Operational Plan 2014-16

Version 9

11th July 2014
Document Control Sheet

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Revision History

<table>
<thead>
<tr>
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<tr>
<td>13/2/14</td>
<td>Draft V1</td>
<td>Louise Browning</td>
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<td>Louise Browning</td>
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Approvals

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# Glossary

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ACB</td>
<td>Acute Commissioning Board</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>AHSN</td>
<td>Academic Health Science Network</td>
</tr>
<tr>
<td>AQP</td>
<td>Any Qualified Provider</td>
</tr>
<tr>
<td>ASC</td>
<td>Ambulatory Sensitive Conditions</td>
</tr>
<tr>
<td>ASD</td>
<td>Autistic Spectrum Disorder</td>
</tr>
<tr>
<td>AT</td>
<td>Area Team</td>
</tr>
<tr>
<td>BCF</td>
<td>Better Care Fund</td>
</tr>
<tr>
<td>C&amp;B</td>
<td>Choose &amp; Book</td>
</tr>
<tr>
<td>CAUTI</td>
<td>Catheter Acquired Urinary Tract Infection</td>
</tr>
<tr>
<td>CAMHS</td>
<td>Children’s &amp; Adolescent’s MH Services</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CCNT</td>
<td>Children’s Community Nursing Team</td>
</tr>
<tr>
<td>CFS</td>
<td>Chronic Fatigue Syndrome</td>
</tr>
<tr>
<td>CHC</td>
<td>Continuing Health Care</td>
</tr>
<tr>
<td>CHD</td>
<td>Coronary Heart Disease</td>
</tr>
<tr>
<td>CIP</td>
<td>Cost Improvement Programme</td>
</tr>
<tr>
<td>CNUCN</td>
<td>Central Norfolk Unplanned Care Network</td>
</tr>
<tr>
<td>CoM</td>
<td>Council of Members</td>
</tr>
<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
</tr>
<tr>
<td>CPA</td>
<td>Care Programme Approach</td>
</tr>
<tr>
<td>CPS</td>
<td>Crown Prosecution Service</td>
</tr>
<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>CQRM</td>
<td>Clinical Quality Review Meeting</td>
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<tr>
<td>CQUIN</td>
<td>Contracting for Quality and Innovation</td>
</tr>
<tr>
<td>CRN</td>
<td>Clinical Research Network</td>
</tr>
<tr>
<td>CVD</td>
<td>Cardiovascular Disease</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose &amp; Throat</td>
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<tr>
<td>DASH</td>
<td>Disability and/or Additional Healthcare Needs</td>
</tr>
<tr>
<td>DCLG</td>
<td>Department for Communities &amp; Local Government</td>
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<td>DH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DHR</td>
<td>Domestic Homicide Review</td>
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<tr>
<td>DoLS</td>
<td>Deprivation of Liberty Safeguards</td>
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<td>EASC</td>
<td>Emergency Ambulatory Sensitive Conditions</td>
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<td>EDS</td>
<td>Equality Delivery System</td>
</tr>
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<td>EEAST</td>
<td>East of England Ambulance Services NHS Trust</td>
</tr>
<tr>
<td>EoE</td>
<td>East of England</td>
</tr>
<tr>
<td>EoL</td>
<td>End of Life</td>
</tr>
<tr>
<td>EPAU</td>
<td>Early Pregnancy Assessment Unit</td>
</tr>
<tr>
<td>EPOC</td>
<td>Effective Practice and Organisation of Care Group (Cochrane)</td>
</tr>
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<td>ERPHO</td>
<td>East of England Public Health Observatory</td>
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<td>FAP</td>
<td>Frequently Admitted Patients</td>
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<td>FFT</td>
<td>Friends &amp; Family Test</td>
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<td>FOP</td>
<td>Frail Older People</td>
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<td>FOPP</td>
<td>Frail Older People’s Project</td>
</tr>
<tr>
<td>FT</td>
<td>Foundation Trust</td>
</tr>
<tr>
<td>GB</td>
<td>Governing Body</td>
</tr>
<tr>
<td>GBAF</td>
<td>Governing Body Assurance Framework</td>
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</table>
GP General Practitioner
GSF Gold Standards Framework
HALO Hospital Ambulance Liaison Officers
HCA Health Care Assistant
HCAI Healthcare Associated Infection
HEE Health Education England
HEI Health Environment Inspectorate
HR Human Resources
H&WBB Health & Well Being Board
IAPT Improving Access to Psychological Therapies
ICO Integrated Care Organisations
IP&C Infection Prevention & Control
IM&T Information Management and Technology
IST Intensive Support Team
IV Intravenous
JHWS Joint Health and Wellbeing Strategy
JPUHFT James Paget University Hospital Foundation Trust
JSNA Joint Strategic Needs Assessment
KPI Key Performance Indicator
LA Local Authority
LAC Looked After Children
LD Learning Disability
LOS Length of Stay
LT Leadership Team
LTCs Long Term Conditions
MCA Mental Capacity Act
MDT Multidisciplinary Team
ME Myalgic Encephalopathy
MFE Medicine for the Elderly
MH MH
MONITOR NHS Foundation Trust Regulator
MRI Magnetic Resonance Imaging
MRSA Methicillin Resistant Staphylococcus Aureus
MSK Musculoskeletal
MSOA Middle Layer Super Output Area
NCC Norfolk County Council
NCHC Norfolk Community Health & Care
NELCSU North East London Commissioning Support Unit
NEPTS Non Emergency Patient Transport Service
NHS National Health Service
NHSE NHS England
NHSIC NHS Information Centre
NICE National Institute for Health and Care Excellence
NIHR National Institute of Health Research
NCCG Norwich Clinical Commissioning Group
NNCCG North Norfolk Clinical Commissioning Group
NNUHFT Norfolk and Norwich University Hospitals Foundation Trust
NRRLS National Reporting & Learning System
NSCB Norfolk Children’s Safeguarding Board
NSFT Norfolk and Suffolk NHS Foundation Trust
OOH Out of Hours
PANSI Projecting Adult Needs and Service Information
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<td>PbR</td>
<td>Payment by Results</td>
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<td>PMS</td>
<td>Primary Medical Services</td>
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<tr>
<td>POPPI</td>
<td>Predicting Older People Population Information</td>
</tr>
<tr>
<td>PPG</td>
<td>Patient Participation Group</td>
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<tr>
<td>PTL</td>
<td>Primary Targeting List</td>
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<tr>
<td>Qaly</td>
<td>Quality Adjusted Life Year</td>
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<tr>
<td>QEHLFT</td>
<td>Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust</td>
</tr>
<tr>
<td>QIP</td>
<td>Quality, Innovation, Productivity and Prevention</td>
</tr>
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<td>QOF</td>
<td>Quality and Outcomes Framework</td>
</tr>
<tr>
<td>QR</td>
<td>Quality Requirements</td>
</tr>
<tr>
<td>R&amp;D</td>
<td>Research &amp; Development</td>
</tr>
<tr>
<td>RCPCH</td>
<td>Royal College of Paediatrics &amp; Child Health</td>
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<tr>
<td>RTT</td>
<td>Referral to Treatment</td>
</tr>
<tr>
<td>SNHIP</td>
<td>South Norfolk Health Improvement Partnership</td>
</tr>
<tr>
<td>SPA</td>
<td>Single Point of Access</td>
</tr>
<tr>
<td>SCN</td>
<td>Strategic Clinical Network</td>
</tr>
<tr>
<td>SCR</td>
<td>Serious Case Review</td>
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<td>SEND</td>
<td>Special Educational Needs &amp; Disability</td>
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<td>SI</td>
<td>Serious Incident</td>
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<tr>
<td>SNCCG</td>
<td>South Norfolk Clinical Commissioning Group</td>
</tr>
<tr>
<td>SNC</td>
<td>South Norfolk District Council</td>
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<td>TIA</td>
<td>Transient Ischaemic Attack</td>
</tr>
<tr>
<td>T&amp;O</td>
<td>Trauma &amp; Orthopaedics</td>
</tr>
<tr>
<td>UTI</td>
<td>Urinary Tract Infection</td>
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<td>VFM</td>
<td>Value for Money</td>
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<td>VTE</td>
<td>Venous Thrombo-Embolism</td>
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<td>WSHFT</td>
<td>West Suffolk Hospital Foundation Trust</td>
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<td>2ww</td>
<td>Two Week Wait</td>
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National Background & Context

This section gives an overview of the national context in which South Norfolk Clinical Commissioning Group (SNCCG) is working and key areas of healthcare policy guiding our planning and commissioning process.

Introduction

NHS England’s publication “Everyone Counts: Planning for Patients 2014/15 to 2018/19” establishes the approach for CCGs to work with providers and partners in local government to develop strong, robust and ambitious five year plans to secure the continuity of sustainable, high quality care for all.

This document emphasises the need for an outcomes focused approach to planning, aligned to the NHS National Outcomes Framework, and for Clinical Commissioning Groups (CCGs) plans to reflect stretching local ambition over the next 5-year period.

SNCCG Strategic Plan 2014/15-18/19

SNCCG has joined together with North Norfolk CCG (NNCCG) and Norwich CCG (NCCG) to work as one strategic unit of planning particularly in relation to the interface with the principal acute services provider, the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT). We are committed to working with all providers, local government partners, patients and the public to develop a strong, robust and ambitious 5-year strategic plan. This collaborative plan will secure the continuity of sustainable high quality care for everyone in North Norfolk, Norwich and South Norfolk and is due for publication in June 2014.

Organisations in Norfolk are already committed to creating and delivering an integrated health and care system that supports our population to remain living independently with a good quality of life for as long as possible. All partners are committed to delivering high quality person-centred services, and agree that the only way to do this effectively is to work together to remove barriers, share the financial commitments and risks and ensure that we spend as much as possible of our budgets on integrated care.

The current national, regional and local position provides a significant opportunity for planning transformational change in the system, integrating service provision where it is appropriate and radically re-thinking how care can be provided to the populations of NNCCG, NCCG and SNCCG.

To do this, the three CCGs and all our local health services, primary and community care services, District and City Councils, Norfolk County Council (NCC), our local General Practitioners (GPs) and our voluntary sector and communities need to develop a common, united vision for integrated services.

However, this transformational change is taking place when the health and social care system in Norfolk is facing a number of major challenges over the next few years including:

- Workforce and staffing – significant recruitment and retention difficulties in certain key areas and an ageing workforce
- Seven day working leading to further staffing and resourcing issues
- The impact of the Care Bill\(^2\)
- Significant financial constraints – against a background of an ageing population, an increase in Long Term Conditions (LTCs), rising costs and increased public expectations
- Significant continued reductions in social care funding/services

Our collaborative strategic planning process will consider all options to ensure resilient, viable, high quality services are available for SNCCG, NCCG and NNCCG residents. It is therefore imperative that this is co-produced with providers, patients/service users and other stakeholders and develops a joint approach between health and care for assessment and care planning. The development of our 5-year Strategic Plan will be informed by the planning and implementation of the Better Care Fund initiatives.

Our draft 5-year strategic ‘Plan on a Page’ is contained in **Appendix 1**

**Better Care Fund (BCF)**

The £3.8 billion national Better Care Fund\(^3\) (formerly the Integration Transformation Fund) was announced by the Government as part of the Comprehensive Spending Review in June 2013. It requires local areas to formulate joint plans for integrated health and social care, and to set out how the single ‘pooled’ budget will be used to facilitate closer working between health and social care to provide consistent, joined-up, high quality services for everyone and achieve the best outcomes for local people.

In order to access the BCF, CCGs and Local Authorities (LAs) must submit a five year delivery plan for approval by Government.

In addition to the Norfolk Health and Wellbeing Board (H&WBB) and individual partner organisations, the process of developing the delivery plan is supported jointly by SNCCG, NNCCG and NCCG, under the governance of the System Leadership Partnerships that bring together relevant commissioners and providers.

The BCF provides an opportunity to progress rapidly the delivery of the vision of the Norfolk H&WBB. In particular the focus is on early intervention and prevention, ensuring services are integrated at the point of delivery, that there are seamless services, including Mental Health (MH), and a focus on reducing loneliness and social isolation for older people.

The BCF provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and in doing so, providing them with a better service and quality of life. It will also support the aim of providing people with the right care, in the right place, at the right time, including a

\(^2\) [http://services.parliament.uk/bills/2013-14/care.html](http://services.parliament.uk/bills/2013-14/care.html)

\(^3\) [https://www.gov.uk/government/publications/better-care-fund](https://www.gov.uk/government/publications/better-care-fund)
significant expansion of care in community settings. This will build on the existing work of Norfolk CCGs and the LA. Further detail around the use of the BCF locally, and the 5-year delivery plan that underpins it, is set out in the Out of Hospital and BCF workstream sections (pages 60-68).

**NHS Outcomes Framework**

The *NHS National Outcomes Framework 2014/15*[^4], together with the *Adult Social Care*[^5] and *Public Health Outcomes*[^6] Frameworks together support the Government’s desire to improve integration of services. These documents set the national policy context and describe a range of indicators by which performance and outcomes for the NHS will be measured. These policy documents support SNCCG’s desire to improve integration of services.

The *NHS Outcomes Framework* is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. They focus on:

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

The *Public Health Outcomes Framework* consists of two overarching outcomes that set the vision for the whole public health system and outline what is to be achieved for the public’s health. The outcomes are:

<table>
<thead>
<tr>
<th>Outcome 1</th>
<th>Increased healthy life expectancy, i.e. taking account of the health quality as well as the length of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome 2</td>
<td>Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).</td>
</tr>
</tbody>
</table>

[^6]: http://www.phoutcomes.info/
These outcomes have been translated into **seven specific, measurable ambitions**, or critical indicators of success, which form the foundation of this Operational Plan, and against which SNCCG will demonstrate significant improvement:

<table>
<thead>
<tr>
<th>Ambition 1</th>
<th>Securing additional years of life for people with treatable mental and physical health conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambition 2</td>
<td>Improving health-related quality of life for people with LTCs, including MH</td>
</tr>
<tr>
<td>Ambition 3</td>
<td>Reducing the amount of time people spend in hospital by having better more integrated care in community</td>
</tr>
<tr>
<td>Ambition 4</td>
<td>Increasing the proportion of older people living at home independently following discharge from hospital</td>
</tr>
<tr>
<td>Ambition 5</td>
<td>Increasing the number of people with physical and MH conditions who have a positive experience of hospital care</td>
</tr>
<tr>
<td>Ambition 6</td>
<td>Increasing the number of people with a positive experience of care outside of hospital, in General Practice and in the community</td>
</tr>
<tr>
<td>Ambition 7</td>
<td>Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care</td>
</tr>
</tbody>
</table>

Additionally, NHS England (NHSE) has identified **three more key measures** where there is an expectation of significant focus and rapid improvement:

<table>
<thead>
<tr>
<th>NHSE key measure 1</th>
<th>Improving health through promoting healthy environment and lifestyles</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSE key measure 2</td>
<td>Reducing health inequalities between communities and within communities</td>
</tr>
<tr>
<td>NHSE key measure 3</td>
<td>Moving towards parity of esteem, ensuring an <em>equal</em> focus of improving MH and physical health</td>
</tr>
</tbody>
</table>

**Improving the health of local people**

In November 2013, NHS England published “A *Call to Action: Commissioning for Prevention*” which suggests prevention programmes can be important enablers for reducing acute activity and capacity over the medium term, and sets out a five-step framework intended to support CCGs in commissioning for effective prevention:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Analyse key health problems</th>
<th>Prioritise &amp; set common goals</th>
<th>Identify high-impact programmes</th>
<th>Plan resources</th>
<th>Measure &amp; experiment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mature</td>
<td>Local analysis of deaths, chronic disability &amp; risk factors in place, with understanding of sub-populations &amp; potential future trends</td>
<td>Small set of priorities focused on top health problems</td>
<td>Jointly commissioned primary &amp; secondary initiatives highly focused on risk factors &amp; key causes of morbidity and mortality</td>
<td>Reallocation is meaningful &amp; phased realistically</td>
<td>Outcome &amp; process metrics in place to measure progress on each prevention priority &amp; programme</td>
</tr>
<tr>
<td></td>
<td>Performance bench-marked nationally</td>
<td>Priorities supported by all major players: local health economy</td>
<td>Early detection initiatives identified</td>
<td>Innovative use of health economy-wide funding including ITF</td>
<td>Experimental approaches where evidence base is poor that can be evaluated</td>
</tr>
<tr>
<td>Emerging</td>
<td>Local analysis of causes of premature deaths, chronic disability &amp; risk factors is in place</td>
<td>Priorities are focused on the big problems but set organisation-by-organisation</td>
<td>Isolated primary &amp; secondary programmes driven by different organisations</td>
<td>Targets for reallocating resources over time established</td>
<td>Outcome &amp; process metrics in place to measure progress on each prevention priority but tend to be long-term</td>
</tr>
<tr>
<td></td>
<td>Collaboration with peers in the area/region to understand relative performance</td>
<td>Some key players are not engaged in prevention goals</td>
<td>No early detection activities outside nationally mandated programmes (e.g. screening)</td>
<td>Funding for priorities provided organisation-by-organisation, little joint commissioning</td>
<td>Innovations are difficult to evaluate</td>
</tr>
<tr>
<td>At the start</td>
<td>Data on premature deaths, chronic disability &amp; risk factors are national only</td>
<td>Priorities attempt to embrace too much</td>
<td>Prevention initiatives are limited to rational screening, OOF-driven activities &amp; other centrally driven initiatives</td>
<td>Priorities not backed up by reallocation in resources</td>
<td>Difficult to measure progress against preventative priorities</td>
</tr>
<tr>
<td></td>
<td>Understanding of performance vs peers is anecdotal</td>
<td>Priorities are driven by legacy activities rather than epidemiology</td>
<td></td>
<td>Funding driven by what’s been done in the past rather than future needs</td>
<td>Measures are very long-term (e.g. survival rate) and reactive (e.g. prevalence)</td>
</tr>
</tbody>
</table>
SNCCG will proactively work with Norfolk H&WBB partners, utilising the principles outlined in the above framework, to deliver the Health and Wellbeing Strategy\(^8\) including those areas of the strategy focusing on health improvement and prevention.

As part of the development of a combined 5-year strategic plan with NNCCG and NCCG nine areas of intervention have been agreed to support the ambitions and outcomes framework. They are as follows:

<table>
<thead>
<tr>
<th>Intervention 1</th>
<th>Development of primary care localities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention 2</td>
<td>Implementation of integrated community care teams (based on primary care locality footprints)</td>
</tr>
<tr>
<td>Intervention 3</td>
<td>Proactive use of predictive modelling and risk stratification</td>
</tr>
<tr>
<td>Intervention 4</td>
<td>Easy to access, seven day health and social care provision for people with complex mental and physical health and care needs</td>
</tr>
<tr>
<td>Intervention 5</td>
<td>Enable independence, self care and self management</td>
</tr>
<tr>
<td>Intervention 6</td>
<td>Improved support for people with Dementia and their carers</td>
</tr>
<tr>
<td>Intervention 7</td>
<td>Deliver major redesign of urgent care system</td>
</tr>
<tr>
<td>Intervention 8</td>
<td>Ensuring effective end of life pathways and support</td>
</tr>
<tr>
<td>Intervention 9</td>
<td>Ensuring effective workforce planning</td>
</tr>
</tbody>
</table>

\(^{8}\) [http://www.norfolk.gov.uk/view/NCC122775](http://www.norfolk.gov.uk/view/NCC122775)
Parity of Esteem

SNCCG understand that the delivery of health improvement and a reduction in health inequalities for the people of South Norfolk must also be delivered alongside a focus on improving mental as well as physical health i.e. ensuring there is parity of esteem.

SNCCG will seek to utilise the tool produced by NHS England Parity of Esteem: transformative ideas for Commissioners which outlines how CCGs can achieve parity of esteem between physical and MH by allocating their resources differently through the provision of an evidence base, case studies and a guide to managing, securing and evaluating services.

SNCCG will also ensure that the principle of parity of esteem is a central and fundamental element of all commissioning decisions, work streams and projects. This will be done by ensuring that the SNCCG population’s MH needs become a core consideration at each stage of the commissioning process for all services being commissioned not just MH services. Key to this will be moving to the development (through our responses within the BCF) of further joint working and integration between MH and physical health care services at every level. In addition SNCCG will ensure effective joint working across children and young people’s MH and physical healthcare services.

Reducing health inequalities

Health inequality can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in mortality rates between people from different socioeconomic groups. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned.

The diagram below summarises the national framework through which NHS England’s overarching vision and ambitions will be delivered, and which the CCG will deliver locally for the people South Norfolk.

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How SNCCG will reduce health inequalities

SNCCG’s demography is outlined on pages 19-28 of this ‘Integrated Commissioning Strategy’ and presents a number of challenges in reducing health inequalities.

SNCCG will tackle health inequalities by:

- Continue to work with Norfolk & Suffolk Primary & Community Care Research Office in understanding the health challenges facing South Norfolk’s patient population, and the national context of health and social care research
- Collaboratively commission and strategically link with Public Health Norfolk to target health improvement programmes to areas of need, based on the ethos of the ‘Fair Society, Healthy Lives’ Marmot Review.
- Engage with stakeholders across health and social care, local government, the voluntary and community sector and the wider statutory sector to understand areas of health inequality across South Norfolk and commission effectively.
- Work with patients and the public in areas of demographic deprivation and across rural communities to ensure that SNCCG is involving the population in the health and social care services it commissions
South Norfolk
Clinical Commissioning Group

- Co-produce commissioning intentions and service developments by working with the communities it impacts on, with particular emphasis on under-represented communities and areas of deprivation.
- Development of the accessibility of SNCCG’s communications aimed at the population of South Norfolk, focusing on areas of deprivation and information needs of specific groups.

