Norfolk & Waveney STP

Norfolk & Waveney (Footprint #22)
STP Submission
30 June 2016

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1 Our vision

"To support more people to live independently at home, especially the frail elderly, and those with long term conditions".

We the leaders of the health and social care system in Norfolk and Waveney are committed to working together to achieve better health outcomes for our community. The unique demography and geography of our area has made the current structures and models of care unsustainable. Our population is much older than most of the country and will become increasingly so. We cater for a largely rural geography with many remote communities and dispersed settlements as well as cities and towns. The challenges facing every part of the health and care system are already an urgent and pressing case for change here in Norfolk and Waveney.

We recognise that we will only be able to offer customer-oriented, safe and sustainable quality services by innovating and successfully implementing change together. We can do more and deliver better with the resources we collectively have by working together rather than by working separately. We will turn around the pressures that currently drive people into ambulances, hospital and specialist services, by working with local people to manage demand differently and together construct better health outcomes. We know that when we do this successfully, we will have achieved better financial and patient health.

That is why fifteen health and care organisations came together in October 2015 to form the Norfolk and Waveney Health and Care Partnership. In February 2016, we agreed to seize the opportunity afforded by the Five Year Forward View, and the placed-based system-wide planning framework introduced to ensure its implementation.

Working together, we will deliver a joined up health and social care system that is very different from the one we have today. Our system will work differently with the increasing number of people who are living longer with multiple long term conditions, living in more atomised communities with more fragile families than ever before.

1.1 STP Executive Guiding Principles

The STP Executive has agreed the following guiding principles to help us work together on challenging issues:

- We recognise and will address the predominant issue facing our local health and social care system; that of Frail Older People and associated Long Term Conditions
- We recognise that we have to make significant changes, we cannot maintain the status quo
- We will be system players and will work to a wider agenda beyond our organisational self-interest
- We will be respectful, but also challenge each other
- We strive for safe and sustainable primary and secondary care services
- We will localise where possible, centralise where necessary
  - We want to localise delivery to integrated teams of people working in the best interests of their populations
  - We want to reduce variation, avoid duplication and pool our capacity into more centralised arrangements where appropriate
  - We will aim for fewer organisations, in number, scope and/or location, to streamline decision-making, achieve pace and take out cost
- We will work to achieve efficiency savings that maximise system benefits, but in a way that does not destabilise parts of the system
- We will create a responsive governance process – to drive the STP, and to deliver the future state
- We will take charge of our destiny and not shy away from difficult decisions

1.2 Our overarching priority – "Keeping me at Home"

"Keeping me at home" has become the touchstone guiding our partnership. Maintaining people's independence for as long as possible. This is what our clients and patients tell us they want. It is what we know will often be the best form of care; care that will accelerate recovery and help people get back to living a fuller life.

We know that to achieve this simple goal, all of us – patients, professionals, leaders - have to think and act differently.

In this future state, any support that people need is wrapped around them, with primary and community support delivered locally in an integrated way, and formal services focusing on maximising people's independence. Care and treatment happens outside of acute hospitals wherever possible. The whole system is geared to getting people back home, supported in community settings. Communities themselves will play an equally important role in supporting this change in focus in our model of care. We intend to enable communities to become more resilient through increased involvement and utilization of all community assets. We know that this is not the current state. We are determined to make it so.

Our services will be designed and delivered to reduce admissions to hospital and support individuals to maintain their independence for as long as possible at home. We know that a wider range of multi-disciplinary care must be available to people in the community. We know that people need the tools to self-diagnose and self-care. Technology, workforce design and behaviour change will be key to delivering these changes.

This whole system approach is reflected in the priorities adopted by our partnership:

- We must focus on preventing illness and promoting well-being
- We want care closer to home
- We can do more by closer and more integrated working, across physical, social and mental health
- We need a thriving and sustainable acute sector
- We have got to provide services within the finances available

1.3 Our principles for patients

Our first act of agreement made by our partnership is a commitment to our patients and clients, expressed through these set of principles:

- Looking at me as a person
- Keeping me at home as long as possible
- Having one person to connect to my care who is easy to get hold of
- Outcomes that are important to me are what matter in my care
- People who care for me talk to each other
- One visit not 5
- I will get good care any time, any day
- I can trust who sees me
- My time is precious

1.4 The change we want to see

We will deliver a shift from acute to primary and community care, and harness our combined energies to manage demand. Changes in five key areas offer short term opportunities to improve health and financial gains:

- People living with frailty and long term conditions
- Acute admissions from Care homes
- End of life
- Frequent users of emergency services
- Prevention of unnecessary mental health admissions into acute care

These priorities are evidenced in our 'case for change'.

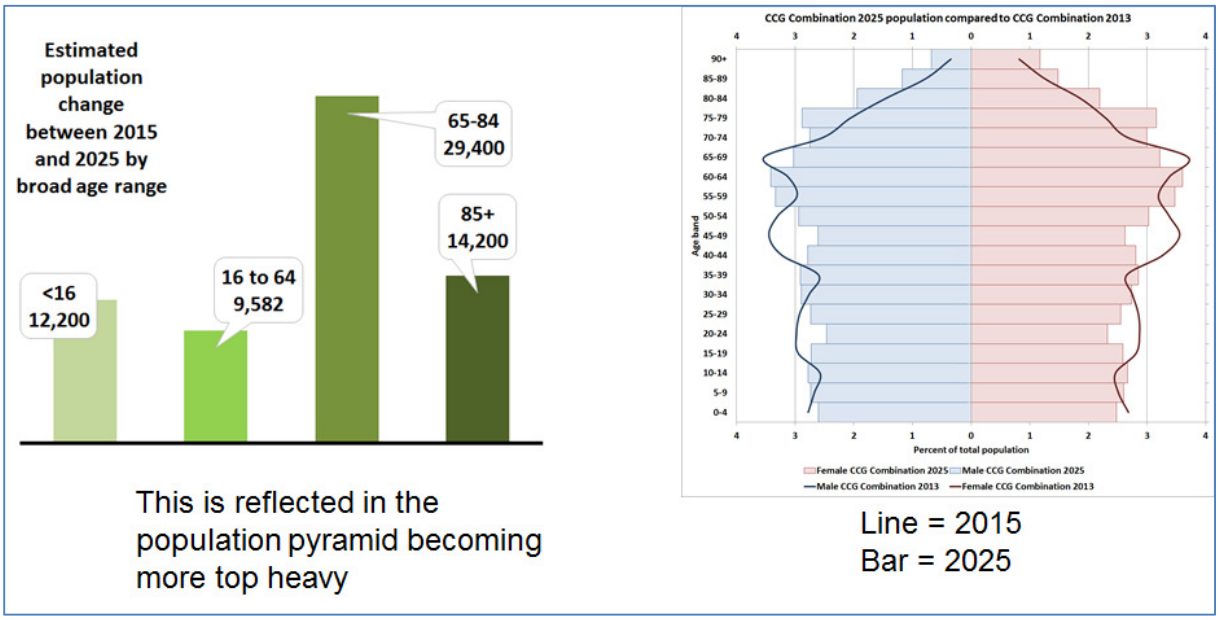
We will invest our resources to make the change we want. As illustrated in our financial bridge, we are determined to enrich the integrated primary and community services in our system by investing our transformation allocation (£70m) and containing the emergency admissions growth (£31m). Moving 1% of our total financial envelope, will increase resources available to strengthen primary care by 20%. This is what we are determined to do.

