West Norfolk health and care system 5 year strategy
2014-2019
Executive Summary

The purpose of this strategy is to paint a compelling vision for the future of health and care delivery in West Norfolk. A vision that excites those that read it and that engages and captures the wishes of our local population. We have a unique population, with particular characteristics – balancing rurality with pockets of deprivation, a mix of ethnicity and demographic need. As a health and care system we aspire to be national forerunners in innovation. Centred around West Norfolk Clinical Commissioning Group (CCG) we have strong, long established relations with local partners across health, social care, borough council and non-statutory agencies.

Our position as a relatively small CCG gives us the unique ability to be exceptionally responsive to our local members and population, dynamic in our decision making and innovative in our thinking, co-creating our future with our partners in a way that often eludes bigger organisations and health systems.

Our track record in our first year of authorisation is demonstrative of this; leadership of strategic system change in the face of significant adversity – a forerunner in health and care system redesign in partnership with NHS England and Monitor, and national recognition in innovation through the award of being 1 of 15 national ‘integrated pioneer sites’ awarded status from the Department of Health. This is in addition to the fulfilment of our statutory obligations to deliver a financial surplus, discharge our commissioning duties effectively and commission innovative local services for our population.

Our aspirations for the coming 5 years are no less ambitious. The challenges we face in West Norfolk are those which in time will be faced on a national level by many more; that of a small district general hospital, operating in a geography and environment that makes it clinically, operationally and financially unsustainable. Colleagues from Monitor, with whom we are working in partnership with NHS England, view the development of a sustainable ‘Kings Lynn’ health economy solution as critical in their finding a solution to the ‘small district general hospital’ dilemma nationally.

We are excited by this challenge. We are leading a unique but rigorous approach, with colleagues from Monitor and NHS England to the development of a local solution; from which lessons can be shared nationally. This will be supported by a Contingency Planning Team (CPT) intervention, but was commenced by us a year previous, and will be led via local commissioners. We are learning from system re-configuration elsewhere, and will continue to engage local clinicians, stakeholders, and the wider population in determining our future in an open and transparent way.

For our future we see transformational change in the delivery of health and care services; locally responsive care driven by quality, innovation and a value for money approach to delivery. Our position as a local health economy will not be known for one that is a small footprint, lacking in scale, facing challenge. It will be one of innovation, creativity, and exceptional local engagement and delivery of locally responsive services. West Norfolk will be an area of choice and opportunity for the public, for providers, as a national exemplar.

Our measure of success in five years time? For West Norfolk to be known nationally as a system for creativity, innovation and positive change for the benefit of our population; where health, care and community organisations work together to drive demonstrable quality improvement for local people.
### Table of contents

<table>
<thead>
<tr>
<th>Subject</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Our plan on a page</td>
<td>5</td>
</tr>
<tr>
<td>The West Norfolk ‘Case for change’</td>
<td>6</td>
</tr>
<tr>
<td>The West Norfolk Vision</td>
<td>6</td>
</tr>
<tr>
<td>The West Norfolk ‘challenges’</td>
<td>9</td>
</tr>
<tr>
<td>Our ‘Call to Action’</td>
<td>15</td>
</tr>
<tr>
<td>Launching the West Norfolk Alliance</td>
<td>15</td>
</tr>
<tr>
<td>The West Norfolk response: leading the development of our future</td>
<td>17</td>
</tr>
<tr>
<td>Our work in 2013/14</td>
<td>18</td>
</tr>
<tr>
<td>Our work in 2014/15</td>
<td>19</td>
</tr>
<tr>
<td>2014/15 CPT and TSA</td>
<td>20</td>
</tr>
<tr>
<td>Delivering sustainability</td>
<td>21</td>
</tr>
<tr>
<td>Interventions</td>
<td>23</td>
</tr>
<tr>
<td>Improving quality</td>
<td>29</td>
</tr>
<tr>
<td>Governance</td>
<td>32</td>
</tr>
</tbody>
</table>

Appendix 1: 2 year Operational Plan

Appendix 2: High level system sustainability programme plan

Appendix 3: Example of detailed system sustainability workstream plan

Appendix 4: Example of weekly reporting template
Introduction

West Norfolk Clinical Commissioning Group comprises 23 GP practices, covering a population of circa 165,000 residents with a budget of circa £220 million. Apart from the small part of Breckland District Council around Swaffham that is covered by WNCCG, it is co-terminous with King’s Lynn & West Norfolk Borough Council. WNCCG has a rapidly ageing population, pockets of urban and rural coastal deprivation, and a higher than average incidence of diseases, such as diabetes and respiratory conditions.

The priorities identified by WNCCG at its formation in 2013 remain relevant now, and in the future. Namely, this includes a focus on:

- **Quality** – improving the quality of services and value for money within budgetary constraints
- **Performance** – minimising variations in performance, reducing the gap in inequalities
- **Integration** – building on health and social care integration, working closely with local authorities, the voluntary sector and the local population

Our core focus remains delivery of optimum health and care services to our local population. Our ambition is for local patients and the wider public to be co-producers of their health and care. We have a strong emphasis on the role of local GP practices, as constituent members of our ‘Council of Members’, who in turn hold to account our Governing Body in discharging its duties.

Our strategic objectives are:

- To ensure population need and clinical quality are at the heart of what we do
- To lead the long term sustainability of health and care services for the West Norfolk population
- Working in partnership with our patients, our public, provider and commissioner partners to promote the health and wellbeing of people in West Norfolk, delivering demonstrable improvement
- To meet statutory financial duties
- To stimulate innovation and integration
- To ensure the resources and capability exist to commission services efficiently and effectively
"Working together to improve and protect health and wellbeing in West Norfolk": Our 5 year strategy

**Context**
- Circles 185,000 population, rural area with pockets of deprivation, ageing demographic
- Planning unit centred around QH and footprint
- QH - local OPH, circa 81.5k, 442 beds, catchment area circa 250,000
- Monitor commissioned review found the trust financially unsustainable
- Strong track record of partnerships working, "West Norfolk Alliance"
- One of 15 integrated pioneer sites nationally

**WNCGG strategic objectives**
- To ensure population need and clinical quality are at the heart of what we do
- To lead the longer term sustainability of health and care services for the West Norfolk population
- Working in partnership with our patient's, our public, provider and commissioner partners to promote the health and wellbeing of people in West Norfolk, delivering demonstrable improvement
- To meet statutory financial duties
- To stimulate innovation and integration
- To ensure the resources and capability exist to commission services efficiently and effectively

**Our interventions**
- West Norfolk 'Alliance' system sustainability programme, driving system transformation to deliver a sustainable LHE, with characteristics of acute reconfiguration, primary and community care at scale, integration and technology enhancement
- Range of clinical pathway interventions, derived from public health analysis, demographic need and best practice evidence base across the following workflows:
  - Primary Care
  - Urgent Care
  - Mental Health
  - End of Life Care
  - Elective Care
  - Women and Children's
  - Frail and elderly, BOP, CIC
  - Prescribing

**Building the future**
- In conjunction with NHS England, Monitor and 'Alliance' partners leading a whole scale, system redesign programme, incorporating a CIP intervention by Monitor
- Reviewing core local services and redesigning a financially, clinically and operationally sustainable health and care system for West Norfolk. This will include consideration of a multitude of levers; clinical networks, integration (community, primary and social care), technology and telemedicine, information sharing, contracting and funding mechanisms. It will also be shaped by the '5 characteristics of future services.'