SNCCG is committed to improving its approach to equality and diversity linked to health inequalities, and has set out four equality objectives:

<table>
<thead>
<tr>
<th>Equality objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Equality objective 1</strong></td>
<td>Patients and carers experience joined-up healthcare, ensuring access to the right services at the right time</td>
</tr>
<tr>
<td><strong>Equality objective 2</strong></td>
<td>The CCG will improve use of equality data and information about SNCCG’s population and communities to inform its work</td>
</tr>
<tr>
<td><strong>Equality objective 3</strong></td>
<td>The CCG will improve the way that the Governing Body (GB) and Leadership Team (LT) can learn from healthcare experiences of diverse and marginalised individuals, groups and carers</td>
</tr>
<tr>
<td><strong>Equality objective 4</strong></td>
<td>Senior leaders and other managers provide leadership, support and motivation for their staff to uphold the CCG’s value of equality of opportunity to improve the health of those most in need</td>
</tr>
</tbody>
</table>

It is acknowledged that significant changes to the way health service are delivered will be required if the above outcomes and ambitions are to be fulfilled.

In terms of the detail around the SNCCG essential elements of Quality, Access, Innovation and Value for Money (VFM) they are as follows:

<table>
<thead>
<tr>
<th>Quality</th>
<th>Focusing on:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Patient safety</td>
</tr>
<tr>
<td></td>
<td>• Patient experience</td>
</tr>
<tr>
<td></td>
<td>• Compassion in practice</td>
</tr>
<tr>
<td></td>
<td>• Staff satisfaction</td>
</tr>
<tr>
<td></td>
<td>• Seven day services</td>
</tr>
<tr>
<td></td>
<td>• Safeguarding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access</th>
<th>Focusing on:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Disadvantaged and minority groups</td>
</tr>
<tr>
<td></td>
<td>• Extending access in primary care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Innovation</th>
<th>Delivering change through:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Innovation</td>
</tr>
<tr>
<td></td>
<td>• Adopting and promoting best practice</td>
</tr>
</tbody>
</table>
Strategic Clinical Networks

Strategic Clinical Networks (SCNs), hosted and funded by NHS England, were established in April 2013 and cover conditions or patient groups where improvements can be made through an integrated, whole system approach. These networks help NHS commissioners to reduce unwarranted variation in services and encourage innovation.

The conditions or patient groups covered by the East of England (EoE) SCNs are:

- Cancer
- Cardiovascular disease (including cardiac, Stroke, Diabetes and renal disease)
- Maternity and children’s services
- MH, Dementia and neurological conditions

SNCCG clinical leaders play an active part in these networks and support the development of quality improvement in local services.

NHS Constitution

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it. The NHS Constitution11 establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.

Under the Constitution patient’s rights and privileges include the delivery of:

- Maximum of 18 weeks from referral to treatment (RTT)
- Maximum 6 weeks wait for diagnostic tests from referral
- Cancer waits for RTT
- Patient admission, transfer or discharge within 4 hours from arrival in Accident & Emergency (A&E)
- Ambulance response times.

SNCCG has embraced these rights and pledges within this Operational Plan and sets out its plans to commission sufficient services to ensure it can deliver those rights and pledges for patients on access to treatment.

Mandated in the Standard NHS Contract\textsuperscript{12} is the requirement for the provider to comply with the NHS Constitution. This is set out in Service Condition No 1, and stipulates that the Parties must abide by and promote awareness of the NHS Constitution, including the rights and pledges set out in it. The Provider must ensure that all Sub-Contractors and all Staff abide by the NHS Constitution.

Specifically, set out in the Particulars, within the Quality Requirements (QR) is:

- The requirement for patients to start consultant-led non-emergency treatment within a maximum of 18 weeks of a GP referral. The provider is also required to take all reasonable steps to offer a range of alternatives if this is not possible.
- The requirement for patients to be seen by a specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected.

As well as the lever to apply financial consequence for failing to meet the mandated Operational Thresholds, there are supportive local Thresholds to hold Providers to account. These include sanctions that can be applied if planned operations are cancelled if escalation is required under General Condition 9 of the Contract, the Provider is required to agree a Remedial Action Plan, and actions will be set out to ensure remedy accommodating demand and peaks in activity.

\textbf{RTT (18 weeks) and monitoring of 18 week data}

While the NNUHFT, as SNCCG’s main provider, achieve the 18 week RTT threshold at an aggregated level as a Trust and for SNCCG, the standard has not been met in all areas at specialty level. Following an action plan in 2013/14 it is anticipated that performance standards will improve during 2014.

An integrated CCG clinical/commissioner working group of the Collaborative Acute Commissioning Board (ACB) is addressing activity and cost pressures in T&O through the review of pre and post hospital musculoskeletal (MSK) services. This work will ensure that every non-surgical intervention is employed prior to referral to the Acute Trust and that surgery is only recommended after appropriate triage, based on clinical thresholds. Additionally every patient will have a complete diagnostic review prior to their first outpatient appointment to improve the efficiency of this process for patients, Consultants and CCG finances.

Assurances around the timely delivery of the 18 week RTT standard form part of the contractual particulars SNCCG has with each Provider delivering services to its population, and are held within Schedule 4 of the particulars within the Operational Standards of Quality Requirements\textsuperscript{13}. Ensuring delivery of these standards is one responsibility of the monthly Service Performance Review Group (SPRG) which functions as the contractual interface between Commissioner and Provider.

A summary of these requirements and performance management mechanisms is illustrated in \textit{Appendix 2}.

\textsuperscript{12} http://www.england.nhs.uk/nhs-standard-contract/
Delivery of timely recovery plans – down to specialty level

Where operational standards are not achieved, the Trust in question is obliged to produce a remedial action plan detailing the specific, time lined tasks they will undertake to rectify the standard. Failure to achieve agreed recovery plans will ultimately result in withholding 2% of the overall contract value.

Delivering improved outcomes for local people

NHS England is asking SNCCG to review its strategic and operational plans that were developed as part of the ‘Authorisation’ process completed in 2013 (the process whereby CCGs were formally ratified).

SNCCG’s ‘Integrated Commissioning Strategy, 2012-2016’ gave a four-year strategic overview of the health and social care priorities in the South Norfolk area, and detailed the commissioning priorities and intentions of SNCCG within the local health economy. This overview was also captured in a visual matrix in SNCCG’s 2013 ‘Plan on a Page’.

‘Everyone Counts: Planning for Patients 2014/15 to 2018/19’ provides SNCCG with the opportunity to refresh its Integrated Commissioning Strategy 2012-2016 and develop a robust and ambitious five-year plan (through to 2018/19) in collaboration with NCCG and NNCCG. The jointly prepared draft 5-year ‘Plan on a Page’ for 2014-19 is illustrated in Appendix 1.

SNCCG along with NCCG and NNCCG already have plans in place to jointly further develop the 5-year strategy that is due for publication in June 2014.

Norfolk Health and Wellbeing Board (H&WBB)

The H&WBB provides a focus for bringing together social care (for adults and children), public health and the CCG’s priorities; its high-level membership reflects this with representatives including Directors of Community Services, Children’s Services, Public Health, as well as representation from SNCCG and the other Norfolk CCGs. It is chaired by the leader of NCC.

The H&WBB’s strategy for Norfolk has helped to inform our Joint Strategic Needs Assessments (JSNAs) which formed the evidence base for our 2013-16 Strategy and the 2014-16 Operational Plan.

The priorities for the H&WBB are:

- Promote healthy lifestyles,
- Strengthen investment in prevention and early intervention,
- Promote integration of care pathways,
- Reduce health inequalities.

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Collaborative working with District Councils

A key approach by SNCCG is to work in partnership with South Norfolk and Breckland District Councils to help deliver a number of commissioning initiatives, in particular around tackling adult and child obesity.

Going forward the CCG is fully committed to continued working and development of a package of bespoke initiatives with District Councils and these will be developed under the auspices of a localised H&WBB. This is key to delivering the objectives of integration and the BCF. District Councils have rich insights into the needs of their communities and are well placed to support the local NHS to identify opportunities for early intervention to support people at home and avoid unnecessary secondary care admission.
About SNCCG

This section gives an overview of South Norfolk Clinical Commissioning Group (SNCCG) as an organisation, summarises the health issues in the population and sets out the vision and strategic goals to tackle these.

SNCCG was formed in July 2012 bringing together two original constituencies – Mid Norfolk and South Norfolk. The CCG has strong collaborative commissioning partnerships with other CCGs, North East London Commissioning Support Unit (NELCSU), NCC and Breckland & South Norfolk District Councils.

There is generally highly regarded primary and secondary care provision and long established clinical relationships across all healthcare organisations.

SNCCG comprises 26 General Practices and has a population of 223,000 (weighted 227,000). The CCG covers a predominantly rural area to the south and west of the city of Norwich and the main district towns are: Thetford, Dereham, Attleborough, Watton and Diss.

The current model of delivery in SNCCG is locality based. Its constituent member Practices are organised into four localities:

- Breckland,
- Ketts Oak,
- Mid-Norfolk,
- South Norfolk Health Improvement Partnership (SNHIP)

SNCCG spans two District Councils:

- South Norfolk District Council,
- Part of Breckland District Council (the remainder forming part of West Norfolk CCG).

SNCCG also commissions services for a section of population who live in Suffolk, but registered to a SNCCG Thetford Practice.
Practice locations and deprivation

**South Norfolk CCG (pop 223,000)**

- Lower deprivation
- Poorer health linked to unemployment
- Local locality variations
- Poorer health linked to deprivation
- Higher life expectancy
- Poorer health linked to lower ed attainment
- Higher number of older people
- No. of older people set to rise
- Smoking & alcohol
- Teenage pregnancy
- Child & adult obesity
- Skin & breast Cancer
- Dementia, depression, Ip & Stroke
- Diabetes, Stroke, COPD & CHD

North Norfolk CCG has developed as a collaborative membership organisation of clinical leaders with a strong Leadership Team. The CCG has a small core team which supports active clinical leadership and Practice engagement with the commissioning agenda.

The NELCSU provide support to SNCCG that includes contract finance, procurement, supporting the negotiation and management of contracts and back office functions such as Human Resources (HR) and Information Management &Technology (IM&T).

During the first year of operation following authorisation in April 2013 SNCCG has grasped the opportunity to focus on service redesign and community and out of hospital services in the localities. This continues to be delivered locally in strong partnership with key providers and LA partners. New structures and processes have also been strengthened in the past year to ensure that this alignment with partners delivers both better services for local people and better value for money, through, for example the development of an Integrated Commissioning Team with NCC.

**Health issues in the population**

People in SNCCG’s area enjoy relatively good health compared with the rest of England. Deprivation is lower than average and life expectancy higher than average but the CCG-wide data mask variation at local level between localities, with some with poor health status largely linked to deprivation, unemployment and the low level of educational attainment.

Over half the population are of working age, there are higher numbers of older people than across Norfolk as a whole and the number of older people is set to rise over the next 20 years.
All cause mortality rates have fallen over the last ten years but there is a high incidence of Diabetes, chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), Dementia, depression, Stroke, Cancer (skin & breast) and hip fracture. Whilst it is important to tackle these diseases it is equally important to focus on the health improvement issues including adult and childhood obesity, smoking, alcohol consumption and teenage pregnancy.

This Operational Plan is being shaped by the health needs of, and the unique service delivery challenges faced by, the rural population of SNCCG, namely:

- An older population living longer with at least one LTC,
- A large rural area with poor transport infrastructure making access to services and the need to deliver more care at or closer to home more challenging,
- Unwarranted variation in health status and outcomes in particular parts of the locality, particularly for young people,
- A need to promote healthy lifestyles and improve quality of life,
- The need to prioritise resources accordingly in a time of economic constraint.

SNCCG also recognise the need to ensure equality of access to services for non UK resident population of approximately 16,075 (6.9%) and 8,838 (3.8%) European residents; particularly Portuguese, Lithuanian and Ukrainian.

All of these characteristics present a challenge to SNCCG in designing services which excel at both preventing and managing the effects of LTCs, avoiding unnecessary reliance on acute hospital admission, and that promote well-being and independent living amongst the whole population but especially older people. SNCCG’s focus remains on areas where it can have the greatest impact by reviewing pathways and seeing how they can be adapted to meet the challenges set out above.

The CCG’s success will be measured by its ability to make consistent, incremental improvements in outcomes and cost effectiveness, and to tackle unwarranted variation, across its whole programme of commissioning activity in order to free up the resources to address future health needs.

Mission and values

The aim of SNCCG’s mission and values is to create a strong sense of purpose and direction and as a new organisation the CCG has worked hard to determine its vision and core values. They will be the guiding principles by which SNCCG will conduct business and on which this commissioning strategy will be shaped.

The mission of the CCG is the statement of intent, setting out ambition for the future. SNCCG has agreed this mission to guide its commissioning as follows:

“SNCCG aspires to deliver the highest quality integrated healthcare, which is appropriate, effective, efficient and sustainable, in order to improve the health and well-being of the whole and diverse population of South Norfolk.”

The values which underpin this mission and will impact on all our activities are:

- The provision of quality services that are evidence-based, focused on patient safety, with measurable outcomes,
- Financial rigour in the planning, commissioning and on-going review of service delivery,
- The inclusion of patients, and others, affected across all elements of clinical commissioning, with particular emphasis on hard to reach groups,
The CCG also aims to support people to have the healthiest lifestyle they can achieve. Central to this will be our continued work with local government and the voluntary sector partners to ensure our population is empowered and well informed to live healthy lives and manage their own health and wellbeing.

**Aims**

The CCG aims to promote its mission and values by:

- Promoting a culture of safety, continuous improvement and innovation through the commissioning of effective clinical services within a clear framework of quality standards,
- Avoiding reactive approaches to commissioning, replacing short-termism with a planned and sustainable approach to pathways of care,
- Working with key stakeholders on true collaboration and integration thereby delivering whole-systems approaches to clinical patient care,
- Nurturing clinical engagement by way of on-going support, development and training
- Utilising local patient experience to inform and challenge process. Embedding patient participation and engagement across all elements of the commissioning cycle,
- Identifying hard to reach groups and looking to innovative approaches to achieve their involvement.

The activities of SNCCG are guided by the** NHS Constitution**, national and regional policy, and **Everyone Counts: Planning for Patients 2014/15 to 2018/19**.

The CCG’s strategy is to commission the best possible health services & outcomes for local people in financially challenging times by:

- Critically reviewing and maximising the value of our current investment in services (which could lead to disinvestment),
- Rigorously driving up the quality, effectiveness and efficiency of our commissioned services by better engagement of clinicians and intelligent but rigorous performance management of contracts,
- Relentlessly reviewing primary care quality markers, such as referral rates, prescribing and outcomes across our Practices so as to minimise unwarranted clinical variation,
- Commissioning care in the right setting, at the right time by the right team and practitioner,
- Delivering fully integrated community health and social care teams as the norm, working in full partnership with local General Practice to support people in their homes.

**Partnership working with NHS England**

The GB of SNCCG will assist and support NHS England in its duty to improve the quality of primary medical services (PMS) and specialised services. This will be undertaken partly through assurance from the CCG’s Quality and Patient Safety Assurance Committee.

The GB will drive progress on the delivery of commissioned Primary Medical Services (PMS) and specialised services through rigorous reporting mechanisms. SNCCG will provide
comprehensive and reliable information to NHS England to identify the use of, and requirement for, specialised services for its population and will work closely with NHS England to agree the optimal way to work in partnership to achieve this.

What will be different by 2016?

The development of this Operational Plan has been led by, and with, GPs. The next two years will have a number of characteristics, these will include:

- The delivery of this plan led by GPs, working with clinicians and patients,
- The patient and their quality of care will be the prime focus of the CCG’s work,
- Collaboration across GP Practices and with key partners will build relationships and ways of working to benefit patients, clinicians, and other local professionals,
- Engagement with patients and the public and their involvement in the CCG’s decision making processes will build a new partnership between a statutory commissioning organisation and the local population it serves using clinical expertise and ideas from others to develop opportunities for innovation.

More recently SNCCG has been developing its vision of what differences its residents would experience in healthcare by 2016/17. The CCG wish to see a health and social care system where the whole population (but especially older people and those with LTCs which impact their quality of life) have access to a fully integrated primary and community health and social care service. Importantly, appropriate and timely access to more specialist healthcare that is safe and delivered with compassion and dignity is critical. Over the next two years there is commitment to focus on specific pathways and the priorities are cancer and stroke.

Our vision of integrated care includes:

- A comprehensive, single assessment process across health and social care,
- Greater local access to services which are planned and appropriate for delivery in the locality,
- Identified key workers who understand individual patient’s social as well as medical contexts,
- Services which are simple to use and can be “switched on” via a single call and assessment,
- Services being arranged around patients’ GP surgeries with access to a wider range of social, voluntary and housing related services,
- Fully integrated health and social care delivery teams which fully support the 26 GP Practices,
- A universal expectation that all services delivered in a timely and safe way at, or close to home, will be delivered with respect, compassion and a personalised approach to care.

SNCCG wishes to see less unwarranted variation in referral practice and we will strive to deliver more care in an out of hospital setting. In order to do this, excellent collaboration between clinicians across primary, secondary and community care must continue in order that services can be redesigned effectively to deliver these goals.

However, SNCCG will ensure that there is a balance between collaboration with providers, the use of contracting levers to secure delivery and the use of competitive procurement approaches to reform services and increase choice for patients and carers.
The conceptual model below illustrates the overall vision for care delivery:

Joint Strategic Needs Assessment (JSNA)

The Norfolk-wide JSNA\textsuperscript{16} has been disaggregated to provide a rich picture of the health needs of the population. Key highlights are set out below.

Summary of local health priorities

The SNCCG health profile puts a clear emphasis on the following key elements that need to be at the heart of the CCG's future commissioning plans:

- Demographic changes - it is estimated that the older people population will increase significantly in number,
- Addressing health inequalities and deprivation,
- An increase in age related conditions putting economic pressures on the health system as a whole, such as prevalent LTCs (in particular Dementia and Diabetes), Falls as a result of increased frailty and Cancers,
- Obesity,
- Promoting healthy lifestyles: tackling smoking, alcohol and exercise as priority areas.

Population demographics

\textsuperscript{16} \url{http://www.norfolkinsight.org.uk/jsna}
The registered population of SNCCG is estimated to be 223,000 (weighted 227,000). The population density is 1.0 and 1.3 persons per hectare in Breckland and South Norfolk districts respectively, both low if compared with Norfolk and the rest of England.

From mid-2008 to mid-2009 the population increased due to gains from migration from England and elsewhere, births and deaths being more or less in balance.

South Norfolk has a relatively larger proportion in the 40-70 year age group compared to England and a lower proportion of all age groups under 40, except for ages 16-19, compared to England. However, the male/female ratio is comparable to the England ratio.

Around 57% of the population in SNCCG are of working age, below the county and national figures, with a higher proportion of children than Norfolk, but lower than England. There also a higher proportion of older people, particularly in comparison with England. As already mentioned there is a 6.9% of our population that are non UK residents and 3.8% from the European Union, particularly Portuguese, Lithuanian and Ukrainian.

Full details of our health needs can be found in the 2012/16 SNCCG commissioning strategy (pages 12-24)\(^\text{17}\).

Key priorities

Although South Norfolk is overall less deprived, there are pockets of deprivation which lead to health inequalities. Health profiles published in 2012 show that while South Norfolk has relatively better scores for health indicators, Breckland has a significantly higher number of people diagnosed with Diabetes and the educational achievement is significantly lower than England average.

South Norfolk has a relatively lower prevalence of adult and childhood obesity, however, the proportion of overweight and obese children is increasing. Similarly, though the ward level teenage conception rates in Norfolk and South Norfolk are generally low, there are some wards which have levels above the England upper quartile. With an ageing population, there will be an increase in Dementia, depression and learning difficulties.

Priorities for improving health in SNCCG include:

- Stopping smoking
- Tackling alcohol misuse
- Addressing obesity by promoting healthy lifestyles.

For the ageing population the CCG will have an increased focus on:
Prevention and management of age related LTCs such as Dementia, Diabetes, cancer and falls. The following table illustrates the predicted increase in the incidence of Dementia over the next eight years.\(^{18,19}\)

<table>
<thead>
<tr>
<th>Condition</th>
<th>2012</th>
<th>2017</th>
<th>2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td>3,437</td>
<td>3,920</td>
<td>4,882</td>
</tr>
<tr>
<td>Depression</td>
<td>5,750</td>
<td>6,032</td>
<td>6,317</td>
</tr>
<tr>
<td>Learning difficulties</td>
<td>4,438</td>
<td>4,602</td>
<td>4,788</td>
</tr>
</tbody>
</table>

*Estimated numbers with condition for South Norfolk CCG (POPPI and PANSI, 2009)*

For primary prevention the CCG will also tackle:

- Reducing variation in referrals and access to healthcare
- Improve flu immunisation

**Key challenges emerging from population demography and epidemiology**

SNCCG recognise the following key challenges:

- Reducing health inequalities within the population – whilst SNCCG covers a population which enjoys relatively good health, the district population data mask variations at super output level.
- An ageing population and the percentage of older people with one or more LTCs, such as Diabetes, COPD and Dementia.
- Rurality and access to treatment and care.


Communications and Engagement with Stakeholders

SNCCG’s Communication and Engagement Strategy is produced and coordinated by the Engagement Lead and GB Lay Member Representative for Patient and Public Involvement in conjunction with the wide range of organisations and groups that represent people who use health and social care services.