We know that to effectively shift care out of hospitals and re-provide services in the community a whole system approach is necessary. Hospital restructuring cannot happen in isolation but must go hand-in-hand with reinvestment in the community and a clear understanding on the impact of the change across the system.

2 The health, service and financial gaps

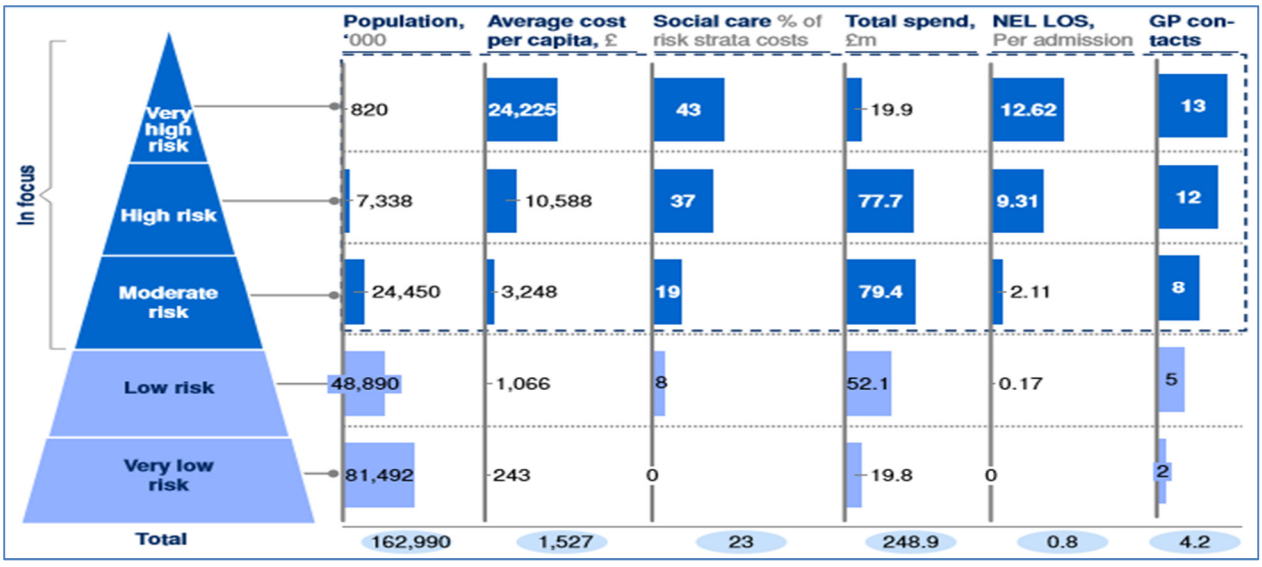
2.1 Health & wellbeing gap

Norfolk and Waveney generally has an older population that is projected to increase at a greater rate than the rest of England. This creates a key challenge for the health and care system. Almost all of the population increase over the last 5 years has been in the 65+ category and we anticipate the largest increase between now and 2025 to be in those aged 85 and over.



The increasing and aging population means that if nothing changes then due to age alone between now and 2025 the footprint will see about **9,000** additional people with **diabetes**, more than **12,000** additional people with **CHD**, more than **5,000** additional people who have suffered a **stroke** and almost **7,000** additional people with **dementia.**

5% of the Norfolk population are in the top 2 risk strata (complex needs); these account for almost 40% of health and social care spend.



We are seeing an increase in life expectancy but not the same increase in healthy life expectancy. Across the footprint the average number of years a man can expect to live in good health is about 64 and for women it is about 66. If people reach 65 then they can expect to live another 20 years where their health deteriorates (PHE, ONS).

The older elderly >85, and multi-morbidity

Unaddressed modifiable risk factors together with increasing age increases the likelihood of multi-morbidity. For example, studies have shown that the percentage of the population with 3 or more long term conditions increases from about 10% for those aged 50 to over 60% for those aged 85 and over.

Work elsewhere has shown that the costs of health and social care are driven far more by an individual's morbidity (19% of cost variation) than by their age (3% of cost variation).

For example, while the average annual health and social care cost of a patient aged over 85 years is £5,200, a patient with 8 or more long term health conditions will cost over £11,000 on average. The annual cost for **diabetic** patients with three other LTCs is on average £3,000 but this increases to £11,000 in patients with six other LTCs.

Whilst numbers are relatively low, the 85+ age group is increasing in size rapidly and

- Accounts for about 16% of all emergency admissions with each person having about a 1 in 3 chance of an emergency admission
- Accounts for about 1,450 chronic ACS admissions and about 2,000 acute ACS admissions

For emergency admissions from care homes, over 90% were attributable to **chest infections**, **falls**, and **UTIs**.

A significant proportion of care home residents were admitted to hospital for **end of life care** who could be managed in their home, given the appropriate support.

Increasing rates of emergency admissions

Across the system between April 2005 and March 2014 the population had increased by 5% and emergency admissions by 30%.

The rate of emergency admissions has increased fastest for people aged 85 and over who account for nearly 5% of the total.