**Our intended outcomes**
- Securing additional years of life for people with treatable mental and physical conditions
- Increase health quality of life for people with Long Term Conditions including Mental Health
- Reducing time spent avoidably in hospital via integrated service provision
- Increase the proportion of older people living independently
- Increase the number of people who have a positive experience of acute hospital care
- Increase the number of mental and physical health conditions who have positive experience of GP and community care
- Eliminating avoidable deaths in hospital
The West Norfolk ‘Case for Change’

We have undertaken in-depth analysis to understand our strategic challenges and operating environment, and shape our strategy accordingly. From early on in our first year of authorisation we identified a number of converging factors which, together created an unprecedented catalyst for change. Through dialogue via our established Chief Executive level commissioner and provider partnership forum in West Norfolk we together articulated our West Norfolk ‘Case for Change: a Call to Action’, which received unanimous support from respective Trust Boards. This ‘Case for Change’ served to highlight the growing opportunities and risks within our system, and called for Board support to demonstrate proactive, strategic leadership to improve our situation. We describe our context in further detail overleaf.

The West Norfolk ‘Vision’ – (‘Pull factors’)

In West Norfolk we have a strong legacy of partnership working across health, social care, voluntary and independent sector. This has culminated in a shared vision for the future – of strong local communities’ whose health and wellbeing is optimised, with people very much at the centre. West Norfolk is a distinct healthcare economy and system with a single Clinical Commissioning Group coterminous with Kings Lynn Borough Council. At its centre is The Queen Elizabeth Hospital, King’s Lynn, which serves the West Norfolk CCG area and some populations from neighbouring Cambridgeshire, Lincolnshire and Central Norfolk (which equates to approximately 30% of the QEHKL’s income).

An integrated West Norfolk health and social care system

Health and care system partners already have a legacy of working together to deliver integration and partnership working. This includes:
- An integrated commissioning team, comprising West Norfolk CCG and Norfolk County Council West commissioning locality team
- Joint health and social care leadership of operational teams via integrated management posts
- Community health and social care teams operating from three integrated locality hubs
- ‘Prevention first’ partnership between health, social care and voluntary sector, district and county councils to target prevention initiatives to maintain the health and wellbeing of the older population
- ‘LILY’ (‘Living Independently in Later Years’) initiative to support older people in navigating available services
- System wide CQUIN initiatives that have targeted the avoidance of emergency admissions to hospital

Our integration work has received national recognition; West Norfolk was a successful pilot site for Integrated Care Organisations (ICOs), and has recently been awarded national integrated pioneer status (1 of 15 nationally) from the Department of Health in recognition of our track record and ambitions to integrate services.

Our ambition is that, through partnership working and integration we can deliver health and care services to higher quality standards, more cost effectively than we do currently. We have a shared commitment across our partnership, now called the West Norfolk ‘Alliance’, to ‘push the boundaries’, challenge status quo and process, and innovate. We intend to do this via the way we provide care, integrate services, share information, utilise technology, develop our staff and contract and pay for services.

We are building on a strong history of ‘localism’. We have a track record as a CCG of commissioning emerging models of best practice, including commissioning of case management interventions for risk stratified frail and elderly population, an integrated ‘step up’ and ‘step down’ community nursing and therapy facility to avoid admissions and expedite acute discharge known as the ‘Virtual Ward’, and an integrated Mental Health liaison service providing acute care at the front door of the QEHKL. Many of our commissioning interventions are replicated in NHS England’s “Any town” commissioning guidance for 2014/15\(^1\) as models of ‘High Impact Interventions’ to drive quality and sustainability.

Our working principles are as important to us as our partnerships. These principles underpin our commissioning ambitions; we want these to embody services received by our local population. Through our work to integrate health and care delivery we will implement these, utilising pooled budgets, single assessment- and care planning, technological solutions and local stakeholder engagement.

**Working principles...**

...to offer independence, choice and quality in all that we do

...to offer patients **one** comprehensive assessment, and **one** care plan

...to ensure **no** patient experiences organisational boundaries

...to foster **shared information and decisions** between health and care professionals and organisations

---

\(^1\) “Any town health system: a guide to finding further information on the interventions”, NHS England, January 2014
Our values matter to us. We pride ourselves in championing local population need, demanding services of the highest quality and leading innovation in service delivery.

We asked our staff what they thought of us; this is what they said:

We believe our values our also evident to our partners. In the 2014 NHS England, via IPSOS MORI undertook a West Norfolk CCG 360 degree stakeholder survey of a wide range of stakeholders comprising GP member practices, Health and Wellbeing Boards, Local Healthwatch/patient groups, NHS providers, Other CCGs, Upper tier or unitary local authorities and wider stakeholders. The purpose of this survey was to ask stakeholders a series of questions about their working relationship with West Norfolk CCG.

Across the full range of domains WNCCG invariably scored either higher than the rating received in 2012/higher than the CCG’s local area team average, and in some cases higher than the CCG national average. In summary,

- Engagement and listening to views
  - To the question, ‘How satisfied or dissatisfied are you with the way in which the CCG has engaged with you over the past 12 months?’, 79% of respondents were ‘Very, or Fairly satisfied’; higher than the national average (74%) and Area team average (69%)

- Working relationships
  - To the question, ‘Overall, how would you rate your working relationship with the CCG?’, 75% of respondents reported it to be ‘Very, or Fairly good’; higher than the Area team average (74%)

- Commissioning decisions
  - To the statement, ‘I have confidence in the CCG to commission high quality services for the local population’, 66% reported that they ‘strongly, or tend to agree’, higher than the Area team average (61%)
To the statement, ‘The CCG effectively communicates its commissioning decisions with me’, 68% reported that they ‘strongly, or tend to agree’, higher than both the national average (59%), and Area team average (54%)

- Leadership
  o To the statement, ‘I have confidence in the clinical leadership of the CCG to deliver its plans and priorities’, 70% reported that they ‘strongly, or tend to agree’, higher than the national average (68%), and Area team average (60%).

The West Norfolk challenges (‘Push factors’)

Mirroring many of the messages in NHS England’s ‘The NHS belongs to the people: a call to action’², we recognise locally an acute interplay of factors which, if left unaddressed will be catastrophic to the sustainability of our local health and care system.

QEH financial position and Monitor intervention

In light of the commissioning financial context, and following detailed financial analysis of its' financial sustainability QEKL delivered a deficit of circa £13 million for 2013/14, with a forecast deficit of circa £15 million for 2014/15. The predicted worsening of the financial position over forthcoming years prompted further investigation from Monitor leading them to issue a notice of breach of license conditions relating to financial performance. Monitor, in conjunction with WNCCG and NHS England are initiating a formal Contingency Planning Team ‘support’ process, to remedy the financial position, and deliver a long term, sustainable solution.

