and reduce variation and demand
• Adaptive and sustainable workforce

*Delivery of the Norfolk and Waveney STP*

All work streams have identified critical success measures and key performance indicators. These will be used to track progress of our STP delivery. System-level metrics have been identified which will cut across work streams, giving a uniting influence and allowing workforce at all levels to buy into our transformation.

By 2021 the Norfolk and Waveney system ambition is to:
• Have reduced the gap in life expectancy across the county through targeted intervention
• Have a sustainable, integrated primary care model which meets locally defined minimum standards and is easily accessible to all
• Reduce A&E attendances and NEL admissions by at least 20% vs do-nothing forecast
• Reduce NEL acute bed days by at least 35% vs do-nothing forecast
• Have a safe and sustainable acute service capable of meeting key access and quality standards, including RTT, the emergency care standard, and cancer 14, 31 and 62 day standards
• Provide physical, mental and social care through integrated place or locality based teams who work together to help the most vulnerable people manage their physical and mental health better and remain in their community
• Achieve parity of esteem between physical and mental health
Priorities for 17-19

Primary Care

New Models of Care

Through this plan, the CCG will continue to deliver its vision of developing seamless services centred on the patient, with care professionals working across acute, primary, community, mental health and social care; essentially an MCP-type model. This model will enable patients to receive the care they require, at the time they require it, in the least intensive environment that can meet their needs. This will increase the level of care provided at home and within practices, further reducing the number of hospital admissions.

2016/17 has seen the four South Norfolk Localities operate in virtual MCP-type models. The remainder of 2016 and start of 2017 will see Localities move from a Virtual to Partial MCP-type model.

The CCG will bring Primary Care, health and social care, voluntary providers and commissioners together to develop and facilitate seven day clinically lead, integrated (health and social care) primary and community care ‘service wrap around’ transformational hubs.

These hubs will (i) be stable and sustainable, (ii) be patient focused, (iii) be quality driven, (iv) deliver care at the right place at the right time and (v) see more individuals and their carers cared for, holistically, in the community.

Through continued development of the MCP-type model commitment is expected for working across all organisational boundaries and structures, benefiting all people within South Norfolk and increasing opportunities for system efficiencies.

During 2017/18 the CCG will:

- Encourage and support Locality mergers, reducing the number of localities from four to three
- Assist Localities to develop and implement partially-integrated MCP models
- Continue, develop and roll out the work commenced in two Localities on integrated care redesign and clinical hubs, based on the health of the local populations, creating new systems of care delivery, supported by new financial and business models.
- Work with community and primary care providers to integrate and embed community nursing services within primary care.

Quality

The CCG is committed to improving quality of services in general practice and this will underpin all developments in the operating plan going forward.

Based on the requirements as set out in the NHS Outcomes Framework and those in the NHS Full Delegated Commissioning agreement, and in collaboration and engagement with Primary Care, the CCG will develop a Primary Care Quality Assurance Framework which will include:

- review of national and local data in a performance and quality dashboard
- a quality assurance visit program to support practices
- focused actions to improve practice where gaps or concerns identified
- robust governance process to monitor progress and escalate concerns.

Planned Outcomes for 2017-19:

- Increase in the number of patients accessing same day GP appointments
- Increase in the number of patients having access to routine appointments within two weeks
- Improved GP recruitment and retention
- Increased proactive management of LTCs through individual care planning
- Reduce duplication through greater primary and community care integration
- Improved quality of care through better information access and the development of a primary care quality and performance dashboard
- Greater use of IT systems, e.g. EPS, e-referrals and mobile working

The next two years will see:
• (By the 5th December 2016, the CCG will have submitted its application for Full Delegated Commissioning, with the intention of commencement from 1st April 2017.)
• By March 2019, improved access to primary care services for patients through procuring and funding of extra capacity
• Improved clinical outcomes for people living with long term conditions, and ensure they and their carers feel supported. Specifically, the CCG will aim to:
  - Reduce premature mortality due to cardiovascular conditions by improving detection and treatment of hypertension and other risk factors
  - Reduce poor outcomes for diabetics such as leg amputations by helping patients improve their control of blood glucose, blood pressure and cholesterol
  - Reduce hospital admissions in asthmatics
• By June 2017, implement integrated and holistic primary and community health care for Locality populations
• During 2017 see a reduction in variation as to the quality of care, and prevent avoidable referrals and admissions to hospital
• By March 2019, support the sustainability of the wider health and care system through the delivery of more care closer to home and greater focus on prevention
• By May 2017 the CCG will have developed and commence trialling a Primary Care Quality & Performance dashboard, for the intention of establishing minimum thresholds all primary care providers will be expected to achieve.