The top five causes of emergency admissions across all ages are for potentially preventable conditions especially **respiratory** infection and **cardio-vascular disease** – where reducing smoking, increasing exercise and improving diet can prevent ill health.

Pneumonia accounts for over 3,500 emergency admissions in the 65+ age band and **UTIs** account for over 2,300 emergency admissions in the 65+ age band.

Ambulatory Care Sensitive Conditions

Across Norfolk and Waveney admissions for chronic conditions in those aged 65+ account for c 5,900 admissions a year (about 5% of all emergency admissions). There is opportunity to better manage these chronic conditions with increasing patient activation and closer to home in integrated multi-speciality provider centres.

Inequalities in health

A high proportion of residents live in the 20% most deprived areas.

If the most deprived areas experienced the same rates as the rest of Norfolk and Waveney then each year more than 400 children would be of healthy weight, there would be 1,000 fewer emergency admissions for older people and there would be 60 fewer deaths due to preventable causes.

In 2014 the life expectancy gap across the footprint between the most deprived 20% and least deprived 20% was 7 years for men and 4.5 years for women. For men, deaths due to **circulatory conditions, cancer, respiratory conditions** and external causes (suicide, drug overdose, accidents etc.) account for about 5 years of the difference. For women they account for about 3 years.

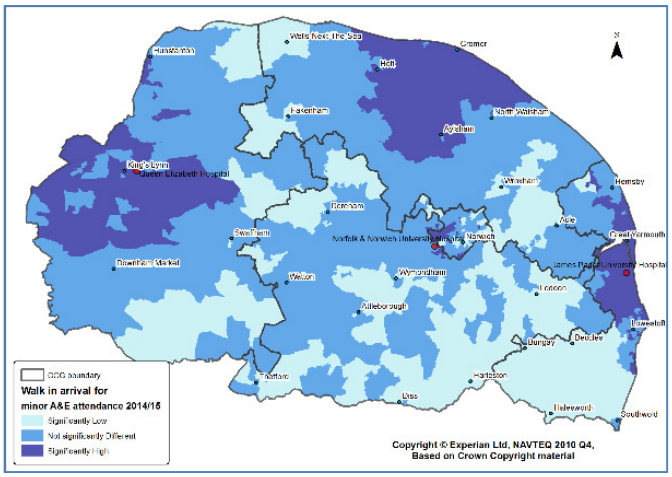
Urgent care activity and unwarranted variation

In 2014/15 there were about 225,000 A&E attendances across Norfolk and Waveney. About 83,600 (37%) attendances were for minor attendances (HRG VB09Z to VB11Z). The rate of attendance and conveyance is increasing (faster for the older age bands) but the conversion rate from A&E attendance to admission has remained relatively flat.

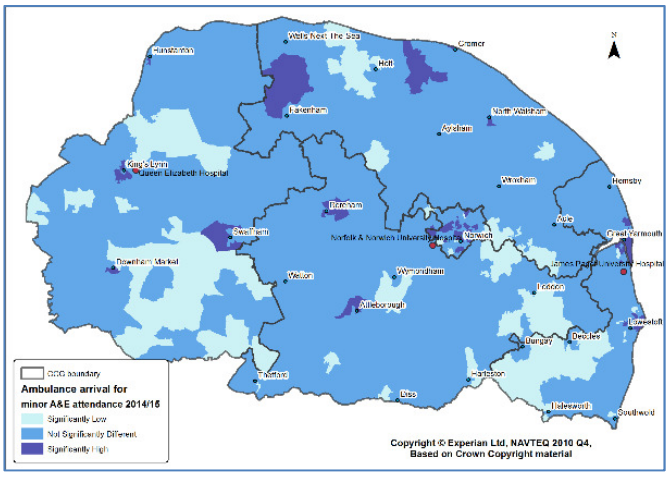
A proportion of the A&E attendances could be dealt with elsewhere or by the patient themselves. Across Norfolk and Waveney in 2014/15 there were about 11,600 ambulance arrivals at A&E for minor attendances and about 72,000 walk in attendances at A&E for minor attendances.

There are some areas that have significantly higher attendances than expected. The walk in arrivals are generally determined by distance from A&E or minor injury unit (Cromer). If the areas where ambulance arrivals for minor attendances are significantly high had the average attendance then about 3,200 A&E attendances could be avoided.

A&E walk in arrival for minor attendance



A&E ambulance arrival for minor attendance



Map of LSOA A&E arrival for minor attendance 2014/15 (HES, HSCIC)

Variations in system activity

Across Norfolk and Waveney the RightCare "where to look" packs suggest that if the CCGs had the same outcomes as the top five similar CCGs then about 50,000 people would have better quality care or better health and wellbeing outcomes.

This includes 7,000 people with better access to psychological therapies, 6,000 people with better controlled blood pressure, 7,000 people with better controlled cholesterol and 2,000 additional people screened for cancer. Potential cost savings include £12 million in elective and day case, £19 million in non-elective and £16 million in prescribing.

In 2014/15 there were 27 patients who between them were admitted 171 times for COPD and there were 13 patients who between them were admitted 115 times for alcohol related disorders. If these 40 patients were managed better then we could prevent almost 300 admissions per year.

Dementia prevalence and related emergency admissions

Reflecting Norfolk's above-average number of people in older age groups, Norfolk's dementia prevalence is high – being third highest in the region behind Suffolk and Southend. Notably 54.1% of people in council-

funded long term residential and nursing care placements are aged 85+, compared to just 4.0% of the population overall.

Conversely the recording of dementia prevalence is one of the lowest in England. Across Norfolk and Waveney there are only a handful of practices where the recording of prevalence is in line with that expected. Taking March 16 as a representative figure for 2015/16 (on the basis that all CCGs were required to be compliant with the trajectory by that date), the CCGs reported the following:

CCG	Target %	Actual % (March 2016)
North Norfolk CCG	67	61.1
South Norfolk CCG	67	55.1
Norwich CCG	67	59.6
West Norfolk CCG	67	59.3
Gt. Yarmouth and Waveney CCG	67	64.1

During 2012/13 to 2014/15 there were about 400 admission per year where the primary diagnosis was **dementia**. There is also variation in emergency admissions where the primary diagnosis is Dementia. If the practices were able to address individual variation then potentially 25 admissions per year could be avoided.