Engagement mechanisms include:

- Annual stakeholder event (most recently in November 2013),
- Working actively with Patient Participation Groups at each of the 26 GP Practices in South Norfolk,
- A Patient Involvement event planned for Spring 2014 to bring representatives from all the PPGs together in one forum where integration will be a key topic,
- Local strategic forums across SNCCG area to bring together key commissioners from health, social care and district councils with input from key provider, service user groups and local Healthwatch,
- Regular attendance and input at health and social care forums in South Norfolk and Breckland, including Older People’s forums, Youth Advisory Boards, MH and Carer’s Locality groups,
- The involvement of members of the public (people who use services, carers) in specific pieces of commissioning work.

The multi-agency integration stakeholders group includes regular input from the older people’s forum and Healthwatch. It is looking to ensure a wider range of voices are involved in strategic planning for integrated services. Discussions are underway with local interested groups about what integration of health and social care means and will look like from the perspective of the people who use services, with particular emphasis in under-represented patient groups and communities.

The existing local links will be built on, specifically with Breckland and South Norfolk Older People Forums; with Opening Doors (a self-advocacy organisation for people with learning disabilities) and with Equal Lives (a user led organisation for people with physical or sensory impairments, mental ill health and people with learning difficulties).

Patient and Public Involvement leads for the central planning cluster CCGs are collaborating to arrange for some joint engagement events to inform integration planning. SNCCG will also involve patients, people who use services and the public in co-producing the implementation programme, which will seek to:

- Involve people across a range of mechanisms (including workshops, discussion forums, online questionnaires and information streams) and build on existing work with Healthwatch Norfolk and the ‘Your Voice’ engagement network in Norfolk, as well as current co-produced commissioning projects,
- Involve people at strategic levels of decision making to inform the vision, strategic and financial forward planning,
- Involve people as ‘experts by experience’ in key aspects of the implementation of the integration programme e.g. in service redesign, as researchers to gather further evidence of people’s experience of health and social care services; to agree co-produced outcomes and measures; as evaluators of the impact of integrated services on the lives of people.
Empowering patients

SNCCG fully recognises that the people in South Norfolk want to be

- Fully engaged in making positive choices about their own health and lifestyles,
- Participating in the shaping and development of health and care services,
- Have access to data and advice about health and services,
- Be able to choose which health services they can use and how to access them.

SNCCG will continue to use a range of ways to ensure patients and the wider public have a much greater say in how health services are organised, and to support patients and their carers in having a greater say in how their personal care is delivered. The CCG will continue to consult with patient forums and local representative groups. SNCCG have developed an inclusive approach to decision-making processes through Board and public meetings and other stakeholder events such as our recent Care homes Pressure Ulcer awareness workshop.

The CCG will continually improve the quality of the services commissioned by both listening and responding the views of patients, carers and the wider community.

SNCCG recognises that communicating effectively is important to everything we do. We aspire to the highest levels of honesty, openness and transparency, and actively promote both its successes and opportunities to improve. The well-established communications service has strong networks of communications professionals in all the provider organisations, and the CCG continues to build those networks with partners.

SNCCG published a Communication & Engagement Strategy 2012-15\(^{20}\) in April 2013 and this document illustrates the approach to working with key stakeholders and partners across a range of sectors in South Norfolk.

SNCCG is in the process of consulting with key stakeholder organisations and patients to:

- Inform on why SNCCG is producing their strategic and operational plans,
- Ensure the role of carers is fully supported in all our strategies and plans,
- Explain and discuss some of the commissioning intentions SNCCG has developed,
- Involve stakeholder views in the development of these detailed plans,
- Ensure that at every stage of the planning and commissioning process there is a parity of esteem between physical and MH\(^{21}\).

We also have plans for real-time experience feedback from patients and carers by 2015.

Engagement with communities

Many of the SNCCG GP Practices already have established patient participation groups (PPGs). These groups consult with their patients on a regular basis providing a formal mechanism for patients to air their views on their insights and choices. These choices will be


brought to the SNCCG Governing Body through regular stakeholder events/feedback sessions and will help to influence future commissioning intentions of the organisation.

Some of the priorities emerging from PPGs are:

- The expansion of towns across South Norfolk and concern about the impact on clinical capacity,
- Clearer articulation of joint working between SNCCG and Breckland / South Norfolk District Councils,
- Clearer articulation of joint working between SNCCG and Norfolk County Council (NCC),
- The cultural and physical barriers restricting access to primary care across the locality.

Promoting patient choice

The CCG will continue to ensure that it meets all of its statutory duties in relation to patient choice and decision making and will work with local Practices to promote and publicise patient entitlement to choice. The rights of patients set out in the NHS Constitution are vital and SCCCG will strive to ensure they are effectively delivered.

Our plans include:

- **Choice in Primary Care** – including greater choice of GP Practice and choice of Any Qualified Provider (AQP) in community and MH services, providing support to people with long term conditions,
- **Choice before Diagnosis** – choice of diagnostic test provider,
- **Choice at Referral** – choice of provider, named consultant led team, MH and maternity services,
- **Choice after Diagnosis** – choice of treatment, choice of alternative provider at 18 weeks, and end of life care.

Equality Delivery System

In January 2014, SNCCG refreshed its Equality Delivery System (EDS) Outcomes Framework after extensive work and consultation with communities (particularly under-represented and protected communities under the definitions of the EDS Framework), support organisations and other local NHS CCGs and organisations. This information can be found on SNCCG’s website.\(^{22}\)

SNCCG’s EDS Framework 2014-17 underpins its legal and statutory role in protecting the rights of the communities it works with and commissions on behalf of; it also outlines how SNCCG will proactively work with under-represented communities within the commissioning cycle to tackle health inequalities and improve access to care.

In the on-going development of SNCCG’s commissioning intentions and strategic planning, the CCG works closely with a wide range of patients, public groups and cross-sector stakeholders to ensure that all opinions and views are recognised.

SNCCG does this by:

- Working with organisations that advocate on behalf of those under-represented and seek their guidance about best practice,
- Implementing Norfolk Guidelines ‘Accessibility Matters’ 1, 2 and 3\(^{23}\) on the publication of printed materials, accessibility of public events and development of consultation resources and materials,
- Utilising equality impact analyses to plan and assess public involvement activities (including information resources, workshops, events and consultations).

\(^{23}\) [http://www.norfolk.gov.uk/view/NCC121308](http://www.norfolk.gov.uk/view/NCC121308)
Provider Landscape and Changes by 2016

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

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

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

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

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

SNCCG is committed to ensuring a clinically and financially sustainable future for the local acute hospitals, and to ensuring that primary, community and social care services ensure that patients are only treated in a hospital setting when this is the best place to deliver the assessment and treatment the patient needs.

The local provider landscape is going through a period of significant change as part of the wider health and care review and we will continue to actively develop the provider landscape to support improved health outcomes, reduced health inequality and ensuring clinical sustainability.

SNCCG interfaces with more than one Acute care provider with near monopoly providers for MH care, community services and ambulance services. Services are generally highly regarded by patients and carers with positive results published in inpatient and GP surveys. The Providers are as follows:

- **Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT)** a large Acute service provider to the south of the city of Norwich. Access to the Trust is a challenge for some patients from some parts of SNCCG.

  Governance risk rating = GREEN

  Financial risk rating = 3

- **West Suffolk Hospitals NHS Foundation Trust (WSHFT)**, a medium sized Acute service provider in West Suffolk that includes a catchment from the south of Norfolk.
Governance risk rating

Monitor is requesting further information following concerns about the Trust’s sustainability and financial governance before deciding next steps.

Financial risk rating = 2

- **Norfolk Community Health and Care (NCHC)**, a county wide provider of community services, an aspirant FT, which operates from a number of community sites across the CCG.

- **Norfolk and Suffolk NHS Foundation Trust (NSFT)**, a large MH and learning disabilities NHS Foundation Trust provider.
  
  Governance risk rating = GREEN
  
  Financial risk rating = 3

- **East of England Ambulance Service Trust (EEAST)**, a large provider, an aspirant but delayed FT, which covers the counties of Norfolk, Suffolk, Cambridgeshire, Bedfordshire, Hertfordshire and Essex for emergency ambulances.

- **SERCO**, provider of community services to Suffolk CCGs and some services to some residents of SNCCG around the Thetford GP Practices.

- A range of Independent and voluntary sector providers based in Norwich, Bury St Edmunds and throughout the SNCCG area deliver local and countywide services.

Current areas of concern regarding variability of performance of providers include:

- Variable performance against key targets e.g. A&E 4 hour wait, 18 week wait RTT targets at NNUHFT,
- Poor ambulance response and turnaround times for EEAST.

**Acute hospital services**

NNUHFT provides around 85% by value of SNCCG’s Acute hospital services. There are fairly small referral flows to the east, to James Paget University Hospitals NHS Foundation Trust (JPUHFT), and west, to Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust (QEHKLFT). The NNUHFT is by far the largest and most influential Acute services provider with whom the CCG needs to work in partnership to deliver service redesign. There are also a number of referrals, around 10%, that are directed to WSHFT in Bury St Edmunds, mainly from Practices in and around the Thetford area.

Independent sector Acute provision is limited with a small SPIRE Norwich facility and Global Diagnostics both close to the NNUHFT site. Other independent sector providers are in King’s Lynn, Cambridge and Peterborough; these are a 1-2 hour journey away from Norwich by car and almost inaccessible from rural areas by public transport.
Urgent care sector

EEAST provide a wide range of emergency and patient transport services across the eastern region.

Performance for category A (8 minutes) and category B (19 minutes) responses is variable even at times when demand is relatively low. This is an area of specific concern to SNCCG. There is a consistent failure to achieve performance targets primarily because of issues of rurality and distances to be travelled which is of significant concern to patients and GPs.

Mental Health (MH) and Learning Disabilities (LD) sector

NSFT was formed by a merger in 2011 of the former Norfolk & Waveney MH NHS Foundation Trust and Suffolk MH NHS Partnership Trust to provide MH services. Approximately 7% of the CCG’s allocation is invested in services delivered by NSFT.

A proportion of Norfolk’s LD services are run by Hertfordshire Partnership NHS Foundation Trust.

An overview of Trust performance is outlined below:

- Waiting times against service line standards are a cause for concern,
- Performance against Care Plan Approach (CPA) indicators is good,
- Performance against the percentage of patients transfer of care being delayed has improved.

SNCCG will continue to work closely with the Trust during its continued implementation of it’s service strategy to assess any potential impact on the quality of patient care across South Norfolk as a direct consequence of proposed change.

Community health services

NCHC provides 50% by value of SNCCG’s out of hospital care services along with a Norfolk-wide integrated LD services and Children’s services. The Trust runs services which include community nursing and therapy, intermediate care beds and specialist community services such as Diabetes, heart failure, COPD, Epilepsy and Lymphoedema, from a variety of community hospital sites including Dereham to the west of Norwich and Ogden Court, Wymondham to the south of Norwich.

As part of the plan for integration and transformation, the Trust is moving to a ‘hub and spoke’ model of service delivery and SNCCG intend that this will be based on localities identified as part of the BCF plan.

Independent sector

There are 374 care homes in Norfolk and there is also a thriving third sector in the community providing domiciliary care and day care services.
Strengths, weaknesses, opportunities and threats in current provider market

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tbody>
<tr>
<td>• General high quality local service provision</td>
<td>• Provider monopoly for a number of service areas which has arguably led to a lack of ambition in service delivery</td>
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<td>• Foundation Trusts are largely financially viable</td>
<td>• Choice operates more within providers rather than through competing providers given the challenges of access to other parts of the region.</td>
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<td></td>
<td>• Service redesign implementation has seen changes to provision that in some cases had a negative impact on delivery and in particular impacted on communications and joint working between services at locality levels.</td>
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<tr>
<th>Opportunities</th>
<th>Threats</th>
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<tr>
<td>• Potential for good collaboration between secondary and primary care to reform pathways</td>
<td>• Financial challenges impact upon maintaining and improving quality and performance</td>
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<tr>
<td>• Potential for greater integration of care at a local level</td>
<td>• Ensuring delivery through challenging times</td>
</tr>
<tr>
<td>• Use of contracting levers including Contracting for Quality and Innovation (CQUIN) to drive up performance</td>
<td>• Ensuring patient and public confidence is maintained about the NHS in the face of significant organisation restructure and change.</td>
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<tr>
<td>• Potential to further join up services for children and families and achieve better outcomes</td>
<td>• Ageing workforce and demographic.</td>
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<td>• Good relationships with Social Services</td>
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Patient Experience, Quality and Safety

Response to Francis, Berwick and Winterbourne View

In February 2013 the Francis report\(^\text{24}\) established that proper accountability, a “zero tolerance” approach to breaches of “fundamental standards” and a “common culture” that puts patients first - these were the themes underpinning the 290 recommendations that form the heart of the report. The negative aspects of culture in the system were identified as including a lack of openness to criticism, a lack of consideration for patients, defensiveness, looking inwards not outwards, secrecy, misplaced assumptions about the judgments and actions of others, an acceptance of poor standards and a failure to put the patient first in everything that is done.

To change that, there needs to be a relentless focus on the patient’s interests and the obligation to keep patients safe and protected from substandard care. This means that the patient must be first in everything that is done: there must be no tolerance of substandard care; frontline staff must be empowered with responsibility and freedom to act in this way under strong and stable leadership in stable organisations.

SNCCG is committed to working with all our providers of NHS healthcare to ensure that our patients receive the best possible care, have a positive experience of healthcare and are treated safely. To ensure this is embedded throughout all our commissioned services we have developed and implemented a robust action plan that reflects the following key principles:

Quality and Safety first (getting the basics right)

- SNCCG will ensure that the services commissioned will demonstrate how safety issues such as infection control, management of serious untoward incidents, treatment interventions and the prevention of pressure ulcers are addressed,
- The minimum standards set by the Care Quality Commission (CQC) should not be the only standard for contracting services. The aim of SNCCG will always be to contract for best practice standards,
- The care that SNCCG commissions needs to be of the highest standard and clinically effective and take into account National Institute of Health & Care Excellence (NICE) quality standards\(^\text{25}\) and new innovations in clinical care and service delivery,
- The CCG is committed to ensuring that children and vulnerable adults are not at risk from being abused or neglected and receive the care they require. Safeguarding is an important function through commissioning and through the delivery of care from those contracted by us.

\(^{25}\) http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp
Ensuring robust accountability

SNCCG will:

- Scrutinise and ensure we have the capacity to undertake audits, inspections and investigations of individual/group cases and clinical services,
- Ensure our Clinical Leaders will be at the heart of our Quality and safety surveillance,
- Ensure clinicians from SNCCG will be visible on provider sites and will work in partnership with the hospitals and community services providing care to patients,
- At all times be accountable for the scope and quality of all the services that we commission.

An open culture (transparency, openness and candour)

- Patient feedback on the services that we commission will be routinely collected and published. We will use this data to act like a smoke alarm to detect service failures. We will also highlight patients who receive good care as well as bad,
- We will use this feedback to address issues of concern with any of our providers,
- As a CCG we will welcome complaints, be open in acknowledging service difficulties, and encourage providers to do the same,
- We will make comparable information freely available at hospitals, surgeries and care homes and we will help patients to make judgments based on objective data about standards & outcomes,
- We will have active and on-going engagements with patients, the public and all interested stakeholders. We will use their feedback and patient stories to both challenge and improve clinical services.

The CCG is actively working with the public, patients, patient group and patient advocates; other commissioners, health regulators, employers and representatives of the professions to ensure mechanisms are in place whereby we are made aware of poor and unsafe practice so we can act quickly to protect patients.

Through joint working with the LA and NHS England Area Team (AT), SNCG is seeking to ensure openness, transparency and candour throughout the system about matters of concern. These are discussed regularly by the CCG’s Governing Body and with other stakeholders, e.g. at the Norfolk Quality Strategic Alliance and Local Area Quality Surveillance Group.

Contracts that work for patients and clinicians

- We will make it clear the standard of services that we expect to be delivered by all of our providers,
- We will ensure that enhanced quality standards are embedded in our contracts and that we incentivise providers to constantly improve and deliver the highest possible care,
- We will ensure that quality standards are agreed by the doctors and nurses who deliver the service,
- The contract standards will be monitored and both the sanctions and incentives will be understandable and acceptable to clinical leaders and patients who receive clinical services,
- We will ensure clinical leadership is in place in all of our providers services.
Contract specifications and incentives e.g. CQUIN, are being used to enable improvement in local services and to encourage and enhance the local providers of services to pursue high quality effective services. The CCG will continue to monitor quality information generated by providers collected through inspections carried out at Quality Improvement Visits and from investigations of incidents and from complaints.

Providers are held to account for necessary improvements and action plans and to report on themes and trends in their Boards and Annual Reports and Quality accounts. The CCG also chair monthly Clinical Quality Review meetings (CQRM) with our main NHS providers, this includes NCHC, NNUHFT, NSFT and Out of Hours/111. This enables commissioners to work collaboratively and effectively together to identify early or potential concerns around the quality and safety of clinical services.

**Berwick Report**

Following on from the Francis Report, In August 2013 the Berwick Report[^26] made further recommendations regarding patient safety in the NHS in England. It made a number of recommendations to help the NHS make care safer. The CCG’s response to each is set out below:

<table>
<thead>
<tr>
<th>Francis Recommendations</th>
<th>SNCCG response</th>
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<tr>
<td>The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning:</td>
<td>Learning from incidents and serious incidents is routinely scrutinised by the Quality and Patient safety team. The CCG Governing Body (BG) and Clinical Executive overview and scrutiny of trends and themes occurs and the monitoring of improvement plans and quality standards and performance supports and triangulates findings.</td>
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<tr>
<td>All leaders concerned with NHS healthcare – political, regulatory, governance, executive, clinical and advocacy – should place quality of care in general, and patient safety in particular, at the top of their priorities for investment, inquiry, improvement, regular reporting, encouragement and support:</td>
<td>The CCG engages in Quality Improvement visits to engage with providers and increase visibility of commissioners. This ensures commissioned services are of a high quality and risk and issues subject to early warning trigger systems.</td>
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<tr>
<td>Patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of Trusts.</td>
<td>The CCG is committed to the active engagement of patients and the public in our work. We work closely with all our providers to ensure this approach is reflective in the services we commission this is evident through the Friends and Family test, Patient Opinion and local patient survey data that we review each month at CQRM. We also are working with NCHC to develop a community hospitals quality dashboard with a range of indicators that will aim to triangulate patient feedback/ information</td>
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<tr>
<th><strong>Government, Health Education England and NHS England</strong> should assure that sufficient staff are available to meet the NHS’s needs now and in the future. Healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times and are well-supported.****</th>
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<tr>
<td>A fundamental element of our clinical quality review process is to ensure that organisations have capacity to deliver safe services through well trained and adequate staffing resource. We do this by reviewing with our providers their Cost Improvement programmes, workforce plans and any transformation proposals to ensure any potential impact on clinical care has been fully assessed as safe.</td>
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<tr>
<th><strong>Mastery of quality and patient safety sciences and practices should be part of initial preparation and lifelong education of all health care professionals, including managers and executive</strong></th>
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<tr>
<td>SNCCG ensures that the providers of services have in place adequate training and support to their staff to ensure that good quality care and patient safety approaches are adopted and are part of the service specification of its commissioned services. Further to this to support the training and education of staff through partnership working and planning through Health Education England (HEE) and locally in relation to Crown Prosecution Service (CPS) e.g. contract with Health Environment Inspectorate.</td>
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<tr>
<th><strong>The NHS should become a learning organisation. Its leaders should create and support the capability for learning and therefore change, at scale within the NHS. Transparency should be complete, timely and unequivocal. All data on quality and safety...should be shared in a timely fashion with all parties who want it, including...the public</strong></th>
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<tr>
<td>SNCCG’s Integrated Performance Report, which reports on clinical quality and patient safety issues is presented monthly to the Leadership Team and also to the public meeting of GB. The report is also made available to members of the public on the CCG’s website.</td>
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<tr>
<th><strong>All organisations should seek out the patient and carer voice as an essential asset in monitoring the safety and quality of care.</strong></th>
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<tr>
<td>The Community Engagement Group is a subcommittee of the GB, made up of appointed members of the public, who influence and scrutinise the CCG at a strategic level. Meeting are held in public across South Norfolk.</td>
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<tr>
<th><strong>Supervisory and regulatory systems should be simple and clear. They should avoid diffusion of responsibility. They should be respectful of the goodwill and sound intention of the vast majority of staff. All incentives should point in the same direction.</strong></th>
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<tr>
<td>The CCG will continue to monitor the implementation of patient safety alerts issued through NHSE in monitoring of its local contracts and quality measures with providers.</td>
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<tr>
<th><strong>We support responsive regulation of organisations, with a hierarchy of responses. Recourse to criminal sanctions should be extremely rare, and should function primarily as a deterrent to wilful or reckless neglect or mistreatment.</strong></th>
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<tr>
<td>The CCG will ensure it collaborates in the use and requests for information from providers in support of quality, safety and regulation by CQC e.g. through quality surveillance groups and shared intelligence. It will utilise datasets and metric available through the NHS Information Centre.</td>
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The Winterbourne View Report\textsuperscript{27}

The Winterbourne report set out the type of care that people with learning disabilities/autism and behavioural issues should receive. These are:

- People should receive local personalised services that meet their needs, which should be planned from childhood,
- People should be supported in the community, in their home or close to their home and family,
- People should only go to hospital for assessment and treatment if it is necessary and they cannot get the support they need at home or in a community service,
- People that do have to go into hospital for assessment and treatment should receive good quality care as near to their home as possible,
- People should be moved on from hospitals as quickly as possible – either back home or on to other community support,
- Commissioners who place people with learning disabilities/autism in hospital or community support settings should have clear responsibility for each person,
- Commissioners should also make sure that people with learning disabilities/autism are able to see and speak to their families regularly,
- There should be local services that stop people with learning disabilities from having a crisis. If a crisis does happen then there should be local services to help people deal with the crisis.