Continued pressure on commissioning budgets and need for challenging provider delivery of cost savings with minimal quality and service delivery impact

The national financial picture is one of a further £30 billion of savings by 2020. In line with the national financial picture there is a growing gap between the available healthcare commissioning budget and anticipated financial costs. This is further compounded locally by an ageing demographic in West Norfolk, with higher than average incidence of long term conditions and lifestyle behaviours that have an adverse impact on health and wellbeing. The figure overleaf shows the financial challenge for the West of Norfolk healthcare system by CCG and provider. Overlaid onto this is a proxy of the additional financial pressure caused by the ageing demography with higher chronic disease prevalence, based on data supplied in a Kings Fund report on the future of NHS funding (Kings Fund, 2009). The pressure on all providers of health and care to deliver annual efficiency targets of 4% on a year-on-year basis, whilst not impacting on quality of care is becoming increasingly challenging to achieve. This is in the context of many providers being constrained by their existing infrastructure, such as an ageing estate, technology and connectivity challenges. Further, the requirement to increase NHS funding flow to social care will present significant issues for consideration of future funding shares across health and social care.

West Norfolk healthcare system financial challenge

The pressure on all providers of health and care to deliver annual efficiency targets of 4% on a year-on-year basis, whilst not impacting on quality of care is becoming increasingly challenging to achieve. This is in the context of many providers being constrained by their existing infrastructure, such as an ageing estate, technology and connectivity challenges. Further, the requirement to increase NHS funding flow to social care will present significant issues for consideration of future funding shares across health and social care.

Population and health outcome challenges

---
3 Monitor enforcement undertakings document, 24th April 2013
4 Proxy taken from Kings Fund report, ‘How cold will it be?: Prospects for NHS funding 2011-17 (Kings Fund, 2009)
The West Norfolk area has a number of specific challenges which inhibit the delivery of high quality services. These include, but are not limited to:

- A rapidly ageing population
- Pockets of urban and rural coastal deprivation
- Higher than average incidence of disease
- Areas of service performance unwarranted variation

The latest Census indicates that in 2011 the population of the Borough of Kings Lynn was 147,451 and that since 2001 the population has increased by 8.9%, over 12,000 people. Since 2001 the number of people aged 60 or over has markedly increased, along with the 15-29 age-group. In contrast however, the number of people aged between 30 and 44 has decreased notably. According to findings in the Council’s Strategic Housing Market Assessment (SHMA) currently being undertaken, this trend is set to continue. Overall the Borough contains a lower proportion of population that are working age than is found regionally and nationally; 60.2% in Borough compared to 63.5% in the East region and 64.8% across England. This is principally because there are a larger than average proportion of people of pensionable age in the Borough (23% compared to 17.5% in East and 16.3% in England).

In addition to the above some 21.3% of the resident population in the Borough have long term health problems or disability, compared to 16.7% of residents in the East region and 17.6% across England. Again reflecting the older than average profile of the population. West Norfolk has a significantly greater proportion of older people for both males and females compared to the national average. Projections for 2028 predict that the number of people aged 90 or over is expected to increase by almost 80%. This will equate to a greater incidence of adults living with morbidities and further pressure on health and care services.

In terms of wider determinants of health, there is a high level of deprivation in parts of Kings Lynn and rural areas bordering Cambridgeshire, as well as pockets of coastal deprivation. Linked to these deprivation areas will be greater incidence of disease and lifestyle behaviours which increase health and care needs as demonstrated by QOF data.

**Other provider context**

The position for all providers and commissioners of healthcare in West Norfolk is challenging, due to funding constraints and increasing demand. This spans health and care, provision and commissioning, for both statutory and non-statutory organisations. Key partners’ relative position has been highlighted below:

**Norfolk County Council**

Norfolk County Council commissions social care services for West Norfolk and directly provides the locality social work service. Between 2011 and 14 the Council has managed a budget reduction of 28% and anticipates a further similar reduction equating to over £180 million between 2014 and 17. Substantial efficiency and service restructuring has been achieved to date, however significant transformation is required in the way that the Council works with partners, providers, voluntary services, communities and citizens to achieve the further savings planned in a way that does not adversely affect delivery of social, or health care services.

**Norfolk and Suffolk Foundation Trust (NSFT)**
Norfolk and Suffolk Foundation Trust (NSFT) provides mental health services, including wellbeing and IAPT services in West Norfolk. NSFT faces a major challenge over the next few years; a combination of the reducing funding settlements from CCGs, tariff deflation and growing demand means that it will not be possible to maintain the current range and types of service in the near future. The Trust is experiencing additional pressures on its services as financial hardship impacts on people’s wellbeing and ability to maintain good mental health and they turn to help from public services. The large elderly populations in Norfolk and Suffolk continue to grow and more and more people are being diagnosed with dementia, which presents a huge challenge for health and social care services. The Trust needs to make savings of 20% or £32m by 2016. The sustained reduction in resources can only be met by the radical steps to change pathways and approaches to treatment in order to be able to meet both financial constraints as well as increasing demand. Such a programme requires an enormous level of engagement and participation from clinicians, staff, service users and carers as well as commissioners and other service partners.

**Norfolk Community Health and Care (NCH&C)**

NCH&C provides services throughout Norfolk which focus on care close to home. These services range from ‘cradle to grave’ with a particular focus on early intervention and hospital avoidance. NCH&C services are closely structured around CCGs, such that they are coterminous and enable integration. A key goal for the Trust is to work even more closely with social care in integrated teams. Cost improvement plans were met last year and for 2013/14 there is a well planned and clinically signed off transformation programme of circa £7.1m however true efficiencies are getting increasingly hard to find.

The above picture for each organisation is consistent; all need to make year on year efficiency savings over coming years, against a backdrop of having delivered this historically. Given the scale of the financial challenge it would be difficult for any organisation in isolation to deliver these efficiencies alone, without detriment to local service provision; delivery of efficiencies at this scale will require radical transformation to the way in which services are commissioned, configured and delivered across the health and care system.

**Rising standards and expectations**

Providers and commissioners are being subject to increasing rigour and scrutiny in both the way in which services are commissioned, and the way they are provided. A number of new, regulatory bodies have been established, with increasing focus on individual organisation and system assurance. This includes, but is not limited to Monitor, CQC and NHS England. Further, patient expectation regarding services commissioned and delivery is rightly increasing; with heightened focus on providers offering choice, and services and treatment options tailored to patient need and expectation. Local providers too are keen to rise to this challenge and ensure services are delivered in a tailored way to meet local population need.

**Configuration challenges**

Acute hospital services have been under review both nationally and regionally over recent years. The current configuration of acute hospital services across East Anglia is depicted below.
District general hospital services have been called into question in terms of their clinical, operational and financial sustainability nationally (Reconfiguring hospital services, Kings Fund 2011). Legitimate questions have been posed regarding:

- The clinical viability of DGHs to provide particular services based on catchment population and national royal college guidance
- The ability of DGHs to deliver services within estate constraints
- The ability of DGHs to operate effectively in a marketplace where choice and contestability is greater

Monitor’s recent guidance on the future of the smaller hospital examines the effect of hospital size on performance and provides an economic analysis of the relationship between some of the variables (such as payment systems, teaching and R&D, number of specialties, rurality and links to other providers) and the financial sustainability of the DGH. A correlation was found between size and financial performance and this relationship is becoming stronger. The report also gives examples of the measures adopted by some of the 6 most challenged small hospitals to tackle the problem, including telemedicine, integrating hospital and community services and re-designing roles to cross traditional boundaries. The report raises the possible unintentional consequences of the national guidance on providing ‘care closer to home’ on the small DGH, by removing some services that make a significant contribution to income. Distance from other providers is highlighted as a major factor in determining the breadth of services that may be required at a small DGH in order to maintain patient access and the report argues that there is no evidence that the size of a hospital affects quality of care.