Falls in older people

Across Norfolk and Waveney admissions for injuries due to falls are lower than average. However, they still account for over 4,100 admissions per year of which about 1/3 of admissions for injuries related to **falls** are for a broken hip – there are over 1,350 admissions per year for broken hip in older people. Across Norfolk and Waveney **fractured neck of femur** admissions in those aged 65 and over cost more than £9.5 million per year.

There is variation by practice in admissions for injuries due to a fall. If practices were able to address individual variation then we could potentially avoid up to 190 admissions per year.

Admissions for UTI in older people

Across Norfolk and Waveney in 2014/15 there were over 2,300 emergency admissions for **UTI** in people aged 65+.

There is variation across Norfolk and Waveney in the number of UTI emergency admissions. If practices were able to address individual variation then potentially up to 90 emergency admissions for UTI could be avoided per year.

Mental health related emergency admissions – excluding dementia related

Each year, on average across Norfolk and Waveney between 2012/13 and 2014/15 there were about 2,770 emergency admissions to acute providers for **mental health** conditions. This represents 0.812 of total admissions. The top five reasons for emergency admissions related to mental health are alcohol related disorders, other nervous system disorders, mood disorders, schizophrenia and anxiety. If practices were able to address individual variation then we could potentially avoid up to 400 admissions per year.

Population Growth

By 2021 there are predicted to be up to 40,000 new homes across Norfolk and Suffolk. This will have a significant impact across all health and social care services.

2.2 Care & quality gap

Health performance

The tables below set out the 2015/16 performance against national standards for the 3 acute trusts in the footprint. It includes data for all patients seen by the hospitals (not Norfolk & Waveney specific). It highlights that the major challenges to the accessibility of services across the three hospitals are the 18 weeks Referral to Treatment (RTT) and the 4 hour waits. The NNUH has challenges in meeting demand for its diagnostic tests, surgery and urgent GP referrals. It should be noted that the RTT standard changed in September 2015 – admitted and non-admitted are no longer national standards.

Theme	Indicator	Target/ Standard	QEHKL	NNUH	JPUH
Infection Control	MRSA	0	1	2	1
	Clostridium difficile		40	56	13
	Clostridium difficile trajectory		53	49	17
Referral to Treatment	18 weeks RTT - admitted (adjusted)	90%	88.6%	74.1%	81.7%
	18 weeks RTT - non-admitted	95%	96.3%	92.2%	98.4%
	18 weeks RTT - incomplete	92%	94.0%	87.5%	92.2%
	Admitted pathways (unadjusted) > 52 weeks	0	2	17	0
	Non-admitted pathways > 52 weeks	0	2	7	0
	Incomplete pathways > 52 weeks	0	0	16	0
Diagnostics	Diagnostic tests < 6 weeks	99%	99.3%	96.0%	99.5%
A&E	A&E 4 hour waits	95%	89.7%	85.4%	94.2%
	A&E 12 hour waits	0	1	5	3
Cancer Waiting Standards	Cancer 2 weeks urgent GP referral	93%	97.4%	96.8%	96.6%
	Cancer 2 weeks urgent GP ref. breast symptoms	93%	97.1%	98.5%	96.7%
	Cancer 31 days - first definitive treatment	96%	98.6%	97.4%	99.3%
	Cancer 31 days - surgery	94%	99.6%	91.6%	100.0%
	Cancer 31 days - drug treatment	98%	99.2%	99.2%	100.0%
	Cancer 31 days - radiotherapy	94%	100%*	97.8%	n/a
	Cancer 62 days - urgent GP referral	85%	83.2%	77.0%	85.0%
	Cancer 62 days - screening referral	90%	96.6%	92.0%	91.1%
	Cancer 62 days - consultant upgrade referral	no stnd	87.5%	60.4%	91.5%
MSA	Mixed sex accommodation breaches	0	54	0	146
Cancelled Operations	Cancelled Operations	100%	90%	80%	100%
	Cancelled urgent operations for a second time	0	4	0	0
Ambulance Handovers	Ambulance handover delays of over 30 minutes	0	2,384	3,571	717
	Ambulance handover delays of over 1 hour	0	1,081	1,430	125

* Qtr 1,2& 4 Data Unavailable; Qtr 3 Partial Data

The table below sets out the 2015/16 performance against national standards for Norfolk Community Health & Care. The data includes North Norfolk CCG, Norwich CCG and South Norfolk CCG. This partial picture of community healthcare performance shows that in most areas providers are satisfactory, it highlights the 3 areas where NWHSCP is an author and where there is opportunity to improve outcomes:

- Died in preferred place of care
- Access to orthopaedics
- Looked after children

Theme	Description	Target	2015-2016*
Communtiy Nursing & Therapy	Access to CN&T - Category A	95%	97.3%
	Access to CN&T - Category B	85%	97.4%
	Access to CN&T - Category C	90%	98.4%
	Fall Screening (High Risk)	100%	99.9%
	Patients Advanced Care Planning	75%	90.5%
	Died in Preferred Place of Care	90%	84.3%
Intermediate Care Beds	IDD recorded	90%	95.6%
	Readmissions - Intermediate Care	15%	12.1%
	Readmissions - Acute	15%	18.0%
	Average LOS	18	19.8 days
	NCH&C Responsible Delayed Transfers of Care	1%	0.4%
Orthopaedic	Percentage of all patients having first seen appointment in month where referral is less than 2 weeks prior - Norfolk	95%	76.3%
Triage	Percentage of diagnostic reports received in month where diagnostic request is less than 3 weeks prior - Norfolk	90%	94.1%
	Percentage of first treatment contacts recorded in month where referral is less than 7 weeks prior - Norfolk	90%	94.2%
Looked After Children	% of Health Care Plans Completed with 4 Weeks - Norfolk	None	49.3%
	% of review assessments completed within 4 weeks - Norfolk		66.2%
Pledge 2	Patients Waiting Over 18 weeks: Seen	5%	1.6%
	Patients Waiting Over 18 weeks: Not Seen	5%	3.4%
	Services Breaching 18 Week	0	

The table below sets out the 2015/16 performance against national standards for East Coast Community Healthcare.