The “9 must-do’s”
Priority 3 of the 9 priorities outlines in the NHS Operational Planning and Contracting Guidance 2017-19 highlights five key areas for Primary Care:

<table>
<thead>
<tr>
<th>Five Key Areas</th>
<th>The How</th>
<th>Delivery Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment</td>
<td>Stabilization of Primary Care through the implementation of the GP Forward View to include plans for practice transformation support and 10 high impact changes</td>
<td>CCG investment of £3 per head (non-recurrent). Ensure local investment meets or exceeds minimum requirements</td>
</tr>
</tbody>
</table>
| Practice Infrastructure         | ETTF submissions for primary care estates and IT                        | GP mobile working and WIFI                             | March 2017
|                                 |                                                                         | Practice redesign                                       | Cohort 1 (x2) by March 2017
|                                 |                                                                         | Potential new Primary Care new builds                   | Cohort 2 (x4) by March 18 or March 19, dependent on allocation |
| Workforce                       | Engagement with local and nation training and education programmers    | Through:                                               | By March 2017
|                                 |                                                                         | 1) PGP Programme                                        | 2016 onwards
|                                 |                                                                         | 2) GP Leadership Programme                              | 2016 onwards
|                                 |                                                                         | 3) Receptionist Training and document management and or online consultation systems | 2016 onwards
|                                 |                                                                         | 4) GP Resilience Programme & STP Leadership              |                                                        |
| Workload                        | Through:                                                               |                                                        | 2016 onwards |
Engagement with local and nation training and education programmers

| 1) Working with Localities to develop and implement MCP type models |
| 2) Training care navigators and assistants for all practices |
| 3) Clinical pharmacy in general practice |

Care Redesign

| Improved GP Access through the £3.34 available from NHS England in 2018/19 |
| Through: During the spring of 2017, commence work with Primary Care develop an improved access model to include greater timing of appointments, including extended access and increased capacity and use of IT |
| Model to be developed by December 2017. Model procurement to commence early 2018. Model ‘go live’ late 2018. |

As per national guidance, the CCG will develop and submit, by 23rd December 2016, to NHS England one GP Forward View delivery plan.

Out of hospital

The OP supports the ambition for system change in the draft Sustainability and Transformation Plan (STP). The STP envisages the integration of community services strongly linked to acute teams and with the key features of case management, holistic care planning, excellent end of life care, close working between community and voluntary sector organisations, a focus upon supporting people to stay at home to reduce acute admissions

Right Care Areas of Improvement

Focus in out of hospital care on Right Care improvements relating to Injuries resulting from a fall in older people; emergency admissions for respiratory conditions and in epilepsy care for adults will result in programmes in 2017-19 to further develop community services and initiatives to achieve Right Care outcomes

Diabetes

Diabetes remains a key priority for South Norfolk with a plan to work collaboratively with commissioners and providers across the STP footprint on the redesign of diabetes pathways to support best care and to tackle variation in access, service delivery and outcomes. There is noticeable variation between areas within South Norfolk I with prevalence considerably higher in the patient population in the Breckland area: reflecting demographic differences. The plan for 2017-19 includes an increased focus upon education and training; focus on diabetic foot health learning from and expansion of the central Norfolk diabetes prevention programme; implementation of a patient online portal; working collaboratively with patient groups to co-design community pathways and personalisation of diabetes care including the next stage of a personal health budgets plan.

Planned Outcomes for 2017-19

- 3.5% reduction for non-elective admissions for over 65s when compared to 2016/17
- Reduction in avoidable emergency admissions to hospital (including UTI, chest infection and Long term conditions when compared to 2016/17
- Reduction for 2017/18 in the number of emergency admissions from care homes
• Reduction for 2017/18 in the number of calls to 999 from care homes which result in a conveyance to hospital
• Reduction in admissions to residential / nursing care compared to 2016/17
• Increase in the number of people being cared for in their preferred place of care in the last few weeks of life
• Reduction in the number of patients aged 65+ conveyed to hospital by ambulance to below 2016/17 levels
• Evidence of further roll out of 7 day working across additional service lines

Achievement of these outcomes in community care depends upon:
• Collaborative working between commissioners and provider organisations: to align performance measures and STP priorities, to agree shared outcomes, and to develop 2 year service development plans
• Use of findings from research including Vanguard and Right Care to identify opportunities for change and improvement
• The development of shared datasets and outcome measures between organisations within the STP partnership e.g. the agreement of a common reporting dashboard for end of life care to be developed in 2017-18

The next two years will see:
• A continued implementation of integrated services and care pathways within the framework of the Better Care Fund and the South Norfolk QIPP plan.
• A more organised approach to the use of care homes for people with health care needs, reducing intermediate care beds use from the independent sector and the further design of intermediate care to support admission avoidance
• Increased support for care homes to be more effective in managing avoidable admissions through a care home practitioners programme that offers training and work on pathways
• A priority to lead and support system wide work (between Norfolk County Council and the CCGs) to improve workforce retention, ensure a consistent approach to quality assurance and to join up in the commissioning of bed based care where it makes sense to do this.
• Redesign of the ways community based care is delivered: testing approaches and laying the ground for a comprehensive and integrated community based model of care envisaged in the draft STP: including the development of an enhanced rapid community response, review of fast track care at home for patients who are at end of life, Further development of GP locality team working to support multi-speciality
• Improvement in support for people living with long term conditions including: education, self-care, the use of personal health budgets and effective, tailored and targeted community services to manage demand/make best use of available resources

Engagement
• QIPP plans shared with local providers through commissioning intentions for 2017-18 developed collaboratively by commissioning organisations within the STP footprint
• Areas of service improvement and transformation discussed and developed with health and social care operational teams in South Norfolk and across central Norfolk
• Engagement forum with local stakeholders including patient groups to develop and inform the implementation of new model of community care