**Workforce challenge**

The Centre for Workforce Intelligence has estimated that if consultant numbers continues to expand according to the number of doctors in higher training, then the total number of consultants in hospital in 2020 will increase by 60%, increasing the pay bill by £2.2 billion (Royal College of Physicians, 2013). This will require significant reconsideration of future medical staffing and training in the future. This is compounded by the ageing population, and growing epidemiological complexity of patients putting further demand on medical staffing. It is further worsened by the impact of the reduction in trainee doctors’ hours enforced by the European Working Time Directive (EWTD).

---

5 Monitor: Future of small district general hospitals (2014)
The above picture, common nationally, is heightened in West Norfolk due to the difficulty in recruiting medical, nursing and wider therapy staff alike. This has led to provider organisations having difficulty in filling vacancies, and resorting to initiatives such as recruitment from overseas to fill vacancies.

Further to the difficulties in recruitment and in delivering a workforce that can cope with the increasing patient demand, there is additional challenge posed by the need to ensure clinical expertise and sustainability of provision in line with specialities and treatments offered by any one provider. For example, interdependencies between services provided will require certain clinical expertise to deliver them effectively, which can be harnessed via direct recruitment, or via networks and collaborative provision. For the QEH, unique challenges will be posed in delivering acute hospital services due to geography, regarding the clinical sustainability (due to recruitment and retention) of a sufficient mix of clinical workforce to deliver services safely and effectively in some specialist areas. Other providers too face a challenge in recruiting and sustaining a workforce. Collaboration and consideration across providers will be necessary to consider how, through innovation and creativity, job roles can be created which prove more attractive to aid recruitment and retention.

Our ‘Call to Action’

The detailed description aforementioned of the context in which the West Norfolk health system is operating is summarised below as a ‘Call to Action’.
It is clear that our not responding to circumstances would lead to system failure. In setting out our ‘Call to Action’, fundamentally our intent is to capitalise on our strategic opportunities, respond to these challenges and ‘get ahead of the game’

Launching the West Norfolk ‘Alliance’

In response to our ‘Call to Action’ our partnership of providers and commissioners serving West Norfolk committed to support our leadership of a programme of transformational change in the commissioning, provision and delivery of care in West Norfolk. We wanted to create a brand that embodied what we wanted to achieve; working together, in an integrated way to safeguard services for our local population. The concept of an ‘Alliance’ was central to this; working together, with aligned objectives and a shared desire to transform services. The West Norfolk Alliance was launched in April 2014, with full support from Chief Executives of all Alliance partners, Monitor, NHS England, and the Minister for Care, Normal Lamb MP.
Our programme to deliver sustainable health and care comprises a number of areas:
- Review of clinical pathways to consider opportunity for transformational change in the way in which services are configured and delivered
- Review of technological solutions to enable service delivery
- Review of information sharing mechanisms
- Review of contracting and payment mechanisms to align incentives and drive performance improvement
- Review of workforce needs now, and in the future, exploring innovative ways of recruiting and retaining skilled workforce

The work of the Alliance is described in more detail on page 25.
The West Norfolk CCG response to the ‘call for action’: leading the development of our future

In responding to our ‘Call to Action’ we had broadly two choices; to allow our circumstances to continue and be passive recipients of the outcome of these, or, to lead a system strategic response to secure sustainable local services. We knew that elsewhere, in cases where acute provider failure had occurred, formal Monitor intervention (Contingency Planning Team, Trust Special Administrator action) has not yet led to a sustainable health economy solution. Work has centred on the Trust in failure, not the wider health economy, and the involvement of the local CCG has been limited.

In considering our response we reflected on our Strengths, Weaknesses, Opportunities and Threats (SWOT) to consider our capacity and capability to respond, shown below. This analysis necessarily needs to form a part of how we create our strategy, and how we develop a risk framework to assure progress.

<table>
<thead>
<tr>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CCG track record of delivering commissioning initiatives and leading momentum for change;</td>
<td>• Current performance on some key national standards is not acceptable (eg Ambulance response times, waiting times in some specialties);</td>
</tr>
<tr>
<td>• Strong and embedded partnership working with County, Borough council, neighbouring CCGs and other stakeholders;</td>
<td>• Underlying financial deficit at the QEH;</td>
</tr>
<tr>
<td>• Forerunner in leading integration of services with partners;</td>
<td>• Quality concerns regarding provision of care at QEH in line with CQC inspection and improvement plan;</td>
</tr>
<tr>
<td>• Strong underlying financial position in first year of CCG;</td>
<td>• Relatively small size of WNCCG and therefore limited capacity to effect change within constrained running cost allowance;</td>
</tr>
<tr>
<td>• Embedded clinical engagement in decision making;</td>
<td>• Only one acute provider (the QEH) within the geography of West Norfolk, with over 40 miles to other similar providers.</td>
</tr>
<tr>
<td>• Highly committed workforce.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OPPORTUNITIES</th>
<th>THREATS / RISKS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Leadership of the “Alliance” programme provides an opportunity to shape local service delivery in an innovative and integrated form;</td>
<td>• Monitor review of the future viability of the QEH may lead to formal intervention in the local health economy;</td>
</tr>
<tr>
<td>• National direction to pool resources with Local Authorities under the Better Care Fund, so as to promote further integration of commissioning;</td>
<td>• Continued requirement for providers in the NHS to deliver 4% efficiency savings each year through Cost Improvement Programmes is increasingly difficult to achieve without impacting on quality of care;</td>
</tr>
<tr>
<td>• Emergence of new models of care within primary and secondary sectors;</td>
<td>• Significant budget pressures in local authority compounds financial pressures on the health sector.</td>
</tr>
<tr>
<td>• Resources identified in 2014/15 to support Transformation initiatives.</td>
<td></td>
</tr>
</tbody>
</table>
Our work in 2013/14

Following our ‘Call to Action’ and decision to lead system reform we strengthened our engagement with NHS England and Monitor and commenced the initiation of ‘Phase 1’ of our system sustainability programme. Learning from Contingency Planning Team (CPT) experience elsewhere we designed ‘Phase 1’ with the objective of undertaking an evaluation of the clinical, operational and financial sustainability of the local health economy. Whilst this analysis had been commissioned by QEHKL from PWC for the Trust, we wanted to replicate this analysis across the health economy; this approach built on learning elsewhere to ensure that our thinking expanded beyond the Acute Trust, and considered fully the situation across the LHE. The second element of ‘Phase 1’ was an initial analysis of Commissioner Requested Services for each of our provider Trusts; an important step to determine at an early stage those services for which we require additional regulatory protection should Trusts reach financial failure. This work is depicted in the figure below:

The output of ‘Phase 1’ of our work confirmed that the financial position of the QEHKL, and therefore the LHE was beyond that which could be ameliorated by incremental efficiency gains (a projected circa £25-30 million deficit as at October 2013\(^6\)). This conclusion led us to seek support from Monitor and NHS England to instigate ‘Phase 2’ of our proposed programme; to develop a sustainable solution for the delivery of care in West Norfolk. Following our production of a business case for progression to ‘Phase 2’, negotiations with Monitor regarding the next steps of intervention at the QEHKL has meant some delay to our programme. However, with support from NHS England and Monitor we have commenced work with our Alliance partners prior to formal ‘Contingency Planning Team’ intervention to develop our thinking.