Theme	Description	Target	2015-16
APS	% of referrals to the Admission Prevention Team assessed within 7 working days from referral	98%	100.0%
District Nursing	% of Service Users on the Leg Ulcer Pathway seen within 4 weeks of referral.	90%	78.4%
	% of Service Users achieving their Preferred Place of Death	100%	68.6%
Pledge 2	RTT 18 week wait breach %	95%	98.8%
Intermediate Care Beds	Delayed Transfers of Care	No target	1.6%
	Average LOS	No target	19.1 days
Out of Hospital teams	% of Service Users referred urgently to the Out of Hospital Team assessed within 2 hours of referral.	98%	99.8%
	% of Service Users referred non-urgent to the Out of Hospital Team assessed within 1 working day of referral	0.98	1.00
	% of all Service Users receiving a care package within 12 hours of assessment (including placement in a bed with care where applicable).	98%	99.8%

The table below sets out the 2015/16 performance against national standards for Norfolk and Suffolk Foundation Trust. The data includes North Norfolk CCG, Norwich CCG and South Norfolk CCG. It shows that our mental health services are facing a number of operational challenges which mean that we find it difficult to deliver quality services. We may be exceeding the target on delayed transfers of care but struggling on most of other areas.

Theme	Description	Target	2015-2016
Mental Health	% of patients on Care Programme Approach (CPA) who were followed up within 7 days after discharge from psychiatric inpatient care	95%	87%
	% of admissions to adult acute wards gate-kept by CRHT teams (denominator the total number of admissions to the trust's acute wards)	95%	65%
	% of patients whose transfer of care was delayed*	7.5%	1.3%
	% of long-term (over 12 months) inpatients that have received an annual health check**	100%	74%
	% of CAMHS patients being seen within 8 weeks of referral received date (completed pathways)	80%	69%
	% of Patients having at least two face to face attended contacts with a valid MHCT assessment and a care cluster.	99%	93%
	IAPT (Increased Access / Wellbeing Access Rate (Note the service delivery model changed in September 2015 which affected how the target was calculated)	15%	15.3%
	IAPT / Wellbeing Recovery Rate	50%	46.3%
	Early Intervention in Psychosis (RTT within 2 weeks standard) – Indicative performance against the standard is as listed but complete and full reporting across all CCGs is still outstanding	50%	34.6%

*It is expected that due to a system issue, DTOCs are being underreported. This is being escalated.

**The Lorenzo PHCF was ratified for use on 6/11/2015. Previous to that, this form was not used as it was not fit for purpose.

Ambulance response times

Ambulance response times, delivered by EEAST, remain a challenge across the footprint across all national standards. However what is of increasing concerns is the locality performance which is, at times, masked by the performance of the footprint as a whole. In some CCGs performance has been as low as 48% against a target of 75% (Red 2 performance, South Norfolk CCG March 16), and 54% against a target of 75% (Red 1 performance, South Norfolk CCG March 16). Similarly, North Norfolk CCG's performance was 32.8% Red 2, in April 2016.

Whilst we recognise that rurality brings its own challenges, there has also been a shift in acuity of activity to a higher level, which adds pressure to the ambulance service and the Emergency Departments of the Acutes.

Analysis has identified the system is also losing a large amount of Ambulance hours to delays which we seek to address as part of our plans.

Workforce gaps

The workforce across community health and social care shows significant numbers of vacancies in a variety of professions and care settings. There were 1,400 (7%) NHS vacancies across all staff groups in March 2016 with some of this gap being covered by agency or bank staff.

Recruiting to key posts, especially adult, mental health and LD nurses, A&E doctors and GPs is especially challenging.

There are marked differences in the number of primary care staff per capita between CCGs. The STP area has over 20% of GPs and over 23% of nurses aged 55 and over – representing a retirement risk in the medium term (2-5 years). Across the NHS the ageing workforce may lead to 17% attrition through retirements alone by 2021.

These vacancy rates and projected loss of experienced staff impact on both the quality of care and the capacity for developing new roles and innovative services.

See Appendix C (Enablers) for a summary of the workforce strategy.

Social care

An analysis of Norfolk's position compared to its 'family group' of statistically similar councils shows the rate of people supported within residential care settings. It suggests we are the highest users of residential care for people with learning disabilities and for people with mental health problems and are fourth out of fifteen councils for older people.

Demographic factors also significantly drive demand for services for people with learning disabilities and physical disabilities, and the number of people requiring these services is rising. Children, often with complex and multiple long term conditions, are now far more likely to survive into adulthood, and require complex and expensive care. These care packages are likely to be the most expensive commissioned by the council, and can cost over £2,000 a week (and with a small number of cases costing significantly more). In addition people with learning disabilities in particular are living to a much older age. Whereas once relatively few people with a learning disability would live beyond the age of 65, around 12% of people being supported by a learning disability team are now over 65.

A significant gap in the availability and quality of care services in Norfolk can be attributed to challenges within the social care market. Increases to the National Minimum Wage, issues with significant ongoing staff turnover (particularly in home care), and an ageing care estate are driving increased costs, and a lack of some services in rural areas. The Council is the object of litigation from its residential care providers because it is seen to pay too little and failure to comply with its duties under the Care Act. Though the Council is defending these challenges, they reflect the growing challenge the NWSCS faces in meeting the social care needs of the population with sustainable systems of care.

CQC assessment

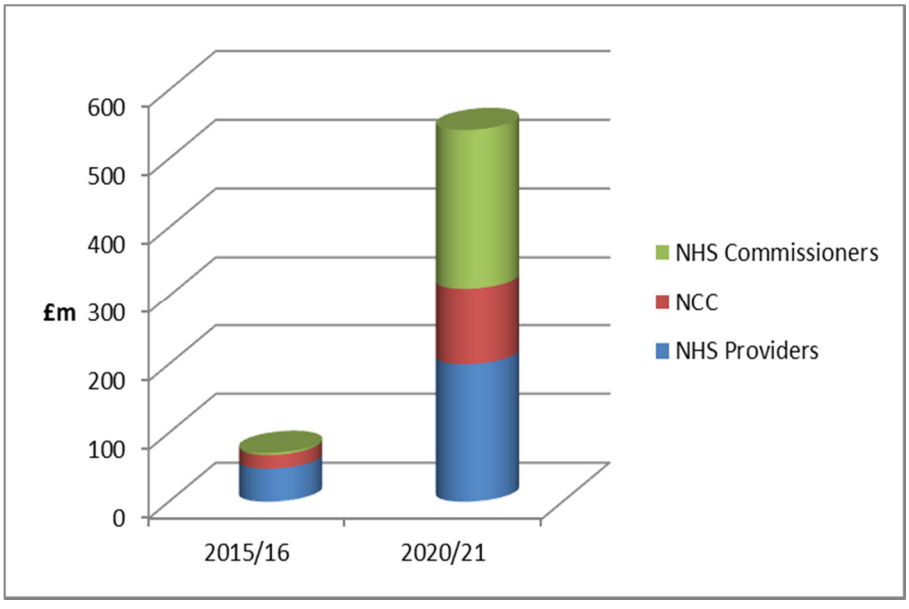
In addition, the Care Quality Commission's assessments of Norfolk's health and community trusts show:

Provider	CQC rating	Outcome	Date of last inspection
NNUH	Yellow	Requires improvement	
QEH	Yellow	Requires improvement	
JPUH	Yellow	Good	
NCHC	Green	Good	
NSFT	Red	Inadequate	Feb 2015

NSFT received an overall 'inadequate' rating from CQC after being inspected in February 2015. All but one of the 5 categories contained in the report were rated as inadequate or requiring improvement. CQC is set to return in July 2016.

2.3 Financial gap

The size of the gap



The 2015/16 position for the Norfolk and Waveney system was a £71m deficit.

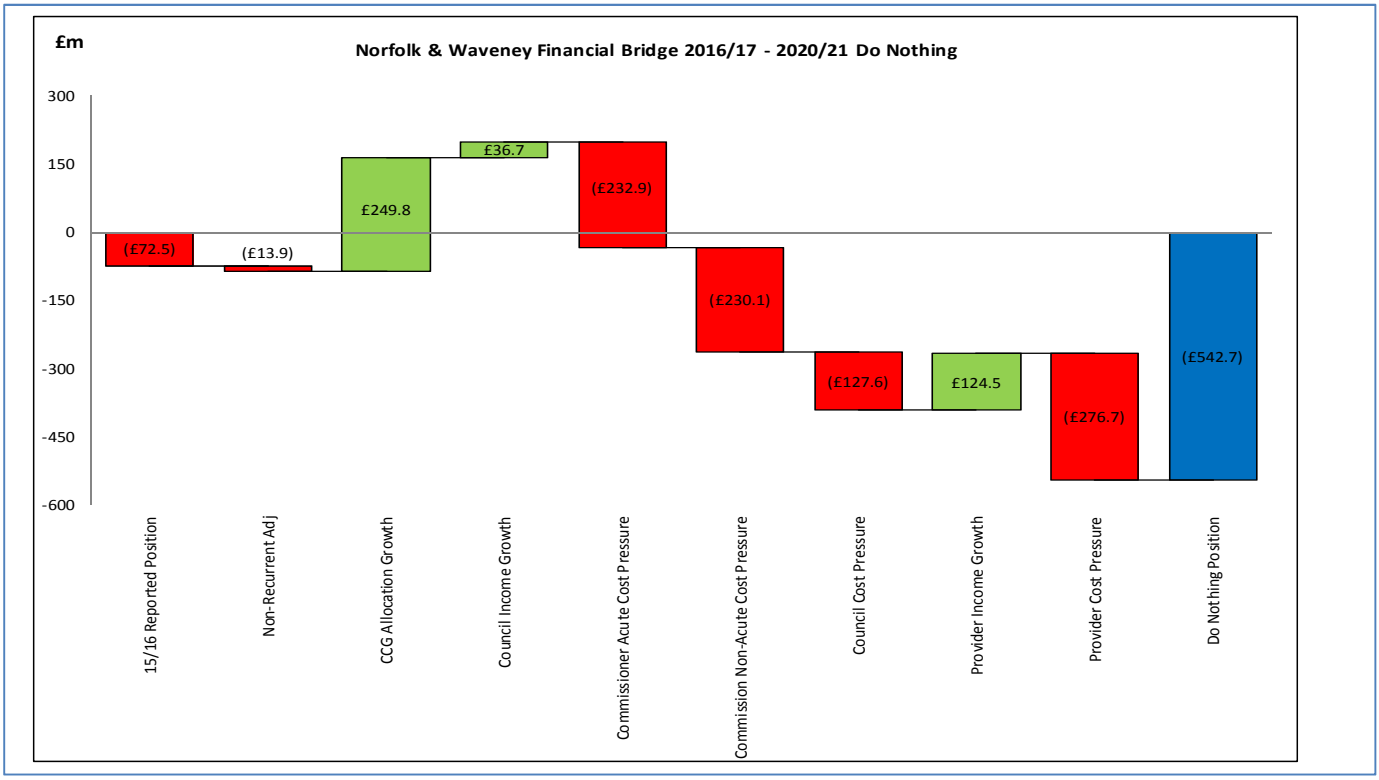
Each year, the in-year system deficit increases by between £9-43m

The size of the financial gap in 2020/21 is £543m.

The £71m deficit reported in 2015/16 splits by acute trusts £42m, other trusts £6m, Norfolk County Council £20m and CCGs £3m.

Each year, the in-year system deficit increases by between £9-43m through annual system income increases driven predominantly by CCG allocations of between 2.2% and 4.8% which do not compensate for the additive effect of demand growth and inflation with acute demand growth of approximately 2%, other demand growth in the areas of primary care, mental health, prescribing of between 2-6% and inflation at 2-3%.

The 'Do Nothing' scenario deficit in 2020/21 is therefore expected to be £543m based on the cumulative effect of 2015/16 position and annual deficits and before any potential QIPP, CIPs or transformational savings.



Closing the gap

Provider CIPs are assumed to continue during the transformation period at a level in line with efficiency expectations within tariff and include savings from implantation of the Carter Review and agency spending. Commissioners will also continue to drive savings out of areas such as primary care prescribing and CHC in line with past trends and in order to manage the growth anticipated in these areas. Risk adjusted values have been assumed where commissioner QIPPs are anticipated to impact on NHS providers.