Key challenges for achieving the NHS England- the 9 ‘must dos’
### Challenges

<table>
<thead>
<tr>
<th>Workforce: The community provider has done good work in looking at staff competencies, skills mix and training in their workforce but, in South Norfolk, recruitment remains a big issue in key areas of work, a relatively high level of the workforce is coming up to retirement, social care also has difficulty in recruiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>New ways of working together presents challenges within the STP footprint in terms of capacity of social care organisations; challenges of maintaining partnerships in difficult financial context; need to increase collaboration with patient groups</td>
</tr>
<tr>
<td>Quality impact on patient care - key is how to free up resources/stop doing some things in order to move to new ways of working</td>
</tr>
<tr>
<td>Financial</td>
</tr>
</tbody>
</table>

### Mitigations

| Development of new models of working |
| Skill mix review |
| Engaging with the STP Primary Community & Social Care work stream |
| Development of partnerships between providers to share training, competence and staff |
| Development of STP Workforce programme |
| Existing strong relationships between health and social care organisations |
| Good examples of working in partnership with patient groups to build on |
| Robust processes for engagement and quality impact assessments |
| Intelligence-driven commissioning of new care models with quality as core |
| QIPP and STP control mechanisms |
| Ongoing efforts to manage demand and patient expectations within new models of care |

### Urgent and Emergency Care

Whilst considerable progress has been made over the previous two years in slowing the rate of non-elective growth, significant pressure still remains on the system. Consistent with the Five Year Forward View, the priority remains on the sustainable delivery of the four hour A&E standard and the five improvement areas of the A&E improvement plan that comes with it.

The solution to a sustainable model of care lies both in the management of patients prior to attendance at a Provider (i.e. the typically transformational change) and then what happens should there not be any alternatives than secondary care.

The primary aim to the management of patients prior to referral is to identify those whose care can be provided in an out of hospital setting and thus minimising onward transfer to 999 and Acute Care. The specific intentions planned for affecting this change involve:

- The development of the integrated clinical hub model (as highlighted in the Urgent Care Review) to manage 111 and 999 calls both in and out of hours. This will be supported by GPs to support multidisciplinary clinical assessment and ensure people are directed to and treated by the most appropriate services including access to primary, social and mental health care. In turn, this will deliver a reduction in the number of 999 calls resulting in transportation to an A&E department.
- The development of Single Points of Access into Providers in order to manage demand, effect clinically appropriate access and aid flow through to discharge and recovery applicable to all Providers including secondary care and mental health. The new operating model will support a reduction in conveyances by appropriate signposting to alternate pathways via the Emergency Clinical Advice and Triage centre within EEAST emergency operations centre (EOC) and utilising
the mobile specialist paramedic staff as a mobile community health service, treating patients in their own home or community.

- The development of a ‘Supported Care’ service focused on providing support to patients to enable them to be care for in their own home, preventing the chances of emergency admission and a potential resulting stay in a community inpatient unit.
- Building on the 2016/17 Frailty CQUIN, CCGs wish to focus on the identification of the pre-frail and align services to support such patients and carers to minimise risk of escalation.

For patients that do attend secondary care the focus will be on front end streaming and coordinated care. This will involve two stage management of patients presenting at A&E with primary care front end operating during weekends to triage and treat minor injuries and illnesses and redirection of patients to the out of hours service where appropriate.

**Planned outcomes for 17-19**

- Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.
- By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.
- Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.
- Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.
- Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.
- From April 2017, mandatory data-sharing agreements for urgent and emergency care providers, enabling commissioners to access cross-provider data about utilisation and effectiveness of services;
- The national transformation and efficiency programmes – Right Care, Continuing Healthcare, New Models of Care, Urgent and Emergency Care, Self-Care and Prevention, Getting It Right First Time (GIRFT), and the Carter productivity programme led by NHS Improvement – will support this process, and learning from early adopters is now available.

**Achieving the A&E standard**

Delivery against the A&E 4hr wait in 16/17 has been inconsistent. Performance against the agreed trajectory has however been delivered with the expectation that the target will be met from month 9. Moving forward any failure to meet this or other standards will be managed via the contract and related contractual remedies.

Delivery of the 4 hour standard requires a whole system approach and the CCG will continue to work with providers to focus on implementing the five mandated initiatives to improve performance:

- Introduce primary and ambulatory care screening in the Emergency Department
- Increase the proportion of NHS 111 calls handled by clinicians
- Implement the Response Programme (Dispatch on Disposition and improved Clinical Coding)
- Implement SAFER and other measures to improve in-hospital flow
- Implement Discharge best practice to reduce DToCs (Discharge to Assess, Trusted Assessor etc)

We expect to continue and embed the reconfiguration of Emergency Department services (ambulatory care and streaming at the ‘front door’) as part of the operating plan.

We are working with the Councils to improve discharge, focusing on enabling ‘discharge to assess’, which will include a re-focus of intermediate care provision.

**NHS 111, Minor Injury Units, GP out of hour’s service and acute GP service**
In line with the national policy around the need for a functionally integrated 111 and Out of Hours Service, which is echoed in local Sustainability and Transformation Plans for Urgent Care, Urgent care is currently under review as part of the urgent care hub initiative.