---

\(^6\) PricewaterhouseCoopers ‘NHS West Norfolk Clinical Commissioning Group: Development of a sustainable healthcare system for West Norfolk’, October 2013
Our work in 2014/15

Our work pre CPT is designed to re-evaluate our designation of Commissioner Requested Services, as an important precursor to formal Monitor intervention. A key component of this work is the formation of a Clinical Reference Group, comprising multi-disciplinary professionals from across the LHE, who were tasked with reviewing of clinical pathways to explore opportunities to reform care delivery in transformational ways. They have approached this task via the creation of 3 clinical sub-groups, convened to review pathways of care through which the traditional boundaries of a district general hospital, care delivery and ways of working would be tested. These are the Frail and Elderly pathway, Maternity pathway and acute non-elective Paediatric pathway. Alongside this clinical dialogue WNCCG is reviewing its Commissioner Requested Services output, and commencing the West Norfolk ‘Alliance’ launch. This work is depicted below:

2014/15 ‘pre CPT’ work overview

- **Monitor:**
  - April-Jun: Monitor process to procure consultancy support to underpin CPT and TSA process.
  - May 2014: Monitor, NHSE, WNCCG review meeting to align work plans, approach, CPT/TSA scope and support.
  - End Jun 2014: Mobilisation of preferred provider, early engagement with Monitor, selected providers, WNCCG, NHSE to refine work plan, Interdependencies and working arrangements.

- **Clinical Reference Group (CRG):**
  - Priority pathways: Frail and Elderly, Maternity, and Paediatric.
  - Sub-clinical workgroups established.

- **WNCCG CRR working group:**
  - Re-established to review and align CRR output from Phase 1.

- **Consolidated output:**
  - Document containing Phase 1 CRR output, refined CRR working group output and sub-clinical workgroups.

- **Stage 1:**
  - Current pathway mapping.

- **Stage 2:**
  - Pathway reconfiguration exploration.

- **Stage 3:**
  - Reconfiguration feasibility test.

- **Final output document containing clinical discussions, working assumptions and reconfiguration options, all of which will be checked against CRR test questions.

- **Review of Phase 1 CRR output, and further refinement to test assumptions, ‘stretch’ of alternative, scale and extent of service line coverage, and early commencement of data modelling to model high level activity and financial impact of considered options.

- **CRS working group consolidation of output from sub-clinical workgroups and CRR review.

- **Enabling work stream mobilisation.**
WNCCG is working closely with Monitor and NHS England to commission a CPT. This has involved the CCG contribution to determining the scope of CPT, and will involve participation in the selection and appointment of a preferred supplier. The process of CPT is prescribed, with the CCG and NHS England playing a key role in local governance and management of the programme. A TSA approach may or may not be initiated depending on the preferred suppliers proposed solution.

**2014/15 ‘CPT’ and ‘TSA’ work overview**

**Consolidated output document containing Phase 1 CRS output documents, refined CRS working group output and sub-clinical workgroups**

**WNCCG inputs 5 yr strategy, commissioning intentions, affordability analysis, recommendations**

**WNCCG inputs to stakeholders engagement and plans development**

**WNCCG**

**Enabling work streams**
Delivering sustainability

Financial projections for West Norfolk CCG are depicted below, over the coming 5 years.

WNCCG financial projections 2014-2019

The 5 year financial plan reflects key assumptions from NHS England on funding growth and national tariff changes, and adheres to the required business rules i.e.:

- Delivery of a 1% surplus each year
- Establishment of a non-recurrent contingency reserve of 0.5% of funding
- Setting aside of 2.5% non-recurrent funding in 2014/15 (of which 1% is available for Transformational purposes), and 1% thereafter.

There is a step change in 2015/16 with the introduction of the Better Care Fund (BCF), whereby WNCCG is required to pool £11.4m of funding with Social Care, of which £3.6m is matched by an increase in funding to the CCG. Running costs are expected to reduce by 10% in 2015/16, in line with national reductions to funding for the Running Costs Allowance. This reduction will be largely achieved via efficiencies within the Commissioning Support Unit.

<table>
<thead>
<tr>
<th>Description</th>
<th>2013/14 Forecast £m</th>
<th>2014/15 Plan £m</th>
<th>2015/16 Plan £m</th>
<th>2016/17 Plan £m</th>
<th>2017/18 Plan £m</th>
<th>2018/19 Plan £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme Funding</td>
<td>215.2</td>
<td>215.9</td>
<td>223.3</td>
<td>227.2</td>
<td>231.1</td>
<td>235.1</td>
</tr>
<tr>
<td>Running Costs Allowance</td>
<td>4.1</td>
<td>4.1</td>
<td>3.7</td>
<td>3.7</td>
<td>3.7</td>
<td>3.7</td>
</tr>
<tr>
<td><strong>Total Revenue</strong></td>
<td>219.3</td>
<td>220.0</td>
<td>226.9</td>
<td>230.9</td>
<td>234.8</td>
<td>238.8</td>
</tr>
<tr>
<td><strong>Baseline Expenditure (before savings plans)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme Spend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Commissioning</td>
<td>127.1</td>
<td>124.7</td>
<td>126.0</td>
<td>128.2</td>
<td>128.7</td>
<td>129.2</td>
</tr>
<tr>
<td>Mental Health Commissioning</td>
<td>16.4</td>
<td>16.2</td>
<td>16.2</td>
<td>16.2</td>
<td>16.1</td>
<td>16.0</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>14.0</td>
<td>13.7</td>
<td>14.9</td>
<td>16.3</td>
<td>17.5</td>
<td>18.7</td>
</tr>
<tr>
<td>Community Commissioning</td>
<td>19.5</td>
<td>19.4</td>
<td>19.2</td>
<td>19.5</td>
<td>19.4</td>
<td>19.3</td>
</tr>
<tr>
<td>Prescribing / Primary Care</td>
<td>36.1</td>
<td>37.0</td>
<td>38.6</td>
<td>40.4</td>
<td>42.4</td>
<td>44.4</td>
</tr>
<tr>
<td>Non-Recurrent / Transformation Reserve</td>
<td>-</td>
<td>5.3</td>
<td>2.2</td>
<td>2.2</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Better Care Fund</td>
<td>-</td>
<td>-</td>
<td>11.4</td>
<td>11.4</td>
<td>11.4</td>
<td>11.4</td>
</tr>
<tr>
<td>Other Reserves</td>
<td>-</td>
<td>3.0</td>
<td>5.0</td>
<td>9.2</td>
<td>13.8</td>
<td>18.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>213.1</td>
<td>219.3</td>
<td>233.5</td>
<td>243.6</td>
<td>251.5</td>
<td>259.8</td>
</tr>
<tr>
<td><strong>Running Costs</strong></td>
<td>4.1</td>
<td>4.1</td>
<td>4.2</td>
<td>4.3</td>
<td>4.4</td>
<td>4.5</td>
</tr>
<tr>
<td><strong>Total Expenditure before savings</strong></td>
<td>217.2</td>
<td>223.4</td>
<td>237.7</td>
<td>247.9</td>
<td>255.9</td>
<td>264.3</td>
</tr>
<tr>
<td><strong>Planned Surplus / (Deficit) before savings</strong></td>
<td>2.1</td>
<td>(3.4)</td>
<td>(10.7)</td>
<td>(17.0)</td>
<td>(21.1)</td>
<td>(25.5)</td>
</tr>
<tr>
<td><strong>Savings required to deliver 1% surplus</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual QIPP requirement</td>
<td>-</td>
<td>(5.6)</td>
<td>(7.4)</td>
<td>(6.3)</td>
<td>(4.2)</td>
<td>(4.4)</td>
</tr>
<tr>
<td><strong>Cumulative total QIPP savings</strong></td>
<td>-</td>
<td>(5.6)</td>
<td>(13.0)</td>
<td>(19.3)</td>
<td>(23.5)</td>
<td>(27.9)</td>
</tr>
<tr>
<td><strong>Planned Surplus / (Deficit) for Year</strong></td>
<td>2.1</td>
<td>2.2</td>
<td>2.3</td>
<td>2.3</td>
<td>2.3</td>
<td>2.4</td>
</tr>
</tbody>
</table>