The CCG has reviewed the cohort of South Norfolk Winterbourne clients as per Winterbourne concordat.

All clients had a joint review by the SNCCG, NNCCG, NCCG and NCC. All clients have discharge dates and are aided to access supported living arrangements in Norfolk, where appropriate. A joint Winterbourne sub-group will feed into a joint commissioning forum to ensure the needs of the learning disability client within Norfolk have the right services in place to ensure they are supported to live as independently as possible. The Winterbourne concordat will also provide a backdrop for improving services for other vulnerable groups including children and young people.

Patient safety

The scrutiny of information and metrics by the CCG of measures including the safety thermometer, never event and serious incident data and the other quality metrics enables the consideration and of emerging themes and trends in patient safety and harm to patients. The CCG cooperates with, and participates in, the emerging patient safety collaborative being set up by NHS England whose aim is to provide a network of patient safety learning and improvement to continually improve care at the front line and to reduce the likelihood of harm to patients.

The increase in reporting of harm and in particular the reporting of medicines related incidents will continue to be promoted through contractual and quality improvement discussions with providers and stakeholders. Monitoring of the levels of reporting through the National Reporting and Learning System (NRLS) and through Serious Incident (SI) reporting routes will support the NHS Outcomes framework aim of higher reporting. SNCCG will continue to work closely with commissioned providers to reduce levels of harm by increasing awareness of best practice and innovative approaches to service delivery. In particular we are focusing on four national high impact actions: Pressure ulcer prevalence, Catheter acquired urinary tract infections (CAUTI), Falls, Venous Thrombo Embolism (VTE). In addition we are focusing closely on the early identification and treatment of Sepsis.

Infection Control

Over the coming year we will build on learning from local reviews with our providers by continuing to optimise the use of root cause analysis of all incidents, including those in the infection control review process for Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile to identify lessons learned and action required to prevent recurrence. We have refreshed all our quality schedules with each provider to ensure latest infection control guidance is reflected in contracts which will be monitored through local audit and observation of practice. We will also continue to participate in the EoE Quality Surveillance group to identify early warnings of service and quality failings, in order to address the risks to patient that the potentially raise.

We continue to strive in Norfolk to achieve zero MRSA bacteraemia cases for 2014-15 as per national guidance. A substantial effort to achieve this end continues throughout Norfolk in terms of implementation of robust Infection Prevention &Control (IP&C) standards in all areas of healthcare. This is reflected in our ongoing excellent performance for MRSA bacteraemias in acute trusts i.e. No acute hospital bacteraemias for 23 months.

Through the Post Infection Review process for some of our most recent community MRSA bacteraemia cases it is apparent that best practice has been met at each stage of the patient journey and unlikely that any other interventions would have made a difference to the patient outcome in terms of developing the bacteraemia. Therefore the question can be posed 'have we begun to reach an irreducible minimum'?

Norfolk will continue to exercise 100% efforts in ensuring the highest standards in IP&C across the health economy to strive to achieve zero MRSA bacteraemias for 2014/15.

Regarding Clostridium Difficile infections, we are committed to keeping the number of infections to a minimum.

For SNCCG we have a target of no more than 59 cases during 2014/15 and have also set our main hospital and community providers individual targets.

Health Associated Infection Control - New initiatives for 2014

- The Public Health Infection Control Team Liaison Nurse will be focusing on the learning from CDIFF Community root cause analysis (RCA.)
- In order to follow up on patients who have been discharged from an Acute setting to a Community setting prior to their MRSA results being received to ensure there is effective liaison with the patients GP and the relevant Community Team. It is anticipated that this
will have an impact by reducing MRSA Bacteraemia which is an outcome from RCA learning.

- The role will also support our understanding around the Epidemiology of Community of Community related CDIFF cases. To date Norfolk has observed CDIFF cases reducing in the Acute setting but not in the Community.
- A greater emphasis will be placed by the Health Care Associated Infection (HCAI) Team on behalf of South Norfolk Clinical Commissioning Group (CCG) on our Care Homes. This will be achieved by working collaboratively with Norfolk County Council (NCC) and other partners to meet the Harm Free Care agenda. A particular focus will on producing Catheter acquired infections by educating Care Home staff and improving clinical competencies.
- The HCAI Team on behalf of SNCCG will work in collaboration with Public Health England to develop and implement a range of study days to support all providers of commissioned health care.
- The HCAI Team on behalf of SNCCG will work closely with domiciliary care providers to identify the needs of domiciliary care staff. This will include joint working with NCC Joint Response Team.
- The HCAI Team with SNCCG will work with other providers including Acute Hospitals outside of the Norfolk area to identify best practice, innovation and shared learning.
- SNCCG will work closely with the HCAI Team to design a 5 year Health Care Infection Control strategy. This will also involve collaborative working with the Norfolk HCAI Network.
- SNCCG will continue to ensure zero tolerance for all MRSA Bacteraemia across all providers.

**Patient Experience**

Patient experience metrics are reviewed contractually for all commissioned providers identifying trends and themes of the complaint and feedback received and whether there are month on month improvements. Evidence is provided through ward to board that complaints are efficiently and effectively addressed.

The CCG will continue to focus on feedback from patients and staff, ensuring whistleblowing policies are known and understood and that staff trust the organisation has a no blame culture.

Patient experience of vulnerable patients will be improved through learning from serious incidents, complaints and serious case review findings.

Joint working through the *Domino* initiative and urgent care network with all providers and CCGs will continue to ensure admission prevention strategies and early supported discharge are in place.

Development of specific feedback mechanisms related to each vulnerable group will continue to be integral to capturing issues important to them as well as capturing carer feedback. Adult safeguarding forums and information sharing mechanisms with Healthwatch, CQC, NCC and the CCG will continue and be strengthened by joining the quality monitoring of providers, particularly in the care home sector and supported living.
All patient experience feedback from both the provider and the CCG is reported monthly through performance reporting to both the Clinical Executive (senior leadership) and the CCG GB.

**Triangulation of Patient Experience, Complaints and Incidents**

The CQRM for NHS provider organisations monitor patient satisfaction, incidents and NHS provider organisations reported complaints. This information is triangulated with the commissioner’s complaints that are received by SNCCG and/or via the NELCSU on behalf of SNCCG. SNCCG regularly review this information for any potential early warning signs and to identify any themes or trends that could affect the quality and safety of services for SNCCG patients.

**Friends and Family Test (FFT)**

The FFT is applicable to all providers’ inpatient areas, A&E, paediatrics, obstetrics and gynaecology, and outpatient clinics. An increase in the number of patients asked is being incentivised through the national CQUIN for 2014/15. This will include FFT staff surveys, as well as annual staff surveys and recruitment that are focused on each organisations values and behaviours.

SNCCG are also working closely with NCHC to design a Community hospitals quality dashboard that will incorporate the FFT along with patient opinion and local patient survey information to provide a robust quality indicator for a number of clinical pathways. It is hoped that this help inform future application of the Friends and Family test across other areas of the NHS. The CQUIN for FFT is driving zero detractors and this will be concentrated within inpatient areas of all providers. This will provide an additional dimension for providers to review patient safety, clinical quality, and patient experience metrics to improve the overall patient satisfaction in their experience of care.

The initial role out of FFT has proved to be a learning curve both locally and nationally. The learning that has been gained has been shared, and will aid us in supporting providers in the further role out.

Through the joined up working of the CCGs, Area Team and providers we are able to look ahead at the future role out plans and prepare providers for what they should expect and ask them in advance to consider how FFT will function and the challenges they foresee, in order to begin trouble shooting early on.

SNCCG has been successful in winning a national bid for a three month project to look at the practicalities of FFT being used within the community hospital setting and on specific pathways. This will enable the CCG to explore with our providers prior to roll out what this will look like and work with the national team to show the practicalities that need to be considered prior to official implementation. This project will also lead to the development of a community hospital quality dashboard that will allow us to easily triangulate patient experience data in a way that will give both ourselves and providers a holistic picture of performance.

NCHC have already piloted FFT for the past year through their own initiative and gathered a wealth of information as to the barriers they have faced. This will be shared in summary with other similar providers locally. We will work with providers to achieve and maintain their FFT
response rates and work with the East Anglia Area Team to learn from other provider success stories, as well as sharing our own.

The FFT scores for providers will be monitored to drive improvement and we will work closely with providers to support them in implementing learning from the qualitative feedback. Ways of using technology to drive patient experience feedback and response rate improvement with providers who are struggling will form part of our ongoing assessments and again our successful project funding will support this. We will also work with local health watch PPGs to evolve our co-production of service improvement through FFT feedback.

Quarterly staff FFT will be reviewed and we will work with providers to ensure they share openly the feedback and work with staff to take on board qualitative comments and where possible implement change.

We want to ensure providers give positive feedback received through FFT to staff and that they work with staff on negative feedback received in a way that gives them ownership and input to improvement and learning. We will be ensuring all providers operate an honest and open environment to share the ‘You said… We did…’ concept in public areas and staff rooms.

The FFT placement in GP contracts for 2014/15 from December will mean GP's are obliged to participate in the collection of this data. SNCCG will commence work early on in 2014 with PPG groups and the AT to look at how this will impact GPs and the way in which they will go about the practicalities of the implementation. Questions we want to answer prior to roll out:

- With what frequency will FFT be delivered to patients?
- How will the frequency be monitored?
- How will the response rate be recorded to match the frequency?

Compassion in practice

The “NHS Nursing Strategy: Compassion in Practice” sets out the shared purpose for nurses, midwives and care staff to deliver high quality, compassionate care, and to achieve excellent mental and physical health and wellbeing outcomes. It builds on the enduring values of the NHS, and the rights and pledges of the NHS Constitution. The strategy sets out six areas for action to be implemented over the next three years:

- Staying independent, maximising wellbeing & improving outcomes,
- Improving patient experience,
- Delivering high quality care & measuring impact,
- Building & strengthening leadership,
- Right staff, right skills, right place,
- Supporting positive staff experience.

http://www.england.nhs.uk/nursingvision/
SNCCG will ensure that all local provider plans are delivering against the six action areas of the Compassion in Practice implementation plans and how the 6Cs are being rolled out across all staff groups through the Clinical Quality Review meetings held monthly each month but more importantly by direct observation of practice during site visits to clinical areas as part of our on-going programme of visits to providers.

Safeguarding

The Norfolk-wide system has reviewed its adult safeguarding strategy as well as developing a system-wide action plan of implementation. This will include information sharing mechanisms and aligning clinical incident and serious incident reporting to NCC, identifying reporting thresholds in line with the national guidance, and ‘No secrets’ guidance which is facilitated by the health sub group chaired by all Norfolk CCGs.

SNCCG are also ensuring the following actions are undertaken with regard to safeguarding:

- Adult safeguarding training will be standardised against the Bournemouth competency framework. The Mental Capacity Act (MCA)/Deprivation of Liberty Standards (DOLS) competency framework will be developed and rolled out as a Norfolk-wide system within health.
- Reporting mechanisms in the form of Key Performance Indicators (KPIs) will be clearly set out in each contract with providers and reporting on all aspects will take place monthly.
- Quality Inspection visits are in place to review safeguarding systems and processes, as well as asking staff and patients for feedback.
- Safeguarding referrals and lack of reporting will be monitored through quality sub group meetings that fit within the contractual process.
- Workshops and training to raise awareness of the Prevent strategy within the healthcare will take place with a DVD-based training package called HealthWRAP – Workshop to Raise Awareness of Prevent. The workshop, aimed at any NHS staff; front line staff, managers and clinicians, is designed to help make them aware about their contribution in preventing vulnerable people being exploited for terrorist purposes. The workshop improves understanding of the processes used by terrorists to radicalise individuals and ensures staff are aware of who to contact within their organisation to discuss any concerns. Numbers of staff who access this training will be monitored through the contractual process.
- All providers have this new guidance built into quality schedules which will be monitored going forward via the CQRM process.

SNCCG’s response to Winterbourne View, requires an end to all inappropriate healthcare placements for every person with a LD and/or Autistic Spectrum Disorder (ASD) with complex needs and challenging behaviour by June 2014, and that they receive the right care in the right place, in accordance with the Winterbourne Concordat

For all detained patients with a LD within private hospitals, both the CCG and NCC have undertaken a joint review of all placements. Where appropriate, discharge dates into community settings and access to supported living arrangements in South Norfolk, have been established.

Safeguarding Adults

Adult Safeguarding has become firmly enshrined in our commissioning activity, with significant amendments made to contracts and quality schedules for the coming financial year. This is to reflect how changes to national policy and guidance impact locally, to build upon locally identified gaps in provision and to ensure that findings of recommendations from Serious Case Reviews (SCR) and Domestic Homicide Reviews (DHR) are implemented. Performance indicators are in place to ensure that NHS provider organisations implement appropriate training and have appropriate systems in place to ensure that their staff have the skills to identify individuals at risk and that they are able to manage their needs appropriately. This includes a requirement to report on provision of training regarding Adult Safeguarding, MCA/DOLS, Domestic Abuse and individuals at risk of radicalisation (Prevent).

The CCG will continue work actively with partnership organisations to support the Norfolk Safeguarding Adults Board and to implement its strategies in delivery of a system that protects adults at risk of harm and that respond appropriately where abuse or neglect have occurred. Key work by health over the coming year will see a bespoke training package rolled out in relation to the MCA/DOLS/Best Interests, which will be available to all NHS providers including those in Primary Care. A number of training sessions will be implemented within CCG’s and NHS providers to widen the understanding of the joint Home Office/Department of Health (DH) Prevent agenda, which looks at early intervention to prevent many of society’s most vulnerable people becoming involved in criminal activity. In addition, in partnership with the Norfolk Police and Crime Commissioners Office, a training package has been developed to increase awareness in primary care regarding the risk factors and early warning signs in domestic abuse, alongside information on how to raise these concerns appropriately and source support for service users.

Safeguarding Children

Health organisations in Norfolk continue to meet requirements as set out in the working together to safeguard children March 2013 and execute their roles and responsibilities to safeguard and protect children and young people from significant harm. They will strive to meet their statutory requirements as stated in statutory guidance (2009) in promoting the health and well-being of Looked After Children (LAC) and implement recommendations from the system wide review for LAC as agreed at the Child Health and Maternity Commissioning Board.

Children and young people in Norfolk continue to be a priority to improve safeguarding and looked after children arrangements. There are clear plans to bring about improvement within the multi-agency context. Norfolk health has a clear structure and ownership at all levels to ensure that there is buy in to achieve a strategic vision to bring about improvement and partnership working. Health will be represented on the improvement board that has been set up following areas highlighted in Ofsted inspections as requiring improvement as well as NSCB and subgroups.

There will be measures in place that is included in contracts to report key areas of performance and any actions that come from those reports. Each health organisation will have a Work plan related to the improvements to safeguarding and Looked After children and the designated team will have an overarching view and have oversight of development and progress from inspection and serious case reviews included in the plans. There will be
single and multi agency audits to demonstrate meeting required standards that have been set which will be reported to boards for further scrutiny.

Key strategies and areas identified as a priority with a national direction such as Child Sexual Exploitation will continue to be progressed and developed within Norfolk health with regular reports on progression.

Identifying and reporting Domestic abuse will be monitored and any identified challenges with recommendation and actions will be delivered and escalated where highlighted.

Safeguarding children Training in health continues will be developed and delivered both single agency and multi-agency in line with the Safeguarding Children and Young People: roles and competencies for health care staff Intercollegiate Document’ (Royal College of Paediatrics and Child Health (RCPCH))\(^3\), September 2010 and Looked after children Knowledge, skills and competence of health care staff Intercollegiate Role Framework (RCPCH, May 2012) and monitored through the contractual framework.

Safeguarding Clinical Leads

SNCCCG has direct support from the Norfolk Health children’s safeguarding team that we commission and there is a named Safeguarding nurse (Sandra Corry) and a Children’s Safeguarding GP (Dr Hilary Byrne). Both are members of the South Norfolk children’s safeguarding board and are represented at the Norfolk Children’s Board.

Governance

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

- The decision making and planning arrangements within SNCCCG, and how this supports delivery of quality services,
- The agreed programme management approach to track delivery of the Quality, Innovation, Productivity and Prevention (QIPP) programme,
- Responsibilities and accountability for performance delivery, including financial balance and activity levels.

Governance arrangements

The CCG GB meets bi-monthly in public and has prime responsibility for the scrutiny and approval of strategic and operational plans. The agenda and minutes of each meeting are published on the CCG website, so they are accessible to all. The GB is supported by a weekly senior management team meeting and a monthly Leadership Team meeting (including elected governing body members and senior managers) as well as monthly GP locality meetings. In addition, we have good links with all of our local stakeholders through a dedicated full time engagement lead.

In accordance with statutory legislation, the GB has responsibility for:

30 http://www.rcpch.ac.uk/sites/default/files/asset_library/Education%20Department/Safeguarding/Safeguarding%20Children%20and%20Young%20people%20202010G.pdf
Ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principles of good governance (its main function),

- Determining the remuneration, fees and other allowances payable to employees or other persons providing services to the group and the allowances payable under any pension scheme it may establish; (2006 Act),

- Approving any functions of the group that are specified in regulations (2006 Act).

As a member of the CCG’s GB, each individual will share responsibility as part of the team to ensure that the CCG exercises its functions effectively, efficiently, economically, with good governance and in accordance with the terms of the CCG constitution as agreed by its members. Each individual is there to bring their unique perspective, informed by their expertise and experience.

Individual members of the group’s GB will bring their unique perspective, informed by their expertise and experience. This will underpin decisions made by the group’s GB and will help ensure that as far as reasonably practicable:

- The values and principles of the NHS Constitution are actively promoted,
- The interests of patients and the community remain at the heart of discussions and decisions,
- The group’s governing body and the wider CCG acts in the best interests of the local population at all times,
- The CCG commissions the highest quality services and best possible outcomes for their patients within their resource allocation, and
- Good governance remains central at all times.

The GB has appointed within its constitution an audit, remuneration and quality and patient safety assurance committee as formal committees of the GB as such, minutes from meetings will be published in the public domain as part of the GB papers.

**Council of Members (CoM)**

The CoM meets quarterly and responsibilities include ratifying the vision, values and strategic direction of the CCG as a whole. The CoM is made up of the practice representative from each member practice. Members of the GB are invited to update members as to the work of the CCG and are held to account by the membership accordingly.

**Clinical portfolios**

Each GB member holds a clinical portfolio and leads on the development and oversees the delivery of the redesign work programme for that area of work within South Norfolk. It is their responsibility to oversee implementation and evaluation of the impact of a redesign programme that supports:

- The vision and priorities for the CCG as outlined in the Integrated Plan,
- Improving quality of care delivery locally,
- Delivery of the QIPP objectives,
- Ensuring that principles of clinical leadership and public engagement are paramount.

The clinical portfolios are: emergency and urgent care; integrated care and out of hospital; MH and learning disabilities; children and families; quality in primary care and planned care.
Performance and Delivery

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

- Performance against key national and local targets;
- Key clinical quality and patient safety issue;
- Delivery of QIPP;
- Financial performance;
- Analysis of acute activity.

The Report provides:

- The Leadership Team with a detailed ‘early warning’ system across the performance landscape, highlighting those areas where performance delivery is not in accordance with agreed targets or trajectories.
- Outlines the mitigating actions being undertaken to address the issues.

The Report is subsequently presented to the GB, providing a further level of scrutiny and accountability.

GB Assurance Framework (GBAF)

GBAF provides SNCCG with a simple but comprehensive method for the effective and focused management of risk. Through the GBAF the CCG GB gains assurance that risks are being appropriately managed throughout the organisation.

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

The GBAF is seen as a working document and is updated regularly by the Senior Management Team, monitored by the Audit Committee and reported to the GB at each of its meetings.

Identified Priority Areas for Quality Improvement

- Development of Clinical Quality review process for LD.
- Continue emphasis on Pressure Ulcer Prevention in the Community.
- Early identification and treatment of Sepsis across Community and Acute settings.
- Focus on continued improvement of reducing unplanned admissions.
- Shift the routine assessment and intervention of Diabetes type 1 and 2 care from the acute setting to Primary Care.
- Focus on prevention of CAUTI.
- Development of Community Hospital quality indicator set/dashboard.
- Development of FFT to provide pathway specific patient and family experience.
- Continue to improve MH provider’s utilisation of data to inform quality and Patient Safety Assurance processes.
- Focus on recruitment and retention of MH staff and improve quality and capability.
- Continue to improve the assessment and on-going monitoring of people with MH needs physical health.
- Work collaboratively with NCCG and NNCCG in the review of the Ligature framework and suicide rates.
- Review with NSFT the use and monitoring of out of area placements.
- Continue to improve patient experience of Section 136\(^{31}\) by redesigning existing arrangements between providers including the police to ensure improved speed of assessment and transportation.

**Commissioning and Planning**

At specific times in the year, the CCG will review its medium to long-term strategic plans and set out its annual commissioning and operational plans. SNCCG adopts the planning model cycle set out below:

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

Commissioning Intentions 2014/15-15/16

The following section sets out SNCCG’s commissioning intentions for 2014/15 and beyond. The detailed projects which support these intentions and continue to provide high quality, sustainable and efficient services to the local population are set out in the following sections.

SNCCG’s commissioning intentions form part of the annual planning cycle which commences development in the summer and finishes with agreed and signed contracts with providers by the 31st March of the following year.

SNCCG is required to demonstrate that the process for developing its plans and priorities is inclusive and transparent and that stakeholders are aware of and understand SNCCG priorities. SNCCG must also ensure that member practices understand, at least at a high level, their local plan and priorities.