We are exploring the appropriate configuration of urgent care centres as part of a system redesign of our model of urgent care.

**End of life**

We are seeking to develop end of life crisis intervention teams with a view to provide a likely service model for increasing specialist outreach support from hospices.

**ED Recovery Board**

The implementation of the ED Recovery Board action plan is incorporated into the system wide plan for implementation of the Sustainability Transformation Plan.

It is our intention to work with providers towards an accredited Home Treatment Team.

**Planned Care**

Similar to urgent and emergency care, the focus of the Five Year Forward View (and hence the Norfolk and Waveney STP) is on recovering and maintaining the constitutional standards – specifically RTT performance and Cancer.

Whilst RTT performance hasn’t deteriorated, it remains a challenge and has shown little sign of improving to the mandated standard. The review of the Intensive Support Team acknowledged the need to take a system wide approach to bridging the demand and capacity gap and this is reflected within the objectives of the STP. The IST are working with the NNUH to develop a revised Remedial Action Plan with a trajectory to return to the mandatory standard but the size of the challenge means recovery is not anticipated until around March 2018.

In 2017/18, we will work with Providers to balance demand across the system and utilise the capacity available at JPUH (James Paget University Hospital) and QEH (Queen Elizabeth Hospital). Indeed, work is already underway to review capacity across the Provider base with this in mind. Equally, we will work with Providers to improve internal efficiency, recognising that there are aspects of this which require solutions from CCGs.

As well as the balance of demand across Providers, our QIPP programme for 2017/18 will continue to focus on supporting our Providers in managing demand into secondary care. Demand management is a core component of our QIPP programme and this will be developed across the STP footprint in the coming months. We will continue to monitor and challenge primary care variation with a focus on reducing this where it is unwarranted. The STP focuses heavily on the need to shift activity out of hospital and this will be facilitated through our QIPP programme alongside our Partners.

One aspect of our demand management plan will be establishing an advice and guidance service through the National CQUIN. The existing eRS infrastructure provides a solution to achieving this and is aligned to the direction of travel in referring all referrals electronically. The CCG will work with the NNUH to continue the progress made in 2016/17 and transition to 100% of referrals being received electronically by April 2018.

In recognition of the above, QIPP programmes will focus on the NNUH, working with clinicians in each directorate to understand and scope opportunities for pathway design. This process began in 2016/17 with a clinical led review of a number of specialties and pathways within. That led to the redesign of a foot and ankle pathway, upper GI cancer pathway, commissioning of a specialist epilepsy nurse and introduction of a community treatment service. A staged programme was agreed and 2017/18 will see the commencement of the second round of specialty reviews. These include reviews of those specialties under considerable pressure at the NNUH and those showing significant benefit under 'RightCare'.
The CCG will adopt the ‘RightCare’ approach in doing this and is an active participant in the roll out of Wave Two areas. The CCG has already begun to scope the areas in which an STP approach to ‘RightCare’ would be beneficial (e.g. cancer) but also the areas in which a local approach may be required. Further details on the QIPP approach are detailed within the financial section.

The Sustainability Transformation Plan is also seeking to optimise use of technology to improve people’s experience of care and enable self-care. As part of all pathways we will expect the redesign to optimise use of virtual clinics, alternatives to face to face outpatient appointments and assistive technologies for self-care.

**Planned outcomes for 17-19:**

- Demand reduction measures include: implementing RightCare; elective care redesign; supporting self-care and prevention; progressing population-health new care models such as multispeciality community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes.
- Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).
- Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.
- Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.
- Implement the national maternity services review, Better Births, through local maternity systems.
- Clinical leadership is vital here. The interaction between referrers and receivers can bring dividends. Safe and expert management outside hospital with support from consultants is something that prison health has been working on for many years. Looking at how electives work in countries where distance is problem is another interesting route.

**Maternity**

Following publication of the national Maternity Services Review, the Trust and CCGs undertook a self-assessment of its performance against the standards within. This led to the production of a subsequent action plan which is being implemented. The CCG has equally recognised the findings and aspirations within the Better Births report.

The CCG is currently working with Dame Cumberlege to trial new models of care designed to offer more personalised care to women with continuity in carer. By breaking down barriers across organisations and providing more multi-disciplinary working, care should become safer in turn. A key element of this new model will be better support for post and perinatal mental health where Norfolk CCGs are represented in the national working group.

**Cancer**

The commissioning vision, aims and objectives for cancer care in Norfolk and Waveney are aligned to the new National Cancer Taskforce report, Achieving World Class Outcomes: A strategy for England DH 2015-2020, the national performance indicators for cancer waiting times, Right Care and the new Quality Premium for cancer. Cancer care shall be provided and commissioned as part of the East of England Strategic Clinical Network for Cancer (EOE SCN) and as part of the forthcoming EOE Cancer Alliance.

South Norfolk CCG will continue to work with Providers to achieve world class outcomes and the sustainable delivery of core cancer standards. Currently all national cancer standards are being met with the exception of 62 day; however the expectation is this will be delivered from month 9 in 16/17. Moving forward any failure to meet this or other standards will be managed via the contract and related contractual remedies.