Investment in primary care and community services, increasing the spending in these areas by 20% and 10% respectively, will enable development of local integrated community providers with the key aim of delivering care closer to home and reducing emergency admissions. Modest investment in prevention services also supports the initiatives around improving lifestyles.

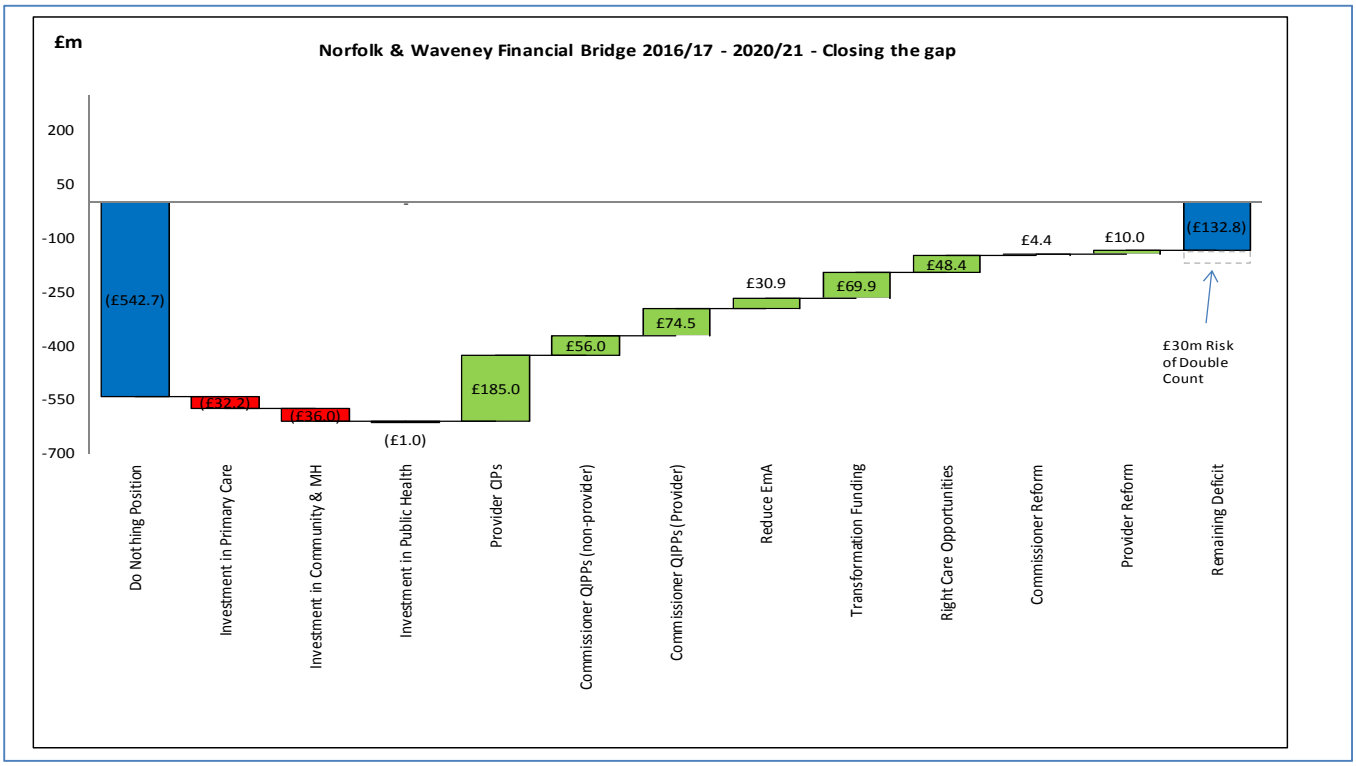
17,000 additional emergency admissions are forecast based on activity continuing at current trends above demographic growth levels. The ambition is to prevent this growth in admissions which will save the system £31m in acute care alone.

RightCare presents a savings opportunity of £48m across a number of disease groups and across elective and non-elective care and prescribing costs.

Organisational landscape changes, both within provider organisations and commissioner organisations could generate £14m in savings and represent in excess of 10% of existing corporate costs.

It is anticipated that the indicative "fair share" of the sustainability funding for Norfolk & Waveney will be available to support this transformation plan.

The remaining gap of £162m is to be met from the transformation outlined in this interim plan; it includes a contingency of £30m for a possible double count of savings within the areas described above.



Adult social care - summary

The local impact of national funding reductions since 2010/11 has seen a reduction of spending on adult social services savings of £77m and changes such as service redesign, reduction in services and social work teams – along with significant integration with community health. The five year plan identifies a total funding gap of £158m for Norfolk's public health and social care services – with in-year gaps ranging from £16m to £40m. The key pressures for the service are demand, inflation and reduction in central government grant funding.

The County Council agreed the 2% council tax precept for social care in 2016/17 and future forecasts are based on council tax continuing to be increased by 2% each year until 2020 for this purpose. The 2% precept generates in the region of £6.4m additional income for the service each year. The five year plan and forecast funding gap assumes that £95m is generated directly from the precept and Council tax increases over this period. This is a risk, as it may not be realised.

In contrast, government grants apportioned to public health and social care services are expected to reduce from £194m in 2015/16 to £171m by 2020/21 – amounting to £60m less funding during the five year period of the STP.

Total costs rise due to inflationary and forecast demand pressures arising from demographic changes. By 2020/21 costs are expected to be £30m higher due to demand for social care alone. This places a £90m pressure on the system during the life of the plan. Inflationary pressures will be driven by general price uplifts, but also the implications of the full introduction of the national living wage by 2020. The five year plans includes inflation driven increases totalling £60m.

The impact of higher average costs for people aged 18-64 that receive services is exacerbated by the fact that the council recovers far less income from this age group compared to those aged 65+. In each year between 2012/13 and 2015/16 between 60% and 70% of the gross expenditure on services to older people was able to be recharged, compared to around 35% for people receiving mental health services, around 12% for people with physical disability services and between 8% and 14% for people with learning disability services.

The LGA has estimated that learning disabilities actually account for 44% of the increasing demographic pressures experienced by councils.