Annual Savings (QIPP) requirement as a % of Programme funding: 3.3%  2.6%  3.3%  2.8%  1.8%  1.9%
The result of the CCG’s financial model is an annual QIPP (Quality, Innovation, Productivity, Prevention) target of 2.6% (£5.6m) in 2014/15, growing to 3.3% (£7.4m) in 2015/16.

WNCCG QIPP PLAN 2014-2019

QIPP PLAN 2014/15 - 2018/19: 5 YEAR SUMMARY

<table>
<thead>
<tr>
<th>Work Programme</th>
<th>Planned Savings per Year</th>
<th>Total Savings £m</th>
<th>Total Savings %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care &amp; Long Term Conditions</td>
<td>1.6</td>
<td>1.3</td>
<td>1.0</td>
</tr>
<tr>
<td>Planned Care</td>
<td>1.4</td>
<td>0.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Pathway Reviews</td>
<td>0.7</td>
<td>2.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Prescribing</td>
<td>1.3</td>
<td>1.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Contract Management (see note)</td>
<td>1.7</td>
<td>0.9</td>
<td>0.8</td>
</tr>
<tr>
<td>Running Costs</td>
<td>-</td>
<td>0.5</td>
<td>0.1</td>
</tr>
<tr>
<td>Unidentified QIPP</td>
<td>-</td>
<td>-</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Total Planned Savings</strong></td>
<td>6.7</td>
<td>7.6</td>
<td>6.3</td>
</tr>
<tr>
<td>QIPP Requirement</td>
<td>5.6</td>
<td>7.4</td>
<td>6.3</td>
</tr>
<tr>
<td>Headroom / (Gap)</td>
<td>1.1</td>
<td>0.2</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Headroom / (Gap)</strong></td>
<td><strong>20%</strong></td>
<td><strong>3%</strong></td>
<td><strong>0%</strong></td>
</tr>
</tbody>
</table>

Note: The annual savings for Contract Management include £0.8m of non-recurrent savings assumed each year

The annual QIPP requirements identified in the 5 year Financial Plan Summary will be met by delivery of a challenging QIPP plan, which is summarised by category in the above table. Best practice indicates that a QIPP plan should target at least 120% of the savings requirement, so as to give some “headroom” to allow for under-delivery of individual schemes. The CCG QIPP plan for 2014/15 achieves this level of headroom but it is not yet identified for subsequent years, and from 2016/17 onwards there is a level of unidentified QIPP savings.

This table indicates that the main QIPP focus is in the following areas:

- Urgent Care & Long Term Conditions – the plan assumes a 2% reduction in emergency hospital admissions in both 2014/15 and 2015/16, with further reductions in A&E attendances and in length of stay. This will be supported by a range of initiatives, and is aligned to the aspirations under the Better Care Fund. This category also includes significant anticipated savings on the prices for Continuing Healthcare packages
- Pathway reviews – to be informed by the system-wide work of the West Norfolk Alliance Prescribing – the QIPP plan assumes annual cost efficiency of 4%, reflecting the fact that current prescribing spend in West Norfolk is an outlier locally and nationally.

As identified in ‘Phase 1’ of our system sustainability programme, delivery of the WNCCG QIPP plan will not lead to financial sustainability across our local providers without whole-scale transformational change. Whilst we do not yet have the full solution for future service configuration for West Norfolk, we believe we have a rigorous and robust programme of work planned, with colleagues from Monitor and NHS England to determine our future.
**Interventions**

The methodology for development of WNCCG 5 year strategy has been informed by NHSE’s ‘Setting Quality Ambitions’ guidance (2013). This methodology is depicted below, with further commentary on WNCCG work undertaken.

| "Scope and engage" | *CCG planning lead appointed with responsibility for leadership of a programme of work to deliver 5yr plan  
*Multidisciplinary working group convened  
*West Norfolk ‘Alliance’ partners engaged |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Data analysis</td>
<td>*A variety of data sources and tools were utilized, including Commissioning For Value data pack, CCG outcomes tool, previous SNA and public health analytics. These were triangulated statistically to draw evidenced themes</td>
</tr>
</tbody>
</table>
| Identify opportunities and challenges from the analysis | *Comparison of WNCCG performance alongside ‘like’ CCGs for rurality and demography, and also for ‘like’ sole acute provider systems  
*Utilisation of ‘Levels of Ambition’ Atlas to identify opportunities |
| Horizon scanning the future | *Data modelling for projections in future demography and demand for services to determine ‘donating’ scenario  
*Inclusion of stakeholder events feedback to identify ‘what good looks like’  
*Preparatory work |
| Generating solutions | *Identification of HIs and EAs within ‘Anytown’ guidance, which mirror current, and have informed future commissioning interventions  
*Further solution generation within ‘Alliance’ programme |
| Exploring the detail | *WNCCG 5 year outcome projections set in line with planned commissioning interventions  
*Commissioning intervention project plans developed to underpin delivery |
| Modelling and projecting | *Utilisation of ‘Anytown’ resource pack and national evidence base to inform modelling impact (activity, finance and quality) of each commissioning intervention |
| Sense checking and pacing | *Project documentation for each intervention includes a stop/go point, accounting for feasibility and likelihood of delivery and other associated risks  
*PMO approach to pacing implementation and ensuring delivery |
| Peer review and stretch | *Early NHSE feedback incorporated in V2; further feedback to be incorporated from NHSE and West Norfolk ‘Alliance’ partners |

Whilst we are still early on in our work locally to determine the future of our health system, and without pre-empting the work of the CPT, there are undoubtedly characteristics that we expect to see in our system in 5 years time.