Specific actions to achieve and maintain cancer standards include:
• Continuing to support the integrated care pathways project at the NNUH and JPUH including survivorship, holistic needs assessment and risk stratified pathways across all Providers.
• The implementation of the national cancer taskforce recommendations.
• Reviewing the feasibility and potential implementation of supportive cancer care and chemotherapy administration in the community, building on the transfer of work into the community that has already taken place.
• Supporting the roll out of evidence based best practice cancer pathways.
• Supporting general practice and working with Public Health England to improve earlier cancer diagnosis and prevention.
• Implementation and monitoring of the national quality of life measure for all local cancer patients once it has been published nationally.
• Implementation of the local cancer dashboard in line with national guidance.

Mental health and Learning Disabilities

The CCG is committed to ensuring delivery against the objectives and standards within the Five Year Forward Plan for Mental Health (February 2016). This is reflected within the Norfolk and Waveney STP and the system wide commissioning intentions for 2017 - 2019.

Mental health has a dedicated work stream within the Norfolk and Waveney STP. This will seek to ensure that in the future community mental health service delivery will be embedded within an integrated service approach that is focused on delivery within and/or aligned to Primary Care, that it enables a preventative approach across all ages and supports a reduction in need for urgent and crisis care interventions.

At the time of the re-submission the contract with the principal mental health provider, Norfolk and Suffolk Foundation Trust, has been agreed and in keeping with the timelines for contract negotiation; those of the 23rd December 2016. The financial envelope has allowed for investment into mental health services over and above the requirement to meet Parity of Esteem which all CCGs, including South Norfolk CCG who is in deficit, has met. No divestment has been made in mental health services at a time of increasing austerity and where provider CIPs and CCG QIPPs are also at an unprecedented high. This has been seen as a positive step by all parties to protect and further develop mental health provision thereby allowing for delivery of the Mental Health 5 yr. Forward View.

Transforming Care

Norfolk and Great Yarmouth & Waveney CCG are one of 48 Transforming Care Partnerships formed in December 2015, who are working together to deliver the ambitions of the Learning Disability Transforming Care programme, which aims to significantly re-shape services for people with learning disabilities and/or autism with a mental health problem, or behaviour that challenges, to ensure that more services are provided in the community and closer to home, rather than in hospital settings.

The programme spans 2016/17, 2017/18 and 2018/19 and is sponsored nationally by NHS England and ADDASS.

We are working towards a model of care that uses fewer inpatient beds both in NHS settings and those in the private care sector. We will go further still to support people in out of hospital settings above and beyond these initial planning assumptions.

The Transforming Care Principles and expectations are supported by a new Service Model for commissioners across health and care that defines what good services should look like. Locally a new Implementation Steering Group is in place which consists of work stream leads and other key members of the programme team from Local Authority, CCG’s and NHSE specialised commissioning.

Norfolk and Great Yarmouth and Waveney Joint Transforming Care Plan was submitted and approved by NHSE in July 2016, the plan was agreed and signed by all CCG’s and NCC. Norfolk and Great Yarmouth
Waveney Trajectory to reduce inpatient numbers has been set and agreed with the aim of reducing the total number of inpatients to 12 by the end of 2019.
The plan has been developed and is being delivered in co-production with Opening Doors who represent service users and carers.
We have already commissioned a new Enhanced Assessment and Treatment Service which is now operational and are looking to further extends this and other new services such as a community Forensic Team in 2017/8 pending the outcome of the next funding round.
Work has commenced on the redesign of Children’s and Adults Care pathway’s focussing on early intervention and prevention. These care pathways will be implemented in 2017/18.
Following a successful capital grant bid two proposed housing schemes will continue to be developed in 2017/18 in collaboration with Norfolk County Council.

Next Steps for 2017/8:
- Standardisation of existing Risk of Admission Register (RoAR) Development of Dynamic Support Register
- Create shared data base across all CCG’s and NCC to hold and manage the Dynamic Risk Register.
- Commence work on Learning Disability Strategy for 2016 - 2020
- Provider engagement with event to take place in 2017.
- Financial modelling and development of risk share to agree how costs transferring from NHSE to CCG’s and to NCC as patients move to a community support model of care are apportioned.
- Completion of Business Cases to support new NHSE bid scheme opened December 2016 to include:
  - CAMHS ADHD/ASD
  - LD Forensic Community Team
  - Extended EATS team

Reduce inpatient bed capacity by March 2019 to 10-15 in CCG commissioned beds per million population
The local plan describes how we will fully implement the national service model including alignment to the Transforming Care principles and expectations starting with the national planning assumptions set out in Building the Right Support.
These planning assumptions are that no area should need more inpatient capacity than is necessary at any one time to cater to:
- 10-15 inpatients in CCG-commissioned beds (such as those in assessment and treatment units) per million population
- 20-25 inpatients in NHS England-commissioned beds (such as those in low-, medium- or high-secure units) per million population