The 2014/15 planning process commenced in June 2013 to ensure there was sufficient time to develop plans that have evolved from a local level based on the JSNA and SNCCG Commissioning Strategy 2012/16.

SNCCG Locality Groups were all made aware of the requirement for their involvement during June 2013 and the Commissioning Intentions Process was presented at the CoM on 10th July 2013.
The draft commissioning intentions were discussed and prioritised at a GB Workshop on 6th August 2013 where the GB evaluated the commissioning intentions via a two stage process designed to support them in prioritisation:

**Stage 1** - comprised a standardised scoring system against which all commissioning suggestions could be evaluated to ensure that the scheme would deliver cost savings and/or quality improvement. It also looked in more detail at the scheme’s QIPP aspects.

**Stage 2** - considered which, if any, strategic requirements it supports, overall impact and importance to SNCCG’s members.

SNCCG then proceeded to issue letters to all major providers setting out the Commissioning intentions for 2014/15 in line with the priorities agreed by the GB.

The Commissioning Intentions fall into two categories:

**Contract Negotiation**

The contract issues have been negotiated from November 2013 onwards with an anticipated completion date for negotiations by 28th February 2014. Although some items are clarification...
of technical coding and counting, much of the negotiation will be around improving patient experience, and quality and safety.

**Commissioning for QIPP**

The remainder of the commissioning intentions will form SNCCG’s QIPP programme for 2014/15. The QIPP process for SNCCG developed during 2013 has resulted in a sophisticated QIPP Tracker that will be used for all commissioning projects in 2014/15. It is designed to record the essential information and data to enable electronic monitoring of progress and performance. Each project has a charter and progress against the QIPP targets in these is reported monthly to the NHS England Area Team via the usual financial reporting returns and at the quarterly assurance meetings.

The QIPP Tracker and its associated business processes give the GB greater assurance of progress as it provides:

- Timeframes and electronic reporting templates
- Summary highlight reports for each project delivered by the project team
- Key Risks for each project
- Milestones for each project
- Work Stream descriptions for each project
- Deliverables for each project
- Measurable outcomes for each project
- Areas within the commissioning programme affected by each scheme.

SNCCG has a QIPP target of £8.8m in 2014/15 and has developed plans to this value. To provide some contingency and risk mitigation other potential initiatives are in development.

Details of the developed plans, other potential initiatives and their related QIPP targets are provided in the programme areas detailed in the following sections. For more detail on the Finance and Governance of QIPP please see the Financial Plan section of this document.
SNCCG aims for 2014-16

Our Aims
To deliver the highest quality INTEGRATED healthcare to improve the health and well being of the people of South Norfolk

These aims are supported by six main programme areas that will drive the delivery of this Operational Plan and are illustrated overleaf;
SNCCG Programmes

Out of Hospital Care
- Full integration of out of hospital, social and community care service delivery
- Developing new forms of organisations
- Stimulating the market for providers
- Continuing care
- Integrated services for Primary care, intermediate care (rehabilitation) and falls prevention
- Maximising independence
- End of life delivered at right time, right place
- Identify and support dementia
- Primary care mental health focus

Better Care Fund*
- Reduce variation
- Right setting, right time
- Daycase to outpatient shift
- Patient choice
- Pathway review and patient flow
- Reduce length of stay
- Refine prior approval and thresholds

Planned Care
- Reduce A&E attenders and A&E admissions
- Deliver stroke services according to best practice tariff and service specification
- Pre-admission services
- Local ambulance RPIs
- Right clinical decisions makes in right place

Emergency Care
- Address impact and harms of drug and alcohol use
- Re-commission improving Access to Psychological Therapies (IAPT)
- NSFT strategy delivery re: quality and access
- Identify and support dementia
- Primary care mental health focus

Mental Health & LD
- Early health and intervention services
- Accessible, high quality CAMHS pathway
- Children & Families Act 2014
- Healthy weight & obesity prevention (Tier 3)
- High admissions pathway i.e. long term conditions
- Looked after children

Child Health & Maternity

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Programmes and initiatives

The CCG’s work programmes and initiatives are delivered through six work stream sponsored and led by GB members. Each of the work stream is clinically led except Child Health & Maternity.

The SNCCG Health Profile puts a clear emphasis on the following key elements that will impact on the health of the local population and need to be at the heart of our commissioning and operational plans:

- **Demographic changes** – particularly increases in the population of older people,
- **Increases in age related and long term conditions** - putting economic pressures on the health system as a whole; in particular Dementia, Diabetes, Cancers and Falls as a result of increased frailty,
- **Obesity**
- **Promoting healthy lifestyles** - tackling smoking, alcohol and exercise and addressing health inequalities and deprivation,
- **Reducing variation in referrals and access** – particularly given the rurality challenges.

A summary of the key health issues that have informed the healthcare strategy and commissioning intentions of SNCCG during the planning period 2014-16 are:

- Cardiovascular Disease (CVD)
- Coronary Heart Disease (CHD)
- Stroke or Transient Ischaemic Attacks (TIA)
- Cancer
- Diabetes Mellitus (ages 17+)
- Depression
• Chronic Obstructive Pulmonary Disease (COPD)
• Obesity
• Teenage Pregnancy
• Depression and Mental Illness
• Dementia
• Falls
• Osteoporosis
• Smoking, including smoking in pregnancy

Health improvement interventions to tackle smoking, alcohol consumption and exercise will be commissioned by NCC’s PH team, supported by the SNCCG. This team will also take on the responsibility for the commissioning of 0-5 years children’s services from April to October 2015 but this may happen earlier and SNCCG are preparing to work collaboratively with PH when required.

All workstream projects are also summarised in an accompanying Excel document [http://www.southnorfolkccg.nhs.uk/about-us/publications](http://www.southnorfolkccg.nhs.uk/about-us/publications) that illustrates:

• Workstream leads
• Key aims of each project
• Timeframes for commencement
• Proposed KPI / project metrics
Out of Hospital Care

SNCCG’s overall aim with regard to out of hospital service and service integration is:

“Better outcomes for people and patients in South Norfolk, indicated by maximising their potential for independence and living (or dying) at home wherever possible if they choose”

The vision of integrated care includes:

- A single assessment process across health and social care, with systems to allow appropriate sharing of necessary information,
- Identified key workers who understand individual patient’s social as well as medical contexts,
- Services that are simple to use and can be “switched on” via a single call and assessment,
- Services being arranged around patients’ GP surgeries with access to a wider range of social, voluntary and housing-related services,
- A Single Point of Access (SPA) to the range of services available in both health and social care,
- A universal expectation that all services delivered at or close to home will be delivered with respect, compassion and a personalised approach to care.
- A reduction in health inequalities and inequities in access for disadvantaged and minority groups.

A key focus of integrated care is the need to achieve increased levels of integration of service delivery across services provided by different providers, both NHS and beyond, in
order to improve service quality, efficiency and clinical outcomes. SNCCG is developing a performance management framework that will drive integration through measurement against a range of key indicators.

Examples include:

- Reduction in number of visits to site and no repeated tests,
- Patients only give information once,
- Patients are provided with public health / well being advice at each visit,
- Develop and improve End of Life (EoL) care at home (including ‘closer to home’ and local specialised services),
- Develop and review information sharing protocols and adopt “e-PACCS” system or similar (with the pilot project already in place),
- Integration (contractual not just organisational) of health providers (community and investigate potential for acute) and social care and third sector (plus independent sector), e.g., SNCCG will plan to commission all care for the people of South Norfolk, i.e., not just health but social care, housing, advice and support to ensure that the outcomes of all organisations are focussed on the same goal – the patient/service user – despite different organisational objectives and government-driven pressures,
- Community-based rehabilitation and reablement; effective model of and management of community beds and virtual wards integrated with social care and independent providers.
- Develop a system of hospital care at home,
- Greater emphasis on prevention; i.e., falls, LTCs; attempting to reduce avoidable emergency hospital admissions further and slow the rise in inappropriate referrals,
- Define outcome-based performance indicators for each provider and the health and social care system,
- Develop a universal currency for health (and social care) interventions based on outcomes not just inputs,
- Develop integrated care pathways with GPs and social care to support more (older) people to live independently at home for longer with lower calls on the care system and to develop systems that allow the GP to be at the centre of (older) people’s care.

What initiatives will SNCCG undertake to tackle these health challenges?

Primary care Provided at Scale

SNCCG will support NHS England in the development of wider primary care – delivered at scale – particularly for people with long term conditions, including mental health conditions. This work runs through every aspect of the out of hospital plan and will enable general practice, community pharmacy services, dental services and primary eye health services to play a much stronger role in integrated services.

Support for people with Long Term Conditions: Case Management and Self Management

SNCCG seeks to improve the patient experience by promoting and enabling self-management and is aiming to provide support to allow people to manage their own conditions. The LTC priorities for SNCCG currently include:

- Dementia
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Heart Disease (CHD)
The improved outcomes for people with LTCs will be measured through:
- Reduced permanent admissions of older people to residential and nursing care;
- Increased proportion of older people still at home 91 days after discharge into reablement/rehabilitation;
- Reduced delayed transfers of care from hospital;
- Reduced avoidable emergency admissions;
- Improved patient/service user experience of care.

SNCCG is undertaking an evaluation of case management as a model of improved coordination of care and outcomes for the patient, not simply as an admission avoidance technique (for which the latest evidence indicates it is not truly effective). SNCCG is considering a risk-stratification approach to case management and we wish to review the effectiveness of established education programmes for LTCs and develop further into other clinical areas such as neurology, pulmonary rehabilitation, angina and arthritis care. There is also a plan to expand and improve the specialist heart failure nurse service over time. The risk stratification approach will also allow identification and prioritisation of those people with clinical risk factors, enabling support to be delivered as described below.

Plans for case management of LTCs and self management builds on the developments and foundations that the Frail Older Person (FOP) and integrated care organisations (ICO) projects have provided, particularly that of the Integrated Care Liaison Officers (ICLOs) and the embedding and strengthening of Practice based multidisciplinary team (MDT) meetings (which are being included in the ‘Better Care’ proposals). The CCG has recognised the value of targeted use of assistive technology in the management of certain LTCs and will investigate this further and where practicable link to GPs being at the heart of the care for older people and to risk stratification and integration.

The CCG’s outcomes for people with LTCs are outlined in the ‘Better Care’ /integration proposals and include:
- People with long-term conditions being comprehensively supported because their care is closer to home;
  - GPs and practices will be at the centre of teams in which access to skills, knowledge and health and social care is seamless;
  - GPs, patients and carers will feel confident that there are support services available following diagnosis;
  - People will feel more confident about managing their long-term conditions with services arranged to deliver ‘the right intervention at the right time’ to prevent unnecessary hospital admission and to support timely discharge.
- Effective liaison and support will enable mental health problems to be picked up in a timely way, especially where there are concurrent physical health problems, and will promote effective management and recovery;
- Patients and carers will have planned ahead, will be in control if their care at the end of their life and will feel confident the right support will be there when they need it.

Community Nursing Specification Improvements

SNCCG has led improvements in its Community Nursing Service specification (in collaboration with the other Norfolk CCGs), seeking to simplify and better performance-
manage the service provided by NCHC. The intention is to develop better outcome-based performance and a wider recognition by the provider of the whole-system approach to patients – a ‘virtual integration’ through the coordination of specifications and a more transparent link to the NHS ambitions and the ambitions of the CCG.

**Continuing Healthcare**

SNCCG continues to work towards avoiding patients having automatically to change their provider (community health and/or social care) as a result of becoming eligible for continuing healthcare.

Working with NCHC and NCC and NNUH, the CCG wishes to ensure that the majority of patients identified as potentially eligible for NHS Continuing Healthcare while in an Acute hospital are more appropriately assessed in a community setting, where possible, as this is a more robust indicator for a person’s long-term care needs. It can also enhance their chances of maintaining their current level of independence and quality of life – one of the stated ambitions of the CCG.

**Reablement (enhanced)**

The SNCCG area has been the site of two successful pilot schemes to integrate the health and social care elements of reablement and improve discharge from hospital. SNCCG wishes to roll these principles out into community hospital (rehabilitation and intermediate care) beds in NHS and independent-sector facilities. The intention is to reduce the length of stay (LOS) in all bed environments and maximise independence for individuals for as long as possible at the lowest level of appropriate health and/or social care intervention.

**Falls service**

Recognising the importance of falls prevention and of helping older people recover their independence after illness or injury we have established a local falls and dementia group to coordinate improvements. We have enhanced the existing specifications within the Community Nursing and Therapy service to increase the element of primary prevention and make links with other partners (especially District Councils and Housing Associations) to ensure they are able to form part of a network of prevention. Further work with partners should see a reduction in the number of people conveyed to hospital and a much wider emphasis on, and understanding of, falls prevention and risks across all sectors of the community.

**Frail and Older Peoples Project (FOPP)**

SNCCG is planning to refine, review and develop the approach to the FOPP, integrated care and care homes initiatives (and building further through the ‘Better Care’ plans) and multi-agency working via the BCF plans (see following section).

This initiative is designed to reduce the impact of acute non-elective admission for the over 65 age group, vulnerable adults and at risk patients. SNCCG will continue to use (and explore greater exploitation of) case management, local step-up/admission avoidance beds and access to local Medicine for the Elderly (MFE) clinical advice. We are looking to work more closely with our providers to develop integrated ‘hubs’, taking advantage of the specialist skills and knowledge from centres providing specialist intermediate care and rehabilitation and the clinical cover within to be more widely available across the community, including the independent sector as part of the team, as recommended in our recent intermediate care review.
SNCCG will also look at case management of patients in care homes, e.g., review of care plans by community matrons or therapists, work with care home staff – nutrition, tissue viability, continence and mobility assessments.

**End of Life (EoL)**

SNCCG is looking to deliver FOP and EoL care with a focus on integration and quality of care by collaborative multiagency arrangements that have an impact on Quality Adjusted Life Years (QALYs) of vulnerable patients.

The CCG will also undertake the following to facilitate the delivery of this workstream:

- Establish a SNCCG steering group for EoL services,
- Explore the need for specialist EoL beds in the locality,
- Explore the hospice at home model and better community outreach,
- Explore continuity of care at home when needs change,
- Encourage greater coordination and GP leadership,
- Reduce acute admissions towards the very end of life,
- Increase the proportion of people dying in their preferred place of care,
- Increase the appropriate uptake of patient-held information (currently known as yellow folders) and electronic coordination of information.

**Communications and Engagement action planning for EoL**

During the process of reviewing and redesigning the EoL strategy the CCG will undertake workshops with patients, carers, providers, member practices and stakeholders. The CCG will also seek to promote the local aspects of the strategy to member practices, stakeholders, patients and carers.

**Diabetes**

As part of an end-to-end review for the type 1 and type 2 diabetes pathway SNCCG are leading on a project to provide better clinical outcomes (which include fast access to expert support, and individualised patient-centred care) for patients.

Stakeholder engagement in this project has already started with a multi-agency /multi-disciplinary workshop held in February 2014. This event looked at mapping and analysing the current patient pathways.

This project links with NNCCG and NCCG to develop an improved pathway that will deliver the following aspects of care:

- A standard pre-diabetes pathway with improved levels of screening plus on-line support for clinicians and patients,
- Standardised patient experience across GP practices, and the skills of practice staff including GP leads, diabetes nurses and Health Care Assistants (HCAs),
- A structured education programme for patients who are newly diagnosed with diabetes (this could be DESMOND or EXPERT),
- A review of medicine management in order to identify any cost savings to bring SNCCG in line with other low-cost, high-outcome-performing CCGs,
- A review of the ‘year of care’ process to activate links and minimise patient interaction with practices,
A review of the current service specification of the diabetes facilitator service to ensure appropriate referrals are forwarded.

Clinical Pathways

SNCCG will seek to implement pathways that provide good care and patient satisfaction, particularly for Dementia.

Reducing emergency admissions

SNCCG will focus on reducing the growth of emergency admissions by seeking to move activity, where appropriate, out of an Acute setting.

Community beds for discharge planning and respite

Building on the recommendations of the SNCCG-led review of community beds, the CCG will continue to support a system of cohesive service redesign that encompasses;

- Community beds (intermediate, step-up, step-down etc.),
- Discharge planning beds (social care),
- Respite beds (social and health care beds, including dementia),
- Domiciliary care in order to reduce unnecessary admissions to acute and ensure quicker discharge home and improved patient outcomes,
- Links to the reablement service integration to reduce the length of stay and get people home sooner to increase their potential for independence,
- Work to develop a local tariff for intermediate care beds or home-based intermediate care.

Thetford community health services

SNCCG will finalise the appropriate service specifications, KPIs and a sourcing strategy for community health services for patients at Practices that are on county borders.

Other areas of work include:

- Gold Standards Framework (GSF) (or equivalent standard) for care homes
- Community geriatrician service
- Third sector services review
- Volunteering strategy
- Home Catheterisation Service
- Cellulitis review
- Community Intravenous (IV) Therapy: roll out of CQUIN/IV therapy in all localities;
- Specialist epilepsy service: to increase the scope of epilepsy care in the community and ensure alignment with best practice models of care.
- Non Emergency Patient Transport Service (NEPTS) – working with providers, local patients and stakeholders in developing communication materials advertising the NEPTS. SNCCG will also develop press releases to announce and promote the new service.
Seven day working – report by Sir Bruce Keogh

SNCCG will be working at a local level to develop a more comprehensive “24/7 community integrated support service for older people and people with LTCs” and seeking to develop an operational model with our CCG and LA partners over the next few months taking into account the full financial and workforce implications of delivering this initiative.

SNCCG is expecting to receive a business case for 24/7 working for specialist palliative care cover from NCHC at the April Community Commissioning Board, which will be considered against the developing EoL plan.

Better Care Fund (BCF)

In January 2014 the Norfolk H&WBB received a paper from NCC’s Director of Community Services which set out the new joint initiative from the DH and the Department for Communities and Local Government (DCLG) concerning the BCF.

The paper noted that the initiative is focused on furthering the integration of health and social care services and requires CCGs and Councils with responsibility for social services (i.e. NCC) to create a pooled budget for the provision of integrated community health and care services. A minimum sum is required to be in the pool, and how this pool is made up is specified nationally. For Norfolk the minimum sum to be transferred into the pool for 2013/14 is £3.482m and for 2014/15 is £62.404m.

http://www.england.nhs.uk/2013/12/15/sir-bruce-keogh-7ds/
http://www.norfolk.gov.uk/view/healthwell080114supagendapdf#page=3
The final plan was approved by Norfolk H&WBB in April 2014, it then passed to NHS England and the DCLG for their approval.

**Progress to date**

The latest work around planning for the BCF has been focused on how the BCF will be implemented in Norfolk. This has focused largely at CCG geography level in order to build on existing integration initiatives in the context of local need and local health and care systems. Attention is paid to how the areas work collaboratively in relation to community and acute health services.

The plan is a draft at this stage but it captures the strong vision, engagement and commitment to integration that all partners have affirmed. It is also able to set out the integration models that each area has developed, founded on detailed work prior to this initiative.

Detailed planning is already underway to create better joined up care for South Norfolk and this will be supported by robust financial planning. The plan will set out how the investment we have in services will support the transformation we need and how this will have an impact on service activity.

The planning process has taken account of the JSNA for Norfolk, the voices of patients and service users and of best practice from both local and national experience. The continuing work to develop a final plan will secure further stakeholder engagement in refining the plans to transform the health and care system. This plan will come to the Board for approval by 4th April 2014. There is a broad similarity of approach (e.g. around developing MDTs) between NNCCG, NCCG and SNCCG but the key task now is to bring plans together into one jointly agreed plan including joint decision making around key elements of the plan, such as a shared local measure; a shared risk register; a shared vision; financial and project plans.

SNCCG continue to make good progress both strategically and operationally on integration including:

- Well established FOP initiatives,
- Developing Multi Disciplinary Teams (MDTs) around GP practices,
- Increasing access to vulnerable patients to support which enables self-management of long-term conditions and supports well-being
- Action plan for NCC, NCHC and NSFT integration priorities,
- An outline Integration plan agreed by the GB,
- Intermediate beds programme,
- Communication and involvement of key stakeholders re: BCF and wider strategic plans.

**Communications and Engagement action planning**

**Development of the BCF in South Norfolk will be via:**

- Communication with patients, stakeholders and member practices via newsletters, website and social media.
- Monthly / quarterly stakeholders workshops.
Local meeting across South Norfolk

Development of Integrated Primary Care Team will be via:

- Work with member practices and stakeholders in designing Integrated Care Teams
- Promotion of the recruitment process for Integrated Care Co-ordinators and MDTs.
- Promotion of “good news” stories coming from Integrated Team activity.

Development of supporting independence, wellbeing and self care will be via:

- Utilisation of stakeholder workshops to develop a comprehensive map of supportive and wellbeing services locally, and identify gaps for commissioning.
- Communication and work with the voluntary sector to promote local projects
- Work with local stakeholders to develop joint communication materials.

Development of integrated care for people with Dementia will be via:

- Supporting the local connections of Dementia awareness and the Dementia pathway.
- Supporting the development, dissemination and delivery of the South Norfolk Dementia strategy.
- Promotion of information, advice and guidance available locally to patients and the public (as defined in the Dementia strategy)

Development of Falls Prevention will be via:

- Supporting the development and delivery of the South Norfolk strategic plan for Falls.
- Working with local stakeholders, patients and member practices in mapping and reviewing the Falls pathway.
- Supporting the implementation of the Cherry Tree project (using the Friends & Family test within community treatment settings (for fractured neck of femur cases).