**Right sizing of acute hospital provision**

WNCCG is working in collaboration with Monitor, NHS England and West Norfolk Alliance (including QEHKL) to determine the future provision of acute hospital services for the population of West Norfolk via the CPT process. Our intention is to keep a strong, high quality and vibrant acute service delivered in Kings Lynn, to the West Norfolk population, drawing on centres of excellence to formalise clinical networks, and support patient transfer to such centres for highly complex interventions.

Without pre-empting the work of the CPT, early clinical engagement, review of evidence base and national guidance points to the following likely steps:

- Consolidation of core urgent services at QEHKL, to ensure a sustainable A&E service, with linked Acute medicine, Acute surgery, Critical Care and Maternity provision. The re-focus of these services
will be to ensure high quality, responsive urgent care services that are able to treat urgent cases, and where highly specialised emergency services are required that the QEHKL offers stabilisation care prior to patient transfer. In respect of the Keogh Review QEHKL is likely to be designated an ‘Emergency Centre’, networked with ‘Major Emergency Centres’

- Transfer of highly complex surgical and medical cases to ‘Major Emergency Centres’, ensuring patients are treated at centres where there is sufficient expertise and volume of interventions to provide optimum quality provision
- Possible repatriation of less complex cases from neighbouring Acute Trusts, particularly for those conditions that would benefit from more localised care, integrated with the local community
- Strengthening and formalisation of clinical networks to offer opportunities for sharing of staffing, expertise, cover (both ‘on site’ and ‘off site’), training and development opportunities, staffing rotation etc.
- Either consolidation or rationalisation of services that are on the cusp of sustainable levels in terms of throughput, staffing cover and income generation
- Strengthened links with primary and community care, offering outreach services where this is clinically and cost effective

Ultimately it is our intention to work with partners to create a new DGH model that is fit for the future, and able to provide high quality care for our local population

Enhanced primary and community care at scale

We will continue to build on our work both as a pilot site for Integrated Care Organisations (ICOs), but also as one of 15 national Integrated Pioneer sites identified by the Department of Health. We will have further developed integrated community teams, comprising health and social care configured around practice, and local populations. We will capitalise on opportunities to co-locate multidisciplinary teams.

We will have a consolidated, whole systems approach to assessment, utilising one, validated and recognised assessment methodology which is transferable across care settings – both in terms of governance and information sharing.

Using risk stratification tools we will target our health and care interventions – whether for preventative purposes, case management or crisis intervention – on identified population cohorts, ensuring we align resources to need. In support of this we are likely to see the emergence of locality hubs of care, centred around clustered GP practices and aligned community services to offer scale and viability to general practice, and heightened interventions for target groups.

We will align further resource and funding to enhance primary and community care at scale. This will include, but not be limited to:
- ‘£5 per head’ schemes centred on frail and elderly care, DES and LES enhancements, Better Care Fund utilisation.
- Targeted ‘acute’ outreach, supporting the scope and scale of what can be done safely, closer to home. This could include geriatrician or acute medical outreach to provide oversight to frail and elderly, crisis and care management interventions for population cohorts.
- Enhanced voluntary, independent sector, borough council and community partnerships to provide wider support networks to the community.
- Enhanced carer support via training and growing carer networks.
- Better Care Fund pooling budget for frail and elderly to drive integration across health and social care.
Technology to enable care delivery

In light of our rural geography and population diversity, innovation in technology will offer significant benefits to patients, and enable different models of care delivery.

Our electronic IT prescribing system, Eclipse live, will offer a nationally innovative mechanism for effective and proactive prescribing, to best practice guidelines, supporting pre-emptive intervention. It will allow practices to compare prescribing levels, and ensure they are prescribing effectively.

Our Eclipse Live Smartcard solution will mean that every patient in West Norfolk will have a ‘patient passport’, containing electronic information regarding their status, their health, and their needs that is available via web portal to health and care professionals across organisations, and across the geography. This data will include up-to-date, real time information on health checks and latest physiological measures as well as advanced care planning wishes.

We will utilise both Smartcard, and other technology such as Telehealth and Telemedicine to utilise electronic care planning and monitoring to support admission avoidance. This will support appropriate care for patients who are frail and elderly, who suffer from long term conditions or are near to the end of their life; and provide remote clinical support to care homes, and other health professionals.

The above sharing of information will be supported by informed patient consent, and robust mechanisms to share information across organisations, and across health professionals. In addition to utilisation of IM&T technologies, we will also draw on other technological infrastructure to support our service to patients. A single hub, offering one point of referral for community health care for patients and professionals will ensure care and services are easy to navigate for the public, and professionals. We will continue to work with local partners to deliver the LILY initiative (Living Independently in Later Years); an online and telephone service directory for health and care services, and activities for people later in life.
Integration in health and social care delivery

The West Norfolk ‘Alliance’ is one of fifteen nationally designated integrated pioneer sites. WNCCG and its’ partners’ values flow through the aim of our programme and principles in the delivery of care. We have a number of actions which form part of our wider ‘Alliance’ programme plan as depicted below. This includes the development of care navigator roles to support individuals in accessing appropriate care, the development of a network of community volunteers, extension of service delivery appropriately across the seven day week, and roll out of End of Life care planning folders to support timely and responsive care.

The ‘Better Care Fund’, an integrated pool of money between health and social care designed to facilitate integration in service delivery and improved alignment of resources, has been targeted on a number of areas to support integration.

The Alliance Integration Plan

Aim

Sustainable, co-ordinated services with patients in control

Principles

Independence, choice and quality
One assessment, one plan
No organisational boundaries
Shared information and decisions

Actions

Patient advocates in care navigation
Extending Integrated care teams
Lead provider for dementia care
Community volunteers network
Consistent Care Home policies
Smart Card to access information
Roll-out End of Life ‘yellow folder’
7 day working
Central to our ambition is our belief of the fundamental, positive impact an ‘Alliance’ of providers and commissioners, and integration will bring to patients. We describe below a typical journey for a frail and elderly couple now, and that that we envisage in the future.

A patient’s experience now...

Too many of our most frail and elderly patients receive sub-standard care now, due to fragmentation of services, duplication of effort, ‘gaps’ in provision, lack of continuity of care and unnecessary, untimely intervention. Here is one example...

A patient’s experience in the future...

Our aspiration is for all of our patients, and their carers to be in control of their healthcare. It is to provide them with all of the support they wish to access regarding planning of their care, the timeliness and type of interventions they receive, the services they choose to access. It may include control of the budget for their care, but will always mean that their needs are put first by all...

Our patient, with multiple co-morbidities (Diabetes, COPD) lives in rural West Norfolk. Patient is well supported in the community by her GP and community matron. During an unavoidable admission to hospital, the patient received care and support from a community key worker to arrange timely discharge from hospital, with the right support at home. Throughout their care the patient and her husband remain involved, well supported and feel safe.