**Final trajectories submitted to DCO teams 11/12/16 and UNIFY 23/12/16**

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<thead>
<tr>
<th></th>
<th>Year 2 (2017/18)</th>
<th>Year 3 (2018/19)</th>
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<td>as at 30/06/17</td>
<td>as at 30/06/18</td>
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<td><strong>inpatients</strong></td>
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<td>19</td>
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<tr>
<td><strong>Inpatient Rate</strong></td>
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<td><strong>registered</strong></td>
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<td><strong>CCG</strong></td>
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<td><strong>commissioned</strong></td>
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<tr>
<td><strong>inpatients</strong></td>
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<td>17</td>
</tr>
<tr>
<td><strong>Inpatient Rate</strong></td>
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<td>20.40</td>
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<tr>
<td><strong>registered</strong></td>
<td>26.40</td>
<td>19.20</td>
</tr>
<tr>
<td><strong>population</strong></td>
<td>25.20</td>
<td>19.20</td>
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<tr>
<td><em><em>Total No. of Inpatients with learning disabilities and/or autism</em> (TCP level; and by TCP of origin)</em>*</td>
<td><strong>2017/18</strong></td>
<td><strong>2018/19</strong></td>
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<tr>
<td></td>
<td>44</td>
<td>36</td>
</tr>
<tr>
<td><strong>Total Inpatient Rate per Million GP Registered Population</strong></td>
<td><strong>2017/18</strong></td>
<td><strong>2018/19</strong></td>
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<tr>
<td></td>
<td>52.80</td>
<td>43.20</td>
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</table>

**Improve access to healthcare for people with LD so that by 2020 75% of people on a GP register are receiving an annual check**

SNCCG is working with Primary Care to improve healthcare for people with Learning Disability. The following actions have been agreed as part of joint action plan:
- Triangulation of Data between NHS England, GP Practices and Norfolk County Council (NCC)
- GP Practice Engagement including:
  - Develop an understanding of GP experience regarding physical health checks.
  - Establish what GP’s are currently doing and their views on how to improve the number of LD patients having annual physical health checks
  - Establish what support the GP practice would require to improve LD physical health checks
- Identify challenges affecting compliance levels
- Support GP Practices with sharing good practice - screening tools, appointments
- Develop Standard Operating Practice (SOP) involving GP Practices including:
  - Recommendations
  - Individual Practice Action Plans
  - Duties within Practices
  - Escalation
  - Monitoring
- Identification of Resource within NCH&C to support with improving compliance

**Reduce premature mortality by improving health services, education and training staff, and by making necessary reasonable adjustments for people with LD and/or autism**

SNCCG will continue to commission high quality, cost effective general and specialist health services for people with learning disabilities. It will also continue to work collaboratively with Local Authorities and others to address the social factors which adversely affect the health of people with learning disabilities.

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1The rates per population will be based on GP registered population aged 18 and over as at 2014/15
This will include ensuring that we are implementing annual physical health checks for people with learning disabilities and/or autism; delivery of immunisation programme for flu especially in vulnerable groups; making sure that all our providers have specialist nurses and are complying with the Greenlight Toolkit to make reasonable adjustments for people with learning disability and/or autism and that we are regularly auditing the care given to patients with learning disability.

SNCCG also recognises the importance of the learning to be gained through the review of deaths for people with a learning disability and/or autism in reducing premature mortality. As such we will work with our partners in NHS England to resource and roll out the Learning Disabilities Mortality Review (LeDeR) Programme. This will help to identify the potentially avoidable contributory factors related to deaths of people with learning disabilities; identify variation and best practice in preventing premature mortality of people with learning disabilities and support the development of local action plans to make any necessary changes to health and social care service delivery for people with learning disabilities and/or autism.

Quality

SNCCG as the co-ordinating commissioner for mental health will continue to work with all providers to maintain and improve patient’s experience and outcomes. Specifically we will work collaboratively with Norfolk and Suffolk Foundation Trust in the delivery of the CQC Action Plan following their recent re-inspection that saw them removed form Special Measures but still ‘requiring improvement’.

Outcomes

Key outcomes are to ensure the implementation of Five Year Forward for Mental Health requirements (see pages 7-8) and in addition to these support the development of improved pathways for children, young people and adults with neurodevelopmental conditions such as ASD and ADHD.

NHS England ‘9 must do’s’

<table>
<thead>
<tr>
<th>Must Dos</th>
<th>Actions</th>
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</table>
| 1 - Implement STP | Continued delivery of the mental health objectives within the Norfolk and Waveney STP and CAMHS Local Transformation Plan. The STP covers 4 main programme areas for mental health:  
- Redesign urgent response within the community.  
- Integration of mental and physical health  
- Improving community mental health services  
- Expanding dementia support  
Detailed project plans will be in place to drive the core programme areas in early 2017.  
In line with STP financial plans investment has been made to mental health services within Norfolk at least in line with parity of esteem requirements. The CCGs working with providers will actively seek to coordinate joint approaches to securing national funding to support the STP delivery in line with those areas set out within the Five Year Forward Plan for Mental Health. Linkage between the priorities within the STP and the Five Year Forward Plan for Mental Health have been outlined with cross cutting themes across the STP clarified |
| 4 – Urgent and Emergency Care | Norfolk and Waveney CCGs are joint funding along with NSFT and Suffolk CCGs Mental Health Strategies are taking forward a capacity review of adult mental health services, focusing on acute care, beds and the balance of this with community services.  
The completion of a review of mental health acute and crisis care pathways (including within this mental health liaison services within Acute hospital settings) ensuring that the review takes into account national access and quality standards and that this includes an assessment of services against the Core 24 standards.  
The review work will be completed by end of quarter 2 17/18, with agreed and |
adjusted acute care-pathways implemented from early 2018. The Norfolk and Waveney system is in preparation and planning stage to ensure a proposal is forwarded for the Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care funding