SNCCG’s overall plan for the BCF is summarised in the illustration overleaf:
### QIPP savings for Out of Hospital and BCF work stream

<table>
<thead>
<tr>
<th>PROJECT TITLE</th>
<th>CCG LEAD NAME</th>
<th>PROJECT START DATE</th>
<th>ACTIVITY IMPACT START DATE</th>
<th>Net QIPP Saving</th>
<th>Proposed KPI or Metric</th>
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<td>Chris Coath</td>
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<td>01/07/2014</td>
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<td>Continuing Health Care</td>
<td>Jossy Pike</td>
<td>01/01/2013</td>
<td>01/10/2014</td>
<td>574</td>
<td>Financial performance against the plan</td>
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<td>Return on primary care investment</td>
<td>Rob Cooper</td>
<td>01/04/2014</td>
<td></td>
<td>180</td>
<td>Reduction in admissions for &gt; 75</td>
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<td>Reablement</td>
<td>Hannah Martin</td>
<td>01/04/2013</td>
<td>01/10/2014</td>
<td>163</td>
<td>Actual contract performance</td>
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<tr>
<td>Patient Transport</td>
<td>Hannah Martin</td>
<td>01/04/2013</td>
<td>01/10/2014</td>
<td>150</td>
<td>Reduction of occupancy in of independent sector beds</td>
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<td>Intermediate Care Beds</td>
<td>Wendy Hicks</td>
<td>01/04/2013</td>
<td>01/10/2014</td>
<td>100</td>
<td>Increase in choice of death in care homes and at home</td>
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<tr>
<td>End of Life</td>
<td></td>
<td>01/04/2013</td>
<td>01/01/2015</td>
<td>95</td>
<td>Reduction in emergency admissions over 75s</td>
</tr>
<tr>
<td>Frail &amp; Older People Project</td>
<td></td>
<td>01/04/2013</td>
<td></td>
<td>60</td>
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</tr>
<tr>
<td>TOTAL</td>
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**Potential initiatives**

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<th>PROJECT TITLE</th>
<th>CCG LEAD NAME</th>
<th>PROJECT START DATE</th>
<th>ACTIVITY IMPACT START DATE</th>
<th>Net QIPP Saving</th>
<th>Proposed KPI or Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Conditions Review</td>
<td>Katy Blakley</td>
<td>01/04/2013</td>
<td>01/10/2014</td>
<td>125</td>
<td>Reduction in emergency admissions over 75s for patients diagnosed with diabetes, COPD, CHD</td>
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<tr>
<td>Various Initiative £50k or Less</td>
<td></td>
<td>01/10/2013</td>
<td>01/12/2013</td>
<td>105</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td>230</td>
<td></td>
</tr>
</tbody>
</table>
Planned care

Hospital care, in addition to representing a significant part of overall spend for CCGs, can be a less cost effective means of treating patients than care options which are provided in community and primary care settings. Because of this, the planned care agenda is a key area of focus for SNCCG in responding to the needs of the South Norfolk population and providing high quality, routine services which represent value for money and bringing care closer to home.

SNCCG aim to deliver the best quality clinical services for people with non-urgent medical conditions while curtailing the growth in demand for elective treatments in secondary care. The CCG also aim to reform planned care and systems of referral to ensure that patients receive referral to the most appropriate forms of treatment at the right time and in the best setting for them. SNCCG will work closely, where relevant, with other CCGs through the established collaborative Acute Commissioning Board (ACB) and NELCSU in contract management, pathway redesign and the delivery of strategic objectives.

SNCCG compared its Health Profile Data (from the Eastern Region Public Health Observatory\(^{34,35}\) (ERPHO)) in 2013 and these reflect the following issues:

<table>
<thead>
<tr>
<th></th>
<th>SNCCG rate against national average</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP referral rates</td>
<td>Higher</td>
</tr>
<tr>
<td>Growth trend for GP referral rates</td>
<td>Lower</td>
</tr>
<tr>
<td>Number of non elective admissions</td>
<td>Lowest quintile</td>
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<tr>
<td>Growth rate for non elective admissions</td>
<td>Below national average</td>
</tr>
<tr>
<td>Number of elective admissions</td>
<td>Equal</td>
</tr>
<tr>
<td>Growth trend for elective admissions</td>
<td>Faster</td>
</tr>
</tbody>
</table>

\(^{34}\) [http://www.erpho.org.uk/](http://www.erpho.org.uk/)
What initiatives will SNCCG undertake to tackle these health challenges?

Reduce variation

SNCCG will work to improve the quality of referrals to reduce unwarranted variation by increased clinical education, improved pre-referral work up and closer monitoring of adherence to local or national guidelines.

We also aim to reduce prescribing expenditure and restrict growth to the national levels.

Day case to outpatient shift of activity

SNCCG will continue to review activity which is clinically appropriate for either a day case or an outpatient setting and seek to embed clinical conditions to ensure patients are managed in the most appropriate setting for their condition.

Clinical audits and discussion will take place to review activity that has both a day case and outpatient procedure tariffs. It is our intention to pay for procedures in line with the level of care provided and also in line with national guidance.

Review of day case activity levels will include:

- Age-related macular degeneration and other eye conditions in the community,
- Community Dermatology Service – working to increase the scope of dermatology services provided in the community for conditions such as Cellulitis and skin lesions.

Patient Choice

SNCCG will:

- Continue the development of raising awareness of Patient Choice initiatives and seek to commission alternative services in order to increase patient choice.
- Ensure there is a full menu of services on Choose & Book (C&B) that is published and freely available.
- Continue to work with NNCCG and North East London Commissioning Support Unit in the development of the Patient Choice spreadsheet and ensure fortnightly update.
- Continue to promote the NHS Patient Constitution.
- Work with local providers and stakeholders to ensure member practices and patient have access to the correct information with regard to patient choice.

The National 20% Elective Care productivity challenge

In Everyone Counts: Planning for Patients 2014/15 to 2018/19 NHS England describe the need for elective care, and access to services to be designed and managed from start to finish to remove error, maximise quality and to achieve a major step-change in productivity.
The suggestion is to review how routine planned admissions for patients requiring less complex treatments are delivered. This instruction fits well with SNCCG’s strategy for delivering more treatments for patients either within an outpatient setting or without the need to travel to an Acute Provider, such as for eye and joint injections and minor dermatological procedures.

However, such initiatives are only likely to elicit single year gains when the needs framework stipulates annual productivity gains of 4% year on year until 2019-20. SNCCG are reviewing the most recent guidance such as Better Procurement, Better Value, Better Care (DH, August 2013)\(^3\), and latterly Monitor’s ‘Closing the NHS funding gap: how to get better value health care for patients’ (October 2013)\(^4\) to establish a sustainable productivity improvement strategy. However, early guidance indicates gains can be achieved in four main areas:

1. **Improving productivity within existing services.** Valuable opportunities to improve quality, safety and efficiency are available within existing configurations of primary, community, acute and MH care. These include measures to reduce waste and running costs, improve procurement, reduce LOS in hospitals, collaborate better with social services, redesign clinical roles and avoid using procedures or drugs of low clinical value. Many such measures are in progress as part of SNCCG’s existing QIPP and Cost Improvement Programmes (CIPs).

2. **Delivering the right care in the right setting.** Many patients could enjoy better outcomes at lower cost to SNCCG if their care were delivered in a more appropriate setting. For example, increasing care in the community for the millions of people who have LTCs could both improve their experience as patients and reduce costly hospital visits.

3. **Developing new ways of delivering care.** Measures to improve the productivity of established ways of delivering health care in the two categories above will not be enough to close the whole financial gap. Success will depend on developing new and more productive ways to organise and deliver care.

4. **Allocating spending more rationally.** The direction of NHS spending is determined more by history than an objective and current assessment of the disease burden of the population and the potential for particular interventions to relieve that burden. Redirecting resources to prevention and early diagnosis or rebalancing spend between different diseases could yield important productivity improvements.

The following section describes how SNCCG is applying this guidance to achieve the National challenge:

**Pathway reviews**

Reviews of care pathways during 2014-16 include the following clinical specialities:

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- **Rheumatology** - to ensure compliance with best practice models of care and seek to provide rheumatology services in the community, including the transfer of new drug infusions, where clinically appropriate.

- **Community Injections service** – to provide services in the community at equal quality but better value.

- **Trauma & Orthopaedics (T&O)** - a review of T&O was undertaken by the Royal College of Surgeons (RCS) during 2013. Although the review was limited in clear points of action, we recognise the need to review and simplify the primary care pathway for orthopaedics.
  - Review MSK services
  - Review current Orthopaedic pathways to provide good care, patient satisfaction and conservative management, where appropriate
  - Work with NNCCG and NCCG to ensure the current service provider of orthopaedic triage (NCHC) is able to work towards delivery of a high quality service that is fit for purpose.
  - Redesign pathways for patients presenting to primary care with hip, knee or shoulder pain.
  - Work with PH to ensure all clinical referral policies for hip and knee arthroplasty are amended to include conservative management initiatives prior to referral for surgery.

- **Gastroenterology** – to increase patient satisfaction and to ensure care and conservative management is provided in line with NICE guidelines.

- **Ophthalmology**
  - **Glaucoma** – review services in the community.
  - **Cataract Service** – implement a full cataract pre and post operative service and one-stop service for cataract surgery

- **Aural Microsuctioning** – following a pilot in primary care a full evaluation will be undertaken to assess future options for procurement.

- **Oncology** (led by NCCG)

**Patient flows**

**Discharge Planning**

- To contract specific minimum standards in discharge planning and transparent reporting of all delays and reasons for delay
- To ensure practices have typed discharge letters within 48 hours of discharge to enable the correct clinical care

Daily consultant ward round for all patients in an acute bed and inter-Consultant discharges
To improve clinical care of patients while admitted to an acute hospital and to standardise discharge processes across the week

Seven day working

Seven day working will be an ongoing work stream with NNUHFT during 2014/15 to agree an implementation and action plan based contractual obligations and clinical standards set out in by the NHS Seven Days a Week Forum review.  

Refine prior approval and thresholds

SNCCG will work with PH and other Norfolk & Waveney CCGs to ensure the latest best practice is in place for clinical effectiveness and prior approval.

Tier 3 Weight Management Services

The SNCCG draft weight management strategy identifies the need for adult Tier 3 weight management services to be provided more locally. The CCG will therefore seek to develop and commission a service in 2014/15.

QIPP Savings for Planned Care Workstream

<table>
<thead>
<tr>
<th>PROJECT TITLE</th>
<th>CCG LEAD NAME</th>
<th>PROJECT START DATE</th>
<th>ACTIVITY IMPACT START DATE</th>
<th>Net QIPP Saving</th>
<th>Proposed KPI or Metric</th>
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<tr>
<td>Full Year Effect of initiatives From 13/14</td>
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<td>Prescribing for Quality and Safety</td>
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<td>Age-related macular degeneration and other eye conditions</td>
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<td>Lower Limb</td>
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<td>01/07/2013</td>
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<td>Reduction in hip and knee replacement</td>
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<tr>
<td>Upper Limb</td>
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<td>01/08/2013</td>
<td>01/07/2013</td>
<td>116</td>
<td>Reduction in shoulder operations</td>
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<td>Cataracts</td>
<td>Anne Moates</td>
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<td>01/07/2013</td>
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<td>Reduction in new and follow up ophthalmology appointments</td>
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<td>01/07/2013</td>
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Various Initiative £50k or Less

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<th>Net QIPP Saving</th>
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TOTAL 3763

Potential initiatives

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<th>ACTIVITY IMPACT START DATE</th>
<th>Net QIPP Saving</th>
<th>Proposed KPI or Metric</th>
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</table>

TOTAL 20

Emergency and Urgent Care

Whilst the CCG’s number of non elective admissions is fewer than the national average and growth rate slower, SNCCG has identified that work to improve the commissioning of emergency and urgent care services is of vital importance to reduce expenditure and the need for treatment in secondary care.

<table>
<thead>
<tr>
<th></th>
<th>SNCCG rate against national average</th>
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<tbody>
<tr>
<td>GP referral rates</td>
<td>Higher</td>
</tr>
<tr>
<td>Growth trend for GP referral</td>
<td>Lower</td>
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<tr>
<td>Number of non elective</td>
<td>Fewer</td>
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<td>admissions</td>
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<td>Growth rate for non elective</td>
<td>Higher at &gt;7% (national average 7%)</td>
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<tr>
<td>admissions</td>
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</tbody>
</table>

SNCCG recognise the need to collaborate on matters of urgent and emergency care and are active members of the Central Norfolk Unplanned Care Network (CNUCN).

The CNUCN is the senior strategic CCG Commissioner/Provider clinical/managerial interface that addresses the delivery of an effective 24/7 urgent and emergency care system for the health community in response to current system pressures, and in line with national guidance and local need.

Within the Urgent Care landscape the CNUCN sits between the Capacity Planning Group, and the ACB (as described in the diagram overleaf). The formation of these groups encourages vital and clear two way discussion to occur from the CCG integrated Commissioning Board through senior Provider management down to the operational
frontline, and most importantly back again. This ensures that commissioning initiatives have the best opportunity to succeed in the most efficient way.

Working groups of the CNUCN have been coordinated under the heading ‘Project Domino’.

‘Project Domino’ has seen the urgent care pathway broken into its component parts and then into associated work streams i.e. from the patients home to hospital (blue workstream), from the front door of the hospital to the back door (red), supporting patients coming out of hospital and keeping them at home (green), additional service commissioning (purple).

The following items represent the commissioning achievements of this group:

- Expanding Ambulance Paramedic Skills
- Planning for the A&E refurbishment due to start in 2014/15
- Planning for a clinical decision unit and Acute point of care testing to become core business in 2014/15
- Community IV service
- Community Rapid Response Teams
- Community Matron Acute Pull-out service
- Home Based Therapy Service
- An integrated clinical Directory of Services
- System Operations Centre
The Group has also been instrumental in the distribution of the National fund for winter resilience which has seen the commissioning of the following services:

- A primary care led Urgent Care Unit within the A&E
- Community Early Supported Discharge Team
- Additional Community beds
- Supporting the county councils Norfolk 1st Response service
- Employing Ambulance trust Hospital Ambulance Liaison Officers (HALO)
- Care home GP support packages
- Weekend Social Worker Scheme
- Community Discharge Co-ordinators
- Acute Discharge lounge facility

The nature of urgent and emergency care is such that these initiatives are part of a rolling programme of development that is not exclusive to 2013/14 and will continue into 2014/15 and 2015/16. The evaluation of these initiatives will govern which are commissioned as ongoing core services in the future.

**Urgent and Emergency Care Activity**

While it is without question that our emergency services are stretched, it is also understood that urgent and emergency activity in SNCCG, NNCCG and NCCG is not unusually high.

Both rates of A&E attendance and Emergency Admissions to the two Acute Trusts that serve SNCCG patients are below National standardised rates per head of 1,000 population. These rates are also lower than those of CCG areas with similar demography such as Devon, Cornwall, Somerset, and Cumbria. This is undoubtedly due to the higher number of GP’s per 1,000 population in Norfolk and the good level of access our patients have to Primary and Community care.

Nevertheless, A&E attendances and Emergency Admissions have been rising at a rate higher than the National equivalent, particularly into NNUHFT in the 2013/14 year, and this needs to be halted. This has been particularly felt in the areas of General Medicine and Medicine for the Elderly. With this in mind SNCCG are actively exploring services that offer an alternative to A&E compliment Acute front door services alleviating the need for admission. For example SNCCG continue to support the delivery of a primary care led department within A&E, as well as commissioning a pre-admission assessment unit at NNUHFT and extending diagnostic capabilities in the community such that patients may be ‘pre-streamed’ prior to referral to Acute hospital admission. In this way SNCCG expect to level off the current rise in unscheduled activity in 2014/15 and see a reduction going into 2015/16 and beyond.

**Patient flows**

The following diagram details the current growth trend in Type 1 A&E and overall emergency admission activity at NNUHFT, SNCCG’s primary provider of Acute services:
What initiatives will SNCCG undertake to tackle these health challenges?

Reducing A&E attenders and A&E admissions

A&E attendance followed by zero length of stay (LOS)

- Data has been forwarded to GP Practices for them to review and SNCCG will pursue opportunities for cost savings,
- Review of GP triage and direct access Magnetic Resonance Imaging (MRI) / Point of care blood testing pilot,
- Signposting from A&E to urgent outpatients clinics to avoid duplicate charges for same day A&E attendance and outpatient attendance,
- Reduce levels of cardiac emergency admissions in particular - this has been identified as a potential QIPP saving area and a range of initial data has been gathered to enable a review of admissions,
- Review and discharge redesign for 14 days+ stay patients in order to review and redesign current discharge protocols to ensure maximum integration and ensure the most efficient process,
- Maintain current performance levels on non-elective admissions.
- Continue with the implementation of the Frequently Attenders CQUIN being delivered by the NSFT, with a view to reducing A&E attendance for a core cohort of frequently attending patients and to ensure learning from this and the further development of mental health hospital liaison services is fully explored.

Admission ratio from Accident & Emergency (A&E)

- To maintain the rates of admission from A&E to expected levels and not allow process or targets to distort admission need
Stroke services

It is well recognised that significant improvements in Stroke prevention and care are required across NHS England (Midlands & East) to maximise reduction in morbidity and mortality.

This includes identification of patients at risk, prompt recognition and action on symptoms, effective management of transient ischaemic attacks (TIA) and access to Thrombolysis. SNCCG continues to work collaboratively with NHS England on ensuring high quality stroke services are provided at centres of excellence and will directly reduce the incidence of Stroke and its associated morbidity and mortality. SNCCG will continue work to close the gap between the currently commissioned Stroke service and the Best Practice Service Specification39. This will potentially require operational and structural flexibility, but will not attract additional funding outside the best practice tariff.

Pre admission services

SNCCG intend to commission an acute clinical decision making pre-admission service aimed at ensuring that suitable patients are clinically and diagnostically assessed prior to admission in line with National guidance and recommendations made in the 2012 Department of Health (DH) Emergency Care Intensive Support Team report.

SNCCG are also intending to commission:

- An increase in the availability of telephone advice and same day and next day clinic appointments for patients requiring urgent consultant opinion;
- Emergency outpatient tariff at NNUHFT for Emergency Ambulatory Sensitive Conditions (EASC) and improvement of community management of Ambulatory Care Sensitive Conditions (ACSC) conditions through improved community diagnostics and access to NNUHFT diagnostics prior to, or place of admissions. An agreed number of Acute Medical Unit (AMU) beds will be re-commissioned to operate in an emergency clinic-type system relying more on trolleys and point of care testing than is currently the case. In terms of rationalising and achieving this approach, we will seek to systematically apply the Institute of Innovation’s 2010 Directory of Emergency Ambulatory Care and Implementation of Emergency Ambulatory Care documents.

Right clinical decision makers in the right place

SNCCG will seek to implement the following initiative over the next 1-2 years:

- Direct access to emergency x-rays for suspected small fractures to enable GPs to directly refer to x-ray when they suspect a small fracture
- Urgent Care/Walk in service for SNCCG
- Improved access to urgent care services for the South Norfolk population

Communications and Engagement action planning

SNCCG will work to:

• Provide communications and engagement support for “Project Domino” in conjunction with other local CCGs and providers.

• Support direct communications with local patients, aligned to the overall communications plan of “Project Domino”.

• Develop local communications materials to emphasise the appropriate route of care for patients (developed with local PPGs and voluntary stakeholders).

Ambulance Activity and KPIs

Recently there has been much media interest in the performance of the EEAST, the agency that serves the population of South Norfolk CCG. It is undeniable that EEAST self-reported data shows that patients living within our rural boundaries are currently at a disadvantage when compared to the service provided to patients living in neighbouring and more urban areas.

Response times against all national standards have been poor throughout the 2013/14 financial year. Red2 and A19 performance is the worst in England and there is variation in performance across CCGs. EEAST is meeting standards for some CCGs in some months; whereas performance is well below standard in other CCGs, particularly in rural Norfolk and Suffolk. Green response times are frequently not met.

While SNCCG accept the challenges of delivering an equitable standard of care between rural and urban geographies, it does not accept the current service gap. As such SNCCG have been, and continue to be, active members of the Commissioning Consortium and have strongly lobbied for CCG level KPIs to be introduced into the contract that will be made publicly available and will enable the CCG to ensure performance improvement through operational and contractual actions and aligned to an agreed trajectory.

EEAST are of course aware of the imperative need to address the inequity of service to the population that it serves and have been fully engaged and open about the challenges they face by sharing the results of their Clinical Capacity Review which has underlined a lack of overall numbers and skill mix within their workforce.

There have, however, been a number of areas of improvement including fleet and vehicle management; staff recruitment and induction; staff support; and the audit processes. In a recent visit the CQC noted improvements since their previous visit in February 2013, including: staff engagement; complaints processes; staff sickness (reduced from 12% to 6%); and engagement with MPs and councillors. Trust performance had improved against some, limited clinical quality indicators for cardiac and stroke patients, and for patients treated without the need to convey. Additionally it should be noted that delays in handing patients over at hospital have improved at the NNUHFT more than anywhere else in the region and this has led to hundreds of SNCCG patients receiving ambulance led care more quickly this year than last.

Primary Care

The role of primary care is recognised as a key player in the urgent care system. Similarly building a robust and capable out of hospital sector is a crucial factor in building seven day working. SNCCG does not directly commission General Practice or Pharmacy Services we are however committed to collaborative working with the Area Team.

Examples of this include the potential to use community pharmacy in the out of hours system

SNCCG does commission Out of Hours and 111 services and the Provider of these is heavily involved in both the Urgent Care Network and Capacity Planning Meetings.