CARE PLANNING
Proactive care planning, with full engagement of the patient and her husband

STAFF
Named key worker responsible for coordinating care

RESOURCES
Remove perverse incentives, resources aligned to person's needs

COMMUNICATION
Safe sharing of relevant information between agencies

ASSESSMENT
Tell the story once, leading to a single, holistic assessment
Over and above these characteristics of the West Norfolk system in the future, we also have a series of targeted clinical pathway improvement interventions that are planned. These have been developed as per our earlier ‘Intervention’ improvement methodology shown on page 23 drawing on NHS England guidance, benchmarking resources, opportunity analysis and clinical engagement and feedback. Our detailed, planned interventions are set out in more detail in our 2 year operational plan, however cover the following areas:

The detail of our interventions is set out in our 2 year Operational Plan, attached Appendix 1.
Improving quality

Monitoring provider quality is a crucial responsibility for the CCG to ensure patient safety. We have taken a unilaterally firm line with our three main providers regarding approval of their quality impact assessments for their internal Cost Improvement Plans. We interpret our duty to include scrutinising not just the process that providers implement but the content of the plans and evidence that the consequences will not harm or reduce the quality of care for patients. We were also forerunners in our approach to developing detailed quality schedules in our 12/13 contracts, adding a much sharper focus to the required standards we expected from our providers, negotiated with substantial clinical input from both the CCG and providers.

During the first year since CCG authorisation, the CQC raised a number of serious concerns at the acute Trust in King’s Lynn, culminating in 4 warning notices being issued in October, closely followed by Monitor placing the Trust in Special Measures in November. The CCG played a major part in the quality inspection programme, supporting and approving an integrated action plan. Prior to the CQC concerns being raised, the CCG had established a strong approach to addressing clinical quality, starting with contract negotiations in January to April 2013. A detailed quality schedule was developed, to agree the standards which must be met, with standard NHS contract enforcement consequences. In addition, local CQUINs were used to address some key quality concerns the CCG had that were having a significant negative impact on patient care and patient experience; recruitment and retention of nursing staff and effective discharge planning.

- The Trust was asked to implement exit interviews to ascertain the reasons for so many nurses leaving during the winter 2012/13 period.
- A target for each quarter was set for achieving discharges before midday.

The Head of Quality and Patient Safety and the Chief Officer undertook an unannounced quality visit in May 2013 and gave detailed feedback to the Director of Nursing. The CCG concerns were consistent with those highlighted later by the CQC and subsequently through the 3 day Regional Rapid Review in July, which the Chief Officer participated fully in. The resultant integrated action plan is regularly monitored through the local quality meeting with the Trust as well as the NHS England oversight group.

This approach has paid dividends as the CCG has developed a very constructive clinical relationship with the Trust and has always been appraised of the concerns and risks regarding quality of care. We continue to work closely with the Trust and our Head of Quality and Patient Safety and our Governing Body Lead Nurse both meet regularly with the quality team and interim Director of Nursing to provide constructive challenge and offer support.

We adopt the same approach with all providers, including care homes, where a series of visits and meetings have taken place to assess the standards of care and provide feedback and recommendations. Quality is reported at every Executive and Governing Body meeting and takes precedence over other items. We encouraged fellow CCGs to adopt and actively promote the use of Quality Incident Reporting in primary care, which has given us direct patient evidence about lapses in quality that have been pursued formally with the provider in question. We encourage the public to raise concerns freely with us at our Governing Body meetings, where we either provide an immediate answer or a written response within 5 working days. In these ways, we have developed a reputation as a CCG with high expectations of the quality of care provided for our patients.

The Francis Report (2013) into failings at the Mid-Staffordshire Foundation Trust stressed that high quality care would not be best achieved through radical reorganisation but a re-emphasis of what really matters:

- A structure of clearly understood fundamental standards;
- Openness, transparency and candour throughout the system;
- Improved for compassionate caring and committed nursing;
• Strong and patient centred healthcare leadership;
• Accurate, useful and relevant information;

The main aims of the Francis Report recommendations are to:
• Foster a common culture shared by all in the service of putting the patient first;
• Develop a set of fundamental standards, easily understood and accepted by patients, the public and healthcare staff, the breach of which should not be tolerated;
• Provide professionally endorsed and evidence-based means of compliance with these fundamental standards which can be understood and adopted by the staff who have to provide the service;
• Make all those who provide care for patients – individuals and organisations – properly accountable for what they do and to ensure that the public is protected from those not fit to provide such a service;
• Enhance the recruitment, education, training and support of all the key contributors to the provision of healthcare, but in particular those in nursing and leadership positions, to integrate the essential shared values of the common culture into everything they do;
• Develop and share ever improving means of measuring and understanding the performance of individual professionals, teams, units and provider organisations for the patients, the public, and all other stakeholders in the system.

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 addressed these recommendations through an implementation plan, working with partners across health and social care. The quality governance structures and processes are outlined overleaf.

The “NHS Nursing Strategy: Compassion in Practice” sets out the shared purpose for nurses, midwives and care staff to deliver high quality, embracing the six values; care, compassion, competence, communication, courage and commitment. 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.
The CCG will ensure that all of our providers focus on the ‘Six C’s’ putting the person being cared for at the heart of the care they are given. Where the local population is in need of NHS services, the CCG will seek to guarantee that they are respected and involved in care decisions, treated with dignity by a workforce who are competent, committed and have the courage to act as the patient advocate at all times. Through the Friends and Family Test, ‘Patient Opinion’ and Quality Incident Reporting the CCG will assess the patient’s experience of compassionate care and this will continue to be regularly reviewed at the local Clinical Quality Review Meetings with Trusts and reported to the CCG Governing Body.

The CCG has a statutory responsibility to ensure that all aspects of clinical quality and patient safety are embedded within the organisation, underpinned by a robust governance system. The CCG has a duty to commission services which have quality, safety, patient experience and continuous improvement as an integral element of the commissioning cycle. This is supported by DoH guidance: Quality in the New Health System (2012); High Quality Care for All (2008); and Review of Early Warning Systems in the NHS (2010) which challenges the NHS to go further in developing a health service which focuses systematically on improving quality and has quality as its organisational principle.

The CCG has a very strong quality and safety ethos, with a quality team comprising: Head of Clinical Quality and Patient Safety, a GP responsible for quality, safeguarding and information governance, the Nurse on the Governing Body, and a Quality Improvement lead. The team works closely with the performance team and communications staff (particularly around complaints). Quality is always the highest priority in the work of the CCG and all commissioning plans and decisions are scrutinised from a quality perspective before being ratified. The clinical quality team have strong support from the GPs on the Governing Body, for example through attending committees, reviewing plans and performance data, and making visits to clinical areas.

The WNCCG Patient Safety and Clinical Governance Framework
Governance

In view of the scale of both risk and opportunity presented by the strategic context in West Norfolk it is imperative that we have the strongest programme governance arrangements in place.

Unlike challenged systems yet elsewhere, our approach is one of partnership in terms of governance – with Monitor and NHS England to ensure delivery of programme milestones to time.

We have a resource Programme Management Office, staffed to provide strong governance, reporting and monitoring of progress. We have a programme of workstreams, taking forward interventions to develop clinical pathways, review and explore enablers such as workforce, IT, estates, contracting and finance. These are depicted overleaf.

A high level programme plan is attached in Appendix 2, examples of detailed workstream plan in Appendix 3, and an example of the weekly reporting template in Appendix 4.