Securing increased capacity in CAMHS Crisis Care pathways supported via LTP investment is a core and agreed plan within the Norfolk and Waveney system

<table>
<thead>
<tr>
<th>7 – Mental Health Five Year Forward Objectives.</th>
<th>The following key elements of mental health service delivery will be reviewed to determine future models of care:</th>
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<tbody>
<tr>
<td></td>
<td>• Elements of the Adult Mental Health services that are jointly funded between Norfolk CCG’s and Norfolk County Council. The Mental Health Transformation Plan for Norfolk is in two parts, part 1 has been subject to a tendering exercise and part 2 is in the planning stage for procurement in 2017</td>
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<td>• Dementia services, including within this ensuring that this is aligned to the forthcoming guidance focusing on post diagnostic support.</td>
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<td></td>
<td>• Child and Adolescent Mental Health Services, ensuring future delivery complies with national expectations and local needs.</td>
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<td></td>
<td>The CCG will work proactively with providers to deliver planned and future service developments are fully implemented and that expected access and quality standards are met. Including the following:</td>
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<td>• IAPT Enhanced Care Pathways which will support the Primary Care Mental Health Service (PCMHS) to drive up recovery rates for patients within the core IAPT cohort ensuring compliance against national recovery standard expectations by June/July 2017 (trajectory for this currently being finalised with the provider).</td>
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<td>• The completion of a PCMHS post implementation review in early 2017, which will take into account the national expectation to increase access to IAPT services so that at least 19% of people with anxiety and depression access treatment and consider the further integration of service delivery within Primary Care.</td>
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<td></td>
<td>• Implementation of CAMHS LTP projects supporting the access to provision through the development of a Norfolk and Waveney wide single point of contact shared between the two main CAMHS services. LTP funding and developments will also see increased capacity in eating disorder services, ensuring that provision supports delivery against national standards with 95% of children and young people receiving treatment within 4 weeks for routine referrals and 1 week for urgent cases. LTP investments will also increase support for children and young people affected by domestic abuse and sexually harmful behaviours.</td>
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<td></td>
<td>• A review of the outcomes of the Mental Health Strategies capacity review of NSFT acute and associated adult community provision will be taken forward from February 2017, with recommendations agreed between CCGs and NSFT in relation to service developments/adjustments required to ensure pathways work to best effect and to significantly reduce out of area placements.</td>
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<td>• The development of integrated mental health provision focused around MCP models resulting in closer aligned service provision and integrated working between Mental Health and Primary Care services.</td>
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<td></td>
<td>• Investments have been made to NSFT to support a reduction in suicide rates and the CCG will work proactively with Public Health and wider partners in the further development of wider suicide prevention strategy(s).</td>
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as appropriate and will seek to jointly apply for national funding in support of this.

• Increased capacity within NSFT will enable the expansion of provision to Early Intervention in Psychosis (EIP) patients, meaning a stepped change will be achieved in access to treatment within 2 weeks.
• The Community Specialist Perinatal service will be developed during 2016/17 to cover the Norfolk and Waveney system. Over 300 women and their families will receive direct interventions from this service in 2017/18 rising to 525 women in 2018/19. The service will link directly to the newly commissioned regional Mother and Baby Unit.

The CCG is working across the Norfolk and Waveney CCGs will also ensure that any additional national investment made available to CCGs over the next two years will be invested in line with enabling delivery against national access and quality standards as appropriate.

**Engagement**

The CCG continues to liaise within it member practices in relation to mental health service provision via its locality meetings and seeks to engage service user/patient representation in key aspects of commissioning activity.

**Challenges**

Demand for mental health services across all ages continues to rise. In order for the system to better support this whole system change is needed ensuring that future provision sees mental health care embedded within future delivery models. Current challenges include:

• Progress against meeting national access and quality expectations and in particular that for EIP.
• The main provider of mental health services (NSFT) although now not in special measures has still been inspected and graded as requiring improvement.
• Balancing ongoing service changes against the developing and emerging vision for future integrated service delivery.
• Key pathway and service gaps in delivery within the Thetford area of SNCCG, which require a clear clinical response from the provider and a more robust commissioning approach.
• The CCG remains behind trajectory in its plan to reach the expected dementia diagnosis rate. An updated trajectory and action plan are in place with the aim of stepping up performance against the national expectation of 67% and meeting this by October 2017. Key actions being taken forward include:
  o Working with NSFT to ensure staff are effectively communicating the outcome of dementia assessments via the standardised use of an agreed letter template.
  o Work within care home to help drive up dementia diagnosis for residents
  o Driving up the recovery conversion rates from assessment to diagnosis within NSFT memory clinics.
• In 2014/15 the hospital admission rate for self-harm in young people was higher than the national average.
• Acute care pathways and in particular liaison services within the NNUH require further development and this needs to ensure effective crisis care responses across all age ranges within appropriate timescales.
• There remains an issue with out of Trust placements.