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QIPP Savings for Emergency and Urgent Care Workstream

<table>
<thead>
<tr>
<th>PROJECT TITLE</th>
<th>CCG LEAD NAME</th>
<th>PROJECT START DATE</th>
<th>ACTIVITY IMPACT START DATE</th>
<th>Net QIPP Saving</th>
<th>Proposed KPI or Metric</th>
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Mental Health (MH) & Learning Disabilities (LD)

- Address impact and harms of drug and alcohol use
- Re-commission Improving Access to Psychological Therapies (IAPT)
- NSFT strategy delivery re: quality and access
- Identify and support dementia
- Primary care mental health focus

Norfolk is driving forward the implementation of payment and pricing systems, implementing the National Dementia Strategy, the Local Joint Dementia Strategy and undertaking the Prime Minister’s “Call for Action” in making Dementia a priority area locally.

**MH Parity of Esteem**

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

The CCG’s overarching aims for MH services are that:

MH provision will be open and accessible to all people who need it regardless of their age and the diagnosis and severity of their MH condition

No MH service user should need to be returned to their GP for onward referral for another MH service

MH and learning disability services are integrated with the wider health and social system and which support the recognition that people’s MH should be seen as part of their overall physical and mental wellbeing.

This will apply to all people regardless of their age including those marginalised from society.
Plans to reduce the gap in life expectancy for people with severe mental illness

The gap between life expectancy in patients with a mental illness and the general population has widened in recent times. The higher death rate associated with mental illness has focused on the elevated risk of suicide, whereas most of the risk can be attributed to physical illness such as cardiovascular and respiratory diseases and cancer (80% of deaths). Studies suggest that, nationally, the gap in life expectancy in people with mental illness could be as high as 20 years for males and 15 for females.

What initiatives will SNCCG undertake to tackle MH?

Address impact and harms of drug and alcohol use

- Working with Public Health to reduce the harms and impact of drug and alcohol use and specifically focussing on reducing drug and alcohol hospital related admissions.

Improving IAPT access and ensuring quality of provision.

- SNCCG will further develop and monitor the delivery of an action plan with the IAPT provider to increase the numbers of patients accessing this service. This will include identifying opportunities for the delivery of IAPT within or closer to GP surgeries including where agreed the provision of taster sessions and group work activity within surgeries. SNCCG will also be working with the provider to make links and develop stronger relationships with wider providers, partners and the voluntary sector to encourage sign posting and referral from these services to IAPT and the development of joint working opportunities.

- The medium to longer term actions to improve IAPT access will be taken forward through the re-commissioning of this service, IAPT, developing this into a wider Primary Care Mental Health Service (PCMHS) that is developed in line with as works as part of primary care integrated service delivery model.

- Enabling psychological support for people with long term physical health conditions.

Communications and Engagement action planning for IAPT will be via:

- Support for the re-tendering process for the Wellbeing service for Norfolk & Waveney, including on-going patient involvement in tender negotiation meetings.
- Support for the development of the provider’s communication plan in South Norfolk.
- Communication regarding the launch of the re-tendered service as of March 2015.

NSFT strategy delivery

- SNCCG will closely monitor NSFT Strategy implementation ensuring that this supports and further improves services to patients in South Norfolk and does not have a detrimental impact on care,
- We will also ensure NSFT is fully integrated with the 111 service,
- We will work with NSFT to:
Identify and support dementia

SNCCG will improve the identification and management of Dementia and develop a specific Dementia strategy that incorporates roles and responsibilities of Primary Care, the related elements of Integrated Care approaches, secondary care MH services, care homes, Continuing Health Care (CHC) and wider partner organisations. Key to this will be ensuring the delivery of SNCCGs planned dementia diagnosis rate, this will be supported through the development of the Dementia Strategy but also through the implementation of the dementia workstream within the Better Care Fund. SNCCG will actively monitor indicators of progress against the diagnosis rate including the performance of NSFT’s Dementia Intensive Support Teams.

Communications and Engagement action planning for the South Norfolk Dementia strategy:

SNCCG will:

- Support the development of the South Norfolk Dementia strategy via workshops with local patients, member practices, providers and stakeholders.
- Communicate local priorities to stakeholders via newsletters, the SNCCG website and social media.
- Develop a communications strategy for the delivery of the Dementia strategy, including promotion of local services to patients.

Primary care MH focus

- Ensure a recovery focus is embedded within MH services and that a whole systems approach to meeting MH needs taking into account wider resources and services that are in place to help meet people needs.
- Implementation of new primary care focused IAPT service.

Other

- To further develop Child and Adolescent MH Services (CAMHS) developing seamless pathways of support for children with MH needs and improving service quality and waiting times.
- To review Autistic Spectrum Disorder (ASD) pathways.
To develop cluster pathways, ensuring within this that the needs of adults with Attention Deficit Hyperactivity Disorder (ADHD) are fully considered and that effective transitional arrangement with CAMHS are in place.

To further develop Eating Disorder Pathways and re-commission services.

To review the evidence base of the Mindfulness Pilot and consider future options.

To review MH 1/3rd sector contracts ensuring that these work with and add value to wider system provision.

To further define the services provided to the Thetford area and consider future commissioning approaches to these.

Additional Communications and Engagement action planning

Eating Disorders services

- Support the re-procurement process for Eating Disorder services in Norfolk, including developing a consultation process for working with local patients and stakeholders
- Communicate the changes to the pathway to local patients and stakeholders.

Asperger’s Service Norfolk

- Support the re-procurement of the Asperger’s service in Norfolk (to be implemented March 2015)
- Work with local patients, carers and stakeholders to review the current service and implement ideas
- Promote the re-procurement service to local patients, member practices and stakeholders

Pain Management using Mindfulness

- Communicate Pain Management using the Mindfulness pilot to member practices and patients
- Work with PPGs in the spreading of communications materials.

Children and Families Act

- Work with stakeholders, member practices and patients to promote the Children & Families Act.
- Promote local Children & Families Act workshops and newsletters to member practices

South Norfolk Obesity Strategy

- Support the development of the South Norfolk Obesity strategy, including communicating with local stakeholders and patients.
- Develop a communications plan for the delivery of the Obesity strategy.
- Work with local stakeholders and providers to develop local, targeted communication materials for people in South Norfolk.
### QIPP Saving for MH and LD Workstream

<table>
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<tr>
<th>PROJECT TITLE</th>
<th>CCG LEAD NAME</th>
<th>PROJECT START DATE</th>
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The SNCCG Child Health & Maternity workstream covers the commissioning of a wide variety of healthcare services but also crosses over into areas of prevention, working with Public Health (PH) and Norfolk County Council colleagues. This collaborative work influences the shape of services and the long term outcomes whilst seeking to reduce inequalities in access and provision.

The CCG’s local health profiles highlight that, although children in SNCCG are comparably in good health, obesity in younger children although within the national average range remains a priority for SNCCG. South Norfolk CCG is within the national average range for obesity at year 6, however the Breckland District Council area of the South Norfolk CCG area is at the lower end of this national average range. Tackling obesity and increasing children’s physical activity is a joint responsibility between CCGs, Public Health and NHS England.

The South Norfolk CCG Health Profile also identifies smoking in pregnancy as a risk area.

**What initiatives will SNCCG undertake to tackle these issues?**

**Early health and intervention services**

- **Same day telephone advice service for children (health professionals)** The CCG will undertake a cost benefit analysis of the current level of service and consider increasing the availability of the telephone advice service. The service will offer advice to GPs to help avoid unnecessary admissions and where possibly offer urgent outpatient appointments as an alternative.

- **Children’s Community Nursing Team (CCNT)** Following the expansion of CCNT in 2013/14, the CCG will consider the development of the following services identified in the original NCHC CCNT business case:
- Administration of chemotherapy
- Management of syringe drivers
- Sub-cutaneous granulocyte-colony stimulating factor (G-CSF)
- Plastics and burns dressings
- 24/7 telephone cover
- IV antibiotics for cystic fibrosis and oncology patients

- **Equity of services** – The CCG will work with West Norfolk and West Suffolk CCGs to ensure that children’s community services provided across South Norfolk (including Thetford and Diss) are equitable.

**CAMHS**

- Ensure there is an accessible, high quality CAMHS pathway in place,
- Develop further a common CAMHS offer for children and young people (for targeted and specialist CAMHS),
- Strengthen support and advice for Primary Care and other staff working in universal settings,
- Improve access to joint/integrated CAMHS pathways of care and treatment (for targeted and specialist CAMHS),
- Systematically implement and report approved routine outcome measures across targeted and specialist CAMHS,
- Assess the future of the Intensive Support Team (IST).

**Children and Family’s Act 2014**

In line with National initiatives, the CCG will develop integrated community health pathways for children with special needs which are cost effective and responsive to the needs of this vulnerable group of young people, including providing more care in the community.

SNCCCG will ensure compliance with Health Education and Care Plans related to Special Educational Needs and Disability (SEND) legislation and the implementation of children’s personal health budgets.

We will take this forward through the development of joint commissioning arrangements with NCC and effective engagement within the county wide implementation board.

**Health weight and obesity prevention**

SNCCCG had identified that targeted obesity and prevention services for children are vital for the long term health of our population.

The map overleaf illustrates the healthy weight % for Year 6 across South Norfolk:
The CCG will work with Public Health to ensure that support and services are available to children and their families at a Tier 2 level (prevention, lifestyle and education) intervention and clarify the pathways for Tier 3 weight management services.

**High admissions pathways (i.e. LTCs)**

The CCG is considering the outcomes of the review of the high admission pathways for children’s LTCs identifying and implementing pathway improvements and/or potential avoidance options (by starting treatment earlier in Primary Care). The high admission pathways are:

- Asthma/wheezy child
- Bronchiolitis
- Feverishness illness
- Gastroenteritis (diarrhoea and vomiting)
- Head injury (accidental)
- Abdominal pain

**Looked after children (LAC)**

We will improve outcomes for LACs by working with providers and Children’s Services to ensure appropriate services are in place. SNCCG will also look to commission Health Assessments for LACs.
Other Initiatives

Child Health

- The CCG will support the pathway redesign of the Community Continence Service to improve current service provision,
- To continue the development of integrated pathways for Community Healthcare Services for Children with a Disability and/or Additional Healthcare needs (DASH Service Specification),
- SNCCG are leading on the development of an all age non-complex wheelchair specification, which will include services for those aged 36 months and above,
- A new service specification for the Chronic Fatigue Syndrome (CFS)/Myalgic Encephalopathy (ME) pathway has already been developed in 2013/14 and will be implemented in 2014/15,
- SNCCG will work with the Children’s Complex Cases Panel and the Child Health and Maternity Commissioning Board to further develop pathways for children with continuing healthcare needs and for children who need joint funded packages of care with NCC Social Care.

Maternity

- SNCCG will ensure joint working is in place across primary care, midwifery, health visiting and MH services to ensure early and effective support to expectant and new parents with MH needs.
- SNCCG will negotiate a new maternity service specification and performance dashboard with NNUHFT in collaboration with wider Norfolk CCGs. SNCCG will aim to ensure that this specification enables early identification of parental risk factors including MH, substance misuse, smoking and maternal obesity.

Fertility Services

- SNCCG, as part of a collaborative commissioning agreement, will complete the retendering exercise for level 3 specialist fertility services in 2014/15 and will review level 2 service provision.
Workforce

The CCG will work to ensure that providers have an appropriate, capable and sustainable workforce. The commissioning of local services will need a workforce fit for purpose, as we change the shape of services and where necessary move them closer to patients’ homes.

The local workforce will need to be highly flexible to respond to changes in how we deliver healthcare. As services across health and social care become more aligned and are delivered in more flexible ways in the community, providers and commissioners must work towards easing the transfer of staff between different employers and ensure they can minimise cost and maximise efficiencies where the workforce overlaps.

The CCG will commission services that are appropriately skilled and competent in providing high quality and safe services for patients, however we are particularly aware of the requirement to carefully plan how we can align the capacity of our primary care workforce with the needs of supporting integrated working.

Staff Satisfaction

The people who work for us are a very valuable resource and it is important that the CCG has a good understanding of staff satisfaction. In order to ensure this will be undertaking a staff satisfaction survey in June and this will inform our organisational development plan.

The areas that we are interested in are:

- Staff opinion of the CCG leadership
- That CCG leadership consult with staff on issues that affect them
- That staff believe the CCG has a strategic plan which will deliver its vision
- That manager and staff relationships are constructive
- That good performance is recognised and poor performance is managed well
Research and Innovation

Health research is essential to continually improve health outcomes and the effectiveness of health services for patients. There is an expectation that the UK will be the first research-led health service in the world. Searching for and applying innovative approaches to deliver health care must be an integral part of the way the NHS does business. Doing this consistently and comprehensively will dramatically improve the quality of care and service for patients (Health Wealth and Innovation 2012).

The Health and Social Care Act reflects these commitments and places a clear duty on the Secretary of State, NHS England and CCGs to promote research and champion innovation.

Research

In line with the research commitments, SNCCG accepted responsibility for hosting the Norfolk & Suffolk Primary & Community Care Research Office, on behalf of all CCGs across Norfolk & Waveney in April 13. Patient and clinical involvement in research across SNCCG is strong. The CCG has a statutory duty to promote research including:

- Participation in research
- Supporting research and using research evidence
- Proactive engagement with local partners
- Meeting treatment costs for patients taking part in research (including any Excess Treatment Costs\(^40\))

In line with the research duty the CCG will:

- Agree a plan to enhance the research culture of the CCG-addressing leadership, education, use of evidence and partnership.
- Ensure provider contracts are fit for purpose in relation to the Research Governance Framework, Clinical Research Network (CRN) targets, and Quality Account arrangements.
- Chair the Norfolk and Suffolk Primary and Community Care Research Steering Group which oversees arrangement for Research Delivery through the Norfolk and Suffolk Primary and Community Care Research Office. This group has a mandate to agree strategic direction for research across Norfolk and Suffolk. The Research office supports the Research Design, Research Assurance, Study Delivery and Patient involvement in research across CCGs, academic organisations, primary and community Care providers and will deliver an agreed work plan\(^41\)

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\(^{40}\) Where patient care is being provided which differs from the normal, standard, treatment for that condition (either an experimental treatment or a service in a different location from where it would normally be given) the difference between the total Treatment Costs and the costs of the “standard alternative” (if any) can be termed the *Excess Element of Treatment Costs* (or just “Excess Treatment Cost”), but is nonetheless part of the Treatment Cost, not a Service Support or R&D cost. *DH HSG(97)32*

\(^{41}\) WIN-fs-1-v1\snccg\Departmental Documents\R&D\R&D Policies & Corporate Docs\Workplan\Workplan updated Feb13.docx
Through CRN involvement: continue to support the establishment and development of the CRN; represent the interests of patients, commissioners, and primary care providers; work with CRN partners to support the delivery of the National Institute of Health Research (NIHR) performance framework and agree models of funding for enhanced patient and clinical involvement in research.

Fully implement the research cost policy with NHS England, and Public Health England including agreeing processes for managing appropriate research treatment costs for provider organisations to ensure provider trusts identify research savings and reinvest these in new studies and where appropriate review provider business cases for additional research treatment funding.

Build on the CCG leadership recommendation to enhance research dissemination particularly through GP education routes. A new research dissemination process will be developed and agreed by CCG leadership.

Work with R&D to identify a research priority for a commissioned research call out for preparation of a national research grant application (Research for Patient Benefit Grant) to include a systematic review to feed into commissioning programmes.

Engage locally with the University of East Anglia and other academic bodies.

Innovation

The CCG recognises the importance of the three stages of the innovation agenda – invention, adoption and diffusion and has a statutory duty to champion innovation and the adoption of innovation including:

- Setting out the CCG approach to innovation
- Ensure strong leadership and accountability for innovation within our organisation
- Being an active partner in the local Academic Health Science Network (AHSN).

In line with the innovation duty the CCG will:

- Increase its understanding of opportunities for innovation by joining and working with the East Anglian Innovation Hub.
- Work in collaboration with the Academic Health Science Network (AHSN) to support the delivery of innovation, adoption and spread of evidence for Diabetes, Dementia and Chronic Disease Management.
- For 2014-16, the CCG will work with the Research Office and AHSN to develop a post that will support increased involvement in the adoption and spread of evidence for the CCG/AHSN priority areas.
- Through CCG officer time contribute to the delivery by AHSN working Groups
- Deliver the EPaCCS innovation Project which aims to do the following: develop an options appraisal for an electronic EoL register for SNCCG, engage with stakeholders, agree a pilot area with the GPs involved and work with them on how the register will be implemented, establish robust governance arrangements. The EPoC project was funded from the Innovation fund with the support of the AHSN.
- Use the collaborations such as AHSN that were developed through the EPaCCS Project to identify funding streams for the FFT Early Adoption Wave project which aims to develop a set of quality indicators and dash board for community care providers (fractured neck of femur rehabilitation pathway) using the work of Kings Fund and CQC and align patient data within these core indicators.
- Review and strengthen CCG leadership and CCG innovation plans through the Norfolk and Waveney CCG Chief Officers meetings support the cross CCG representation by West Norfolk CCG on the AHSN Partnership.
Implementation and Delivery of the Plan

SNCCG has implemented a project management approach to its commissioning programme which will be further developed in 2014/15.

All proposed commissioning initiatives require sign off by the CCG Leadership Team with the joint clinical and management sponsors required to identify at the outset clear benefits in terms of improved patient outcomes, access, experience and/or reduced cost against which projects will be measured. Projects also have to demonstrate use of a relevant evidence base and plans for patient/public engagement and robust evaluation in order to get project approval.

SNCCG Leadership Team will monitor delivery of the programme above regularly during 2014-16 using this methodology.

QIPP Governance

To ensure achievement of the QIPP target a number of systems and process have been established. Each QIPP project has a project charter and plan that is signed off by the Senior Management Team, which comprises Chief Officer, Chief Operating Officer, Chief Finance Officer, Director of Quality and Patient Safety and Head of Governance and Strategy.

Each identified QIPP project is monitored and RAG-rated with timescales and the savings clearly recorded.

A live QIPP Working document provides detailed information on each project broken down further by clinical work-stream areas and detailing pro-rated savings to be made during 2013-14. QIPP projects are monitored and reviewed at a number of meetings to provide the necessary rigour and assurance of delivery.

The CCG has appointed a QIPP Programme Director who manages and oversees achievement of QIPP. There are a number of stages in which challenge of QIPP can be undertaken.

The QIPP Programme Director oversees a weekly QIPP meeting which is attended by the CCG’s Commissioning Team, Clinical Workstream Leads as well as a Business Intelligence analyst.

The purpose of these meetings is to ensure that projects are consistently monitored and reviewed, identifying any matters that will impact on the timescales and achievability of each project. Risks are flagged and where appropriate the RAG rating amended.

In addition, a key aspect of the weekly meeting is the development of new QIPP initiatives. Each new initiative is assessed for quality based on the deliverability of savings and quality. The meeting ensures that there is detailed clinical challenge around existing plans and potential new projects.

A further review and assessment of QIPP delivery is then undertaken at the weekly Senior Management Team Meeting, at which any new initiatives are approved.
Where a project is identified as liable to miss savings and/or deadline a rectification plan will be produced by the commissioning team, with the aim to ensure that it is brought back on target. The robustness of the rectification plan is tested and challenged at all stages throughout the process.

A monthly Executive Leadership Meeting including Senior Management Team and Clinical Governing Body members further reviews QIPP initiatives and receives an overview of QIPP delivery. This meeting provides an opportunity for the rigour of the QIPP plan to be tested and challenged by members who include elected Governing Body members. This meeting provides a further chance for broad clinical and managerial input and an opportunity to test robustness of plans.

At monthly Governing Body meetings QIPP plans and initiatives are reported and reviewed enabling discussion about QIPP delivery and management and further challenge is provided by the Governing Body lay members.
Summary operating plan

Our summary operating plan and summary QIPP plan is contained in the accompanying Excel file.
Financial Plan

Introduction and Context

The purpose of this 2-year Financial Plan is to underpin the delivery of NHS South Norfolk Clinical Commissioning Group’s (SNCCG) Operational Plan 2014-16, by establishing a robust, flexible and sustainable financial environment within which to operate. The plan will enable the local health and social care system to develop within the context of the anticipated economic and political climate, providing a financial framework for collaborative working and integration.

The policy context within which SNCCG will deliver this plan is the settling down of the new system architecture (CCG’s, CSU’s, Area Team’s etc.) but still in the midst of the toughest financial constraints ever experienced by the NHS, with £20bn savings to be identified and delivered between 2011 and 2016. The Quality, Innovation, Productivity and Prevention (QIPP) agenda is the response to this national funding gap.

SNCCG is one of five CCGs emerging from the NHS Norfolk and Waveney PCT cluster and although the predecessor PCT consistently delivered its required financial surpluses, in terms of legacy for the successor CCGs, the PCT used non-recurrent measures in 2012/13 to balance its financial plans. SNCCG’s share of this funding gap was £5m and together with other funding pressures planned and unplanned for, meant the SNCCG itself required the benefit of non-recurrent measures to deliver its required financial surplus in 2013/14.

The achievement of savings is becoming more difficult as easier transactional savings have already been made or are being exhausted over the two years of this financial plan. This, therefore, requires the focus of QIPP delivery to move more quickly to transformational change, requiring a level of collaboration and integration with other organisations not previously experienced.

2013/14

The CCG allocation for 2013/14 saw net growth of 2.3%. However, there existed considerable uncertainty regarding the CCGs programme cost resource during the year as the process to align funding to contracted activity, following the transfer of commissioning responsibility for specialised services to NHS England, was only completed in October 2013. Additionally, the four Norfolk CCGs undertook a similar exercise to align funding transferred from Norfolk PCT to contractual liabilities, which was completed in December. The net impact of these reviews is that South Norfolk CCG’s programme cost resource was reduced by £2.3m from that planned.

As a result of these reviews, after reporting month 6 finances, SNCCG was requested to prepare a Financial Recovery Plan to provide assurance to NHS England regarding how it would improve its month six forecast outturn position and demonstrate achievement of the required 1% surplus position for 2013/14. It was also requested to demonstrate how it would achieve the planning requirements for 2014/15 given the change in the month six reported outturn position. SNCCG largely planned and delivered the 1% surplus by managing down non-recurrent costs, such as Continuing Healthcare (CHC) Restitution, and utilising all available contingencies.
NHS England have required CCGs to manage the processes to settle the cost of CHC Restitution claims – claims from individuals who have funded their own care or those of a family member, who believe that the NHS should have funded the care. This process is ongoing and is forecast to be completed by 31st March 2015. Clarity regarding the accounting treatment of these costs was only received in March 2014 when NHS England confirmed their accounting responsibility for a cohort of the cases that were sufficiently advanced at 31st March 2013 to allow Norfolk PCT to provide for those costs as determined by International Account Standard (IAS) 37 – Provisions, Contingent Liabilities and Contingent Assets. CCGs are required to meet the costs of all other claims and at the beginning of the year South Norfolk CCG anticipated the cost of settling these costs to be £3.7m, although at the end of the year the cost to be incurred by South Norfolk CCG was anticipated to be in the region of £1.0m.

A limited risk-share agreement is in place between the five Norfolk and Waveney CCGs so that individual CCGs should not be exposed to financial risk as a result of incurring excessive costs for individual high cost packages and other significant costs. During 2013/14, SNCCG received £1.1m from neighbouring CCGs under the terms of the risk-share agreement, largely as a result of additional high cost packages put in place for patients requiring neuro-rehabilitation and continuing healthcare.

Despite the uncertainties existing in the CCG’s first year of existence, the CCG is on course to deliver its required surplus of £2.3m. This financial performance was achieved by a combination of robust contract management, together with realisation of benefits from locally derived QIPP schemes. Additional costs due to higher than planned acute activity and other cost pressures were mitigated by contingencies that would otherwise have been invested in programme services.

2014/15 and 2015/16

South Norfolk CCG (SNCCG)’s 2-year Operational Plan (Table 1) anticipates the delivery of required financial 1% surplus in 2014/15 and 2015/16. The Plan includes realistic estimates of provider contracts not signed by 31st March 2014.

The financial plan assumes that the required 2.5% Transformational Funds will be spent non-recurrently in 14/15 and 15/16 to support system-wide integration, reduce pressure on the emergency care system and deliver other system provider benefits on a spend-to-save basis. Of this 1% will be spent to support the Better Care Fund. The Plan allows for a contingency of 0.5%, as required by the NHS England Planning requirements.

The planning requirements set out a number of Financial Key Performance Indicators (Table 2). All KPIs meet the requirements of NHS England. The underlying position describes the recurrent planned financial position of the CCG. The decrease in the underlying position reflects the CCG’s planned recurrent delivery of QIPP mitigated by an increasing amount deployed non-recurrently of funds derived from the application of the 70% marginal rate credit on non-elective activity.

The CCG planned to spend £5.580m on its running costs during 2013/14, reflecting the cap of £25 per head of population. This running cost allocation funds staff costs, the costs of clinical engagement, the costs of commissioning support services delivered by North and East London CSU, as well as establishment and other costs. SNCCG did not spend its full allocation during 2013/14, largely as a result of delays in recruiting staff in the early part of
the financial year and the underspend partially mitigated programme overspends. In 2014/15, the allocation increases marginally to £5.610m but due to the anticipated population increase this now represents a per capita allocation of £24.41. The running cost allocation is reduced by 10% in 2015/16 so the available £5.055m represents a per capita allocation of £21.78. SNCCG anticipates absorbing this funding reduction using the 20% efficiency savings committed by North and East London CSU when it took over the running of Anglia CSU prior to April 2014. Additionally, the CCG will mitigate cost pressures by reducing its reliance on non-substantive contractors.

**Table 1 – Financial Plan**

<table>
<thead>
<tr>
<th>Financial Position</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue Resource Limit</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>£ 000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent</td>
<td>241,761</td>
<td>247,036</td>
<td>255,783</td>
</tr>
<tr>
<td>Non-Recurrent</td>
<td>1,727</td>
<td>2,348</td>
<td>2,495</td>
</tr>
<tr>
<td>Total</td>
<td>243,488</td>
<td>249,384</td>
<td>258,278</td>
</tr>
<tr>
<td><strong>Income and Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>126,129</td>
<td>126,230</td>
<td>125,460</td>
</tr>
<tr>
<td>Mental Health</td>
<td>19,999</td>
<td>20,151</td>
<td>20,649</td>
</tr>
<tr>
<td>Community</td>
<td>27,185</td>
<td>27,459</td>
<td>26,875</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>19,746</td>
<td>18,659</td>
<td>18,148</td>
</tr>
<tr>
<td>Primary Care</td>
<td>40,732</td>
<td>42,871</td>
<td>43,645</td>
</tr>
<tr>
<td>Other Programme</td>
<td>1,669</td>
<td>4,663</td>
<td>13,656</td>
</tr>
<tr>
<td><strong>Total Programme Costs</strong></td>
<td>235,458</td>
<td>240,033</td>
<td>248,433</td>
</tr>
<tr>
<td><strong>Running Costs</strong></td>
<td>5,326</td>
<td>5,610</td>
<td>5,055</td>
</tr>
<tr>
<td><strong>Contingency</strong></td>
<td>361</td>
<td>1,247</td>
<td>2,207</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td>241,145</td>
<td>246,889</td>
<td>255,695</td>
</tr>
</tbody>
</table>

One key issue that Norfolk CCGs need to address during 2014/15 is the requirement to develop evidence-based demand management plans funded by the marginal rate 70% threshold deduction. The processes inherited from Norfolk PCT were opaque and SNCCG is working with other Norfolk CCGs and providers, through the urgent care network, to improve the transparency and efficacy of these schemes. Norfolk PCT had used marginal rate credit to fund recurrent expenditure and these, though subject to review, are forecast to continue.
Due to 2013/14 unexpected increases in emergency admissions the amount of marginal rate credit requiring investment has increased but is yet to be agreed with providers. SNCCG has provided for an additional £1.4m to mitigate these costs.

GPIT income and expenditure are not yet confirmed and so are excluded from this financial plan.

**Table 2 – Financial Key Performance Indicators**

<table>
<thead>
<tr>
<th></th>
<th>£ 000</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Risk/Headroom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Adjusted Surplus/(Deficit) Cumulative</td>
<td></td>
<td>2,495</td>
<td>2,583</td>
<td></td>
</tr>
<tr>
<td>Risk Adjusted Surplus/(Deficit) %</td>
<td></td>
<td>1.00%</td>
<td>1.00%</td>
<td></td>
</tr>
<tr>
<td>Risk Adjusted Surplus/(Deficit) (RAG)</td>
<td></td>
<td>GREEN</td>
<td>GREEN</td>
<td>GREEN</td>
</tr>
<tr>
<td>Underlying position - Surplus/ (Deficit) Cumulative</td>
<td>9,103</td>
<td></td>
<td>7,882</td>
<td>7,282</td>
</tr>
<tr>
<td>Underlying position - Surplus/ (Deficit) %</td>
<td></td>
<td>3.77%</td>
<td></td>
<td>3.19%</td>
</tr>
<tr>
<td>Underlying position (RAG)</td>
<td></td>
<td>GREEN</td>
<td>GREEN</td>
<td>GREEN</td>
</tr>
<tr>
<td>Contingency</td>
<td></td>
<td>361</td>
<td></td>
<td>1,247</td>
</tr>
<tr>
<td>Contingency %</td>
<td></td>
<td>0.1%</td>
<td></td>
<td>0.5%</td>
</tr>
<tr>
<td>Contingency (RAG)</td>
<td></td>
<td></td>
<td></td>
<td>GREEN</td>
</tr>
<tr>
<td>Notified Running Cost Allocation</td>
<td>5,580</td>
<td></td>
<td>5,610</td>
<td>5,055</td>
</tr>
<tr>
<td>Running Cost</td>
<td>5,326</td>
<td></td>
<td>5,610</td>
<td>5,055</td>
</tr>
<tr>
<td>Under / (Overspend)</td>
<td>254</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Running Costs (RAG)</td>
<td></td>
<td>GREEN</td>
<td>GREEN</td>
<td>GREEN</td>
</tr>
<tr>
<td>Population Size (000)</td>
<td>228</td>
<td></td>
<td>230</td>
<td>232</td>
</tr>
<tr>
<td>Spend per head (£)</td>
<td>23.41</td>
<td></td>
<td>24.41</td>
<td>21.78</td>
</tr>
</tbody>
</table>

The Key Planning assumptions used by SNCCG to forecast the cost and volume of the services it commissions are set out in Table 3.

**Table 3 – Key Planning Assumptions**
<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notified Allocation Change (£'000)</td>
<td>5,896</td>
<td>8,894</td>
</tr>
<tr>
<td>Notified Allocation Change (%)</td>
<td>2.18%</td>
<td>1.44%</td>
</tr>
<tr>
<td>Tariff Change - Acute (%)</td>
<td>-1.20%</td>
<td>-1.10%</td>
</tr>
<tr>
<td>Tariff Change - Non Acute (%)</td>
<td>-1.80%</td>
<td>-1.10%</td>
</tr>
<tr>
<td>Demographic Growth (%)</td>
<td>0.99%</td>
<td>0.99%</td>
</tr>
<tr>
<td>Non Demographic Growth - Acute (%)</td>
<td>2.50%</td>
<td>2.50%</td>
</tr>
<tr>
<td>Non Demographic Growth - CHC (%)</td>
<td>9.60%</td>
<td>6.60%</td>
</tr>
<tr>
<td>Non Demographic Growth - Prescribing (%)</td>
<td>2.50%</td>
<td>2.50%</td>
</tr>
<tr>
<td>Non Demographic Growth - Other Non Acute (%)</td>
<td>0.50%</td>
<td>1.00%</td>
</tr>
</tbody>
</table>

Tariff assumptions are as per DH guidance. The acute tariff is adjusted in 2014/15 to allow for 0.3% of service developments allowed by NHS England and Monitor to reflect the costs to providers of implementing the recommendations of the Francis Report and the Keogh Review. A further 0.3% adjustment is included to reflect the increased costs of the Clinical Negligence Scheme for Trusts (CNST).

Demographic Growth assumptions are as per ONS 2012 LSOA population assumptions for South Norfolk and Breckland districts.

The Non-Demographic Growth assumptions for acute activity is based on historical trends to 2012/13. The majority (85%) of the acute activity commissioned by SNCCG is delivered by NNUHFT and the activity increases observed in 2013/14 are higher than historical trends. Evidence suggests that there are a number of contributing factors to this increase including the impact of the transfer to NHS England of responsibility for commissioning specialised services. The observed growth is faster than that seen at other acute providers in the East of England and the month-on-month figures suggest a growth rate reverting to historical trends.

The Non-Demographic Growth assumption for Continuing Healthcare has been based on recommendations made by Public Health in a July 2013 report entitled "Long Term Projections of Continuing Healthcare Provision for Norfolk CCGs". The recommendation was that South Norfolk CCG should plan for an annual 2.6% increase in the provision of CHC reflecting the increase in age-specific disease prevalence in its population. Additional growth is anticipated in 2014/15 (8%) and 2015/16 (5%) to reflect a short-term expectation that there remains a backlog of demand to be addressed, as well as to reflect the impact of a reducing attrition rate seen in 2013/14.

The assumption regarding non-demographic growth pressures in prescribing expenditure is based on advice from Anglia CSU in respect of their "horizon-scanning" for anticipated changes in activity due to NICE implementation and guidance changes.

The Norfolk system has historically been largely successful in mitigating the impact of demographic growth pressures on non-acute care though there is recognition that the ageing population will bring increasing pressures on the out of hospital care system.

Other recurrent and non-recurrent pressures for 2014/15 include a £2.8m allowance for the cost to agree contracts with the CCGs main providers, together with an additional £0.5m costs relating to the rebasing of Integrated Community Equipment Store funding between

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Norfolk CCGs and Norfolk County Council, as well as other sundry developments

In 2015/16, SNCCG has forecast an additional cost pressure of £0.700m in respect of an enhanced IAPT service currently being procured, together with a potential liability for costs once the cluster-based Mental Health Payment System is implemented.

Also in 2015/16 the CCG has forecast a contribution of £10.2m (£5.0m net of the additional planned allocation of s256 monies in 2015/16). This sum is yet to be agreed with Norfolk County Council and represents a "worse-case" assumption of the costs required to protect social care services in Norfolk.

QIPP

The QIPP savings required to deliver the CCG’s 2-year Financial Plan are effectively bridging the gap of doing nothing and seeing the costs of healthcare increase in price and volume. This known as the QIPP challenge and for SNCCG the challenge is to deliver £8.8m of savings in 2014/15 and a further £9.1m of savings in 2015/16.
The planned QIPP savings are challenging, at 3.54% for 2014/15 and 3.51% for 2015/16. They largely build on work commencing in 2013/14 to:

- mitigate acute activity by specific contractual levers and by engagement practices to reduce variation in referral activity;
- deliver planned savings following implementation of new pathology contract from Norfolk; leverage the primary care investment of £5 per head to improving care for the over 75 years old cohort of patients by reducing acute admissions for that age group;
- reduce the cost of Continuing Healthcare by market engagement (Care Homes) and improved management of new and existing cases;
- mitigate the cost of prescribing by eliminating variation across practices and clinical area.

Additionally, during 2014/15 SNCCG anticipates some return from its Better Care Fund collaboration with Norfolk County Council, together with Norwich and North Norfolk CCGs. In the first half of the year, the planning and PMO functions of the BCF will ensure that adult social care will become more aligned to the health agenda and that out of hospital health services, including mental health, will be reviewed to ensure improved focus on mitigating pressures on acute emergency activity. SNCCG anticipates that the benefits from this collaboration will begin to be noticed financially in Q4 2014/15, if not sooner.

The QIPP savings will be delivered by six workstreams (Table 4) based on where the intervention will be undertaken as opposed to where the savings will be achieved. For instance, the majority of QIPP interventions in the community are predicated on avoiding hospital admissions.

### Table 4 – QIPP Workstreams

<table>
<thead>
<tr>
<th>Workstream</th>
<th>14/15 £m</th>
<th>15/16 £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>132</td>
<td>-</td>
</tr>
<tr>
<td>Out of Hospital / Better Care Fund</td>
<td>2,816</td>
<td>2,907</td>
</tr>
<tr>
<td>Planned Care</td>
<td>3,323</td>
<td>2,038</td>
</tr>
<tr>
<td>Primary care</td>
<td>574</td>
<td>575</td>
</tr>
<tr>
<td>Unplanned Care</td>
<td>282</td>
<td>-</td>
</tr>
<tr>
<td>Finance and Contracting</td>
<td>711</td>
<td>1,537</td>
</tr>
<tr>
<td>Unidentified QIPP</td>
<td>996</td>
<td>2,000</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>8,834</strong></td>
<td><strong>9,057</strong></td>
</tr>
</tbody>
</table>

**Key Risks and Mitigations**

The risks to the CCG’s financial forecasts are generated in the areas that are not within the control of SNCCCG but need to be managed to ensure financial sustainability. These include:
**Commissioning arrangements with external providers.** The CCG has made allowance for tariff uplift for acute and non-acute activity as per national guidance. However, an increase in prevalence or activity pressures in excess of the demographic and non-demographic growth assumptions will lead to unexpected demand and activity.

**Inflation assumptions,** particularly around high cost drugs and technology and equipment costs may be understated.

**Continuing Healthcare costs rising.** The CCG has seen increasing demand for continuing healthcare costs for a number of years as a result of policy changes and an increasingly aged population. In 2013/14 it was noted that the duration of packages was increasing significantly contributing to greater than planned costs. If these trends continue or increase this will cause greater pressure on the CCG’s finances.

**Reduction on management capacity due to the requirements to meeting national targets for a 10% reduction in running costs could impact on the CCGs ability to achieve the savings and transformation necessary to meet statutory targets.** The CCGs new CSU provider North and East London CSU has committed to delivering efficiencies totalling 20% over three years which will go some significant way to addressing this risk.

**Non-delivery of QIPP**

The CCG has entered into a limited risk share agreement with its four neighbouring Norfolk and Waveney CCGs, largely around the cost of individual high cost packages (costing greater than £100k per annum). SNCCG benefitted from this arrangement in 2013/14 but there is no reason to expect that this will continue and the CCG will incur part of the cost of additional high cost packages of care delivered in neighbouring CCGs.

**For 2015/16 the financial arrangements anticipated under the Better Care Fund are to be agreed with Norfolk County Council.** The challenge is significant to protect social care services and deliver more from greater integration and it is possible that the assumptions of savings included in the financial plan will not be met in full or will be met later than planned. Robust project management and planning during 2014/15 will mitigate against that risk on delivery of QIPP.

SNCCG has planned for a contingency of £1.2m being the 0.5% of Resource required by NHS England. Additionally, the CCG will not commit its remaining non-recurrent funds until it is confident that risks will be absorbed by the planned contingency.

**Balance Sheet Issues**

SNCCG is forecasting a cash balance of £1.95m at the end of both 2014/15 and 2015/16, which is in excess of anticipated maximum cash balance requirements set out by NHS England of 1.75% of the final month’s cash drawdown, or £0.250m whichever is the higher. This is because the CCG hosts the Norfolk and Suffolk Primary & Community Care Research Office, which receives donor funds in advance of expenditure. These funds, represented as deferred income in the financial statements of the CCG are forecast to be £1.7m at 31st March 2014. NHS England has authorised SNCCG to hold these excess funds because they are not derived from the funding allocation available to the CCG. The CCGs
planned Income and Expenditure does not include revenue or expenditure for the hosted organisation, though this will be reflected in SNCCG’s statutory accounts.

Summary

SNCCG recognises that the transformational change necessary to achieve the level of savings required needs a whole system integrated approach. The development of the Better Care Fund, if properly implemented, will be the primary method by which the CCGs statutory financial obligations will be delivered from 2015/16 onwards. As a result it is key that the foundation stones for this fund are put in place during 2014/15.

The risks to delivery of the CCG financial plan are significant but are mitigated either by the contingency or by other non-recurrent expenditure as yet uncommitted.
Appendix 1 – SNCCG, NNCCG & NCCG Strategic ‘Plan on a Page’
### VISION
Improvement in our populations’ health and well-being through affordable, integrated, individualised, high quality, health and care. Available to all that need it and primarily delivered through integrated community primary care teams.

### OBJECTIVES
- Objective 1: Further improve unplanned admission rates and remain in lower quartile
- Objective 2: Reduce all avoidable hospital deaths
- Objective 3: Improvement in patient experience both in and out of hospital
- Objective 4: Public health indicators improve to better than England average
- Objective 5: Maintain financial balance, deliver statutory duties
- Objective 6: Community health and care teams delivering integrated services in localities
- Objective 7: All patients who need it, have access to high quality and appropriate care 7 days per week
- Objective 8: All services at better than England average on the Atlas of Variation

### INTERVENTIONS
- Intervention 1: Development of primary care
- Intervention 2: Implementation of integrated community care teams, working across boundaries (based on primary care locality footprints)
- Intervention 3: Proactive use of predictive modelling and risk stratification
- Intervention 4: Easy to access, seven day health and social care provision for people with complex health and care needs
- Intervention 5: Enable independence, self care and self management
- Intervention 6: Improved support for people with Dementia and their carers
- Intervention 7: Deliver major redesign of urgent care system
- Intervention 8: Ensuring effective end of life pathways and support
- Intervention 9: Ensuring effective workforce planning

### SYSTEM GOALS
- GOAL 1: Continuously improve the quality and safety of health and care
- GOAL 2: Improve the health and well-being of the people of South Norfolk, Norwich and North Norfolk
- GOAL 3: Collectively manage resources effectively, responsibly and ethically, delivering VFM
- GOAL 4: Fully integrate health & social care services working in full partnership with primary care localities, to support people to remain safe & well in their own homes
- GOAL 5: Reduce unwarranted variation in care
- GOAL 6: Develop the necessary underpinning architecture for innovation and effective future services
- GOAL 7: Improve in patient experience both in and out of hospital
- GOAL 8: Public health indicators improve to better than England average
- GOAL 9: Maintain financial balance, deliver statutory duties
- GOAL 10: Community health and care teams delivering integrated services in localities
- GOAL 11: All patients who need it, have access to high quality and appropriate care 7 days per week
- GOAL 12: All services at better than England average on the Atlas of Variation
## Appendix 2

### 18 week RTT waiting times for non-urgent consultant-led treatment

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>% of admitted Service Users starting treatment within a maximum of 18 weeks from Referral</td>
<td>Operating standard of 90% at specialty level (as reported on UNIFY)</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £400 in respect of each excess breach above that threshold</td>
<td>Monthly</td>
<td>Services to which 18 Weeks applies</td>
</tr>
<tr>
<td>% of non-admitted Service Users starting treatment within a maximum of 18 weeks from Referral</td>
<td>Operating standard of 95% at specialty level (as reported on UNIFY)</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £100 in respect of each excess breach above that threshold</td>
<td>Monthly</td>
<td>Services to which 18 Weeks applies</td>
</tr>
<tr>
<td>Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral</td>
<td>Operating standard of 92% at specialty level (as reported on UNIFY)</td>
<td>Review of monthly Service Quality Performance Report</td>
<td>Where the number of breaches in the month exceeds the tolerance permitted by the threshold, £100 in respect of each excess breach above that threshold</td>
<td>Monthly</td>
<td>Services to which 18 Weeks applies</td>
</tr>
</tbody>
</table>