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Mitigations</th>
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<tr>
<td>Complex commissioning and planning landscape</td>
<td>Clearer and where possible more simplified governance routes need to be further developed and a more clearly defined and managed strategy to the commissioning of</td>
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mental health services is needed. Good steps have been taken with the development of the STP and LTP, which will form a basis of a more programme led approach to the further development and strategic to commissioning.

Capacity for change: Managing on going service developments during a progress of whole system change.

SNCCG will work closely with all its mental health providers to seek a balance between the implementation of beneficial service developments that are needed to support demand management and improve service quality with wider work that the providers and Commissioners are engaging with to determine future integrated service deliver models.

Inability to meet national access and quality standards within expected timescales.

Ensuring badged national funding as outlined in Mental Health Five Year forward is secured. Further develop provider reporting mechanisms in relation to these to ensure effective monitoring and the early identification of problem areas.
Ensuring service provision developed within wider whole systems approach and this is supportive of enabling adherence to national requirements.
Realignment of existing capacity to enable a more community focused preventative approach to service delivery.

Workforce: skill levels, recruitment and retention.

Continued engagement with providers to monitor workforce issues. Ensuring full engagement of mental health within STP workforce work stream.

Children and families

The CCG is committed to ensuring that a key focus remains on the development and delivery of children and family services. This in the main will be taking forward through ensuring that their oversight and development is embedded within the wider commissioning and system wide transformations taking place across Norfolk and Waveney and in particular within the STP.

Another key area is the implementation of the CAMHS LTP – please see the Mental Health section for further information.

Lastly the CCG remains committed to ensuring that it is moving forward with the further development of joint commissioning approaches across the Norfolk and Waveney CCG’s and Norfolk County Council and in particular in relation to the joining up of commissioning of services for children and their families with Special Educational Needs and Disability (SEND).

The children and families section needs to be read in conjunction with the details contained within the Primary Care, Community, Acute and Mental Health services section of this plan. In addition to the plans set out within these other sections the CCG plans for the delivery of children and families services contribute to achieving the 9 ‘must-dos’ and the STP. This includes undertaking the national maternity services review, increasing the number of services provided within the community, as well as a number of local priorities, to deliver the following outcomes:

Quality
SNCCG will continue to work with colleagues across the STP to improve service user experience and outcomes for children and young people. We will continue to implement the SEND recommendations as defined in the Children and Families Act that came into force on September 2014. We will work collaboratively to improve the experience of children and young people with SEND and their families and to ensure that they get the support they need, focusing on relevant outcomes that matter to them. This will ensure that outcomes improve for these young people from birth to 25 and that they are supported by more joined up approaches across education, health and care.

Outcomes

- Improved pathways for children, young people and adults with neurodevelopmental conditions such as ASD and ADHD.
- Reduce unplanned paediatric admissions to hospital.
- Children with continuing care needs do not remain in hospital unnecessarily and have their needs met in a timely way.
- Appropriate implementation of the national maternity services review.
- Improved Children’s Community Nursing Team (CCNT) services.

The outcomes outlined above will be achieved through taking forward the following:

- Continued delivery of the mental health objectives within the Norfolk and Waveney STP and CAMHS Local Transformation Plan and in particular for this section the focus within this on ASD and ADHD.
- Ensuring children and family services are fully considered and developed within the STP framework, where needed
- Undertaking a system wide approach to reducing unplanned paediatric admissions to hospital as highlighted by Right Care and the STP
- Review of the local arrangements and service availability for children and young people with continuing care needs, including:
  - Establishing case management
  - Expansion of personal health budgets
  - Ensuring care is available at the right place and right time
  - Market development.
- Implementing a new model for short break services, including a review of CCNT to include training of delegated clinical procedures
- Further development of joint commissioning across the CCGs and NCC
- The CCG will scope current neurodevelopment services and seek to simplify the pathways of care for children with ASD and ADHD. Where required this will be taken forward via service re-design and development.
- Delivering Transforming Care partnership plans with our local government partners, enhancing community provision for people with learning disabilities and/or autism

Engagement

The CCG will continue to engage with children and young people and their parent/carers as well as voluntary and statutory organisations in key aspects of commissioning activity, where appropriate. Family Voice and Healthwatch will remain involved in our commissioning activities, and we will also utilise the Local Authority’s Youth Advisory Boards.

Challenges

- The rate of emergency admissions for children and young people is increasing, with problems of the respiratory system the most common cause in children ages 0-4. As children become older, the leading cause is ‘injuries and poisonings’.
- The rate of hospital admissions for accidental and deliberate injuries in children and 0-14 is statistically above the national average.
- No formal agreement of the draft SEND Joint Commissioning Framework has been achieved and the picture for joint commissioning between the CCGs and NCC remains complex.

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<thead>
<tr>
<th>Challenges</th>
<th>Mitigations</th>
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<tbody>
<tr>
<td>Ensuring children and families services are prioritised where appropriate within system wide service developments.</td>
<td>The CCG will work to champion where appropriate the needs of children and young people within STP planning and implementation. It will also seek to ensure the further development of joint commissioning with NCC for children with SEND.</td>
</tr>
<tr>
<td>Workforce: skill levels, recruitment and retention.</td>
<td>Continued engagement with providers to monitor workforce issues. Ensuring full engagement of mental health within STP workforce work stream.</td>
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