3 Prevention & wellbeing

The hypotheses are:

- A good proportion of NHS time is spent on non-health problems such as housing and welfare
- A good proportion of ill health can be prevented by lifestyle changes
- A good proportion of long term conditions can be prevented from getting worse by good self-management and good NHS primary care
- Significant unexplained variations in activity between areas can be reduced by improving system processes and quality
- We can provide the activity we do efficiently by organising our management and service provision differently

The EPIC (European Prospective Investigation of Cancer 2015) study based on the Norfolk population shows that prevention works. People who drink moderately, exercise, quit smoking and eat five servings of fruit and vegetables each day live on average 14 years longer than people who adopt none of these behaviours . This result demonstrates that modest and achievable lifestyle changes can add years to life as well as life to years.

3.1 The focus

We want to change what health and social care do in order to

- Increase community capacity to directly address individual's socio-economic problems rather than medicalise them and help people be better connected with each other
- Increase primary prevention by getting people to live more healthy life styles; to smoke, eat and drink less and move around more
- Change the nature of the health and social care offer to help people manage their own health especially long term conditions
- Reduce unexplained variations in care by addressing clinical pathways and moving appropriate specialist services into the community

3.2 The interventions at scale

Delivering prevention: pushing the boundaries and reducing variation

- Support population and prevention approaches – e.g. Health Checks, identifying hypertension to ensure early treatment and improving the uptake of flu vaccination
- Obesity & diabetes – roll out the diabetes prevention programme and address obesity at scale, moving 10,000 adults from being obese to normal weight each year
- Improved management of Diabetes in working age adults through patient activation and education and better management in primary care
- Smoking – Reduce prevalence, targeting pregnant women and deprived areas
- Reduce maternal smoking prevalence 10% year on year
- Reducing harmful drinking – identify those at risk from drinking and provide brief advice for 20,000 patients at next consultation and through the alcohol liaison team
- Promoting and enabling workplace health and wellbeing (improving and enabling better health behaviour)
- Roll out Safe at Home accident prevention across North Norfolk and Broadland as part of the Healthy Child Programme
- Improve access to mental health support as part of the Healthy Child Programme

- Additional alcohol liaison nurses and workers in acute providers
- Improved management of children and young people with Asthma, Diabetes and Epilepsy through patient and carer education and better management in primary care
- Reduce acute admissions for ear nose and throat conditions for children and young people by patient education and better use of primary and community care

Adult social care strategy

Promoting Independence outlines a whole-system approach to Adult Social Care that positions 'formal' care services as the best option for only those people with the highest care needs. Correspondingly, it proposes a wider range of informal and community-based care options for people whose needs mean that their independence is restricted but who can be supported to remain at home whilst staying well or regaining wellbeing.

The local Promoting Independence model sets out three stages in which we can think about care:

1. Staying well
2. Regaining wellbeing
3. Living with long term care needs

We are reviewing and revising our approach to working with people at each of these stages.

For those people that do not have formal care needs, but need help to ensure that they maintain their wellbeing and independence, we will help them to make sound decisions and choices about how to protect their wellbeing.

For people whose wellbeing and independence is at risk, and who have experienced a change in their life, we will arrange or provide short term support to help them back on their feet and restore their independence.

For people that are, after this support, managing long term health and care needs, we will provide coordinated and personalised support that puts people in control of their care.

3.3 Impact

This approach signals a step-change in the 'offer' to people as they seek to maximise their independence. We expect, as a result of this change that:

- More people will live free of formal care, and fewer people will need funded care
- More people will live at home, or live at home for longer
- More people, and in particular more people of working age, will not need to live in residential care
- More people with mental health needs or learning disabilities will have opportunities for paid or voluntary work
- More people that do require formal care will take their personal budget as a direct payment
- There will be fewer urgent admissions to hospital or residential care from people with social care needs

4 Primary, community and social care

In 2015 Monitor reported that;

- Well-designed schemes to move healthcare closer to home can deliver benefits in the long term
- The costs of delivering care in the community may be lower than those of delivering care in acute hospitals with a 17% reduction in spend on the example cases used
- However, savings must be balanced against the investment needed for set up costs

To effectively shift care out of hospitals and re-provide these services in the community, a whole-system approach is needed. Hospital restructuring cannot happen in isolation but must go hand-in-hand with

reinvestment strategies in the community and a clear understanding of the impact of change on the future viability of individual acute trusts. Otherwise, there is a possibility of creating a transition gap in service provision, or worse, a non-viable acute unit. Internationally, there is much focus on integration and co-ordinated care as a means to improve continuity, reduce fragmentation within the health and social care systems and deliver good patient outcomes.

Norfolk & Waveney has a history of locality working through a range of models including, Primary Care Groups (PCG), Practice-based commissioning (PBC), Primary Care Trusts (PCT) and currently with Clinical Commissioning Groups (CCGs).

These arrangements reflect historical working relationships at a general practice levels, common demography, rural/urban splits and joint working at locality level.

Given the national emphasis on clinically led GP commissioning it is a key component of the transformation and change programme in Norfolk and Waveney that any system-wide planning must be owned and created locally with ownership from primary care. This needs to be within a consistent and coherent strategic plan for integration and increased efficiency and service delivery across the wider system.

GP led community care has been at the heart of the NHS since its inception. It is considered a cost effective model of care which provides services close to where people live and is well regarded by some patients and the public. However today there are a number of pressures on the traditional model as well as the system as a whole.

4.1 The focus – New Models of Care

For the purposes of this document, 'Community Services' is an umbrella term to include general practice, community physical and mental health care, social care, voluntary and non-statutory care services.

A New kind of Community Care - Building Primary Care capacity and a culture of independence through multi-disciplinary working and the co-ordination of voluntary and third sector health and wellbeing initiatives**.**

In Norfolk and Waveney, primary care services cost around 10% of the total health budget but these services reach more people than any other service. A small increase in the proportional element of funding to primary care represents a large percentage increase to primary care budgets. Primary Care investment can therefore have a bigger proportional impact for a smaller 'slice of the cake' than other services.

Norfolk and Waveney has a mixture of rural and urban centres each with their particular health and wellbeing challenges. The voluntary sector is active but fragmented along with the seven District Councils and County Council, the potential to bring together a new kind of community capacity aimed at to empower individuals and communities.

Learning from local initiatives, the Norfolk and Waveney STP will focus attention on providing the right services in the right place, supporting independence and ensuring:

- Better social and clinical outcomes for people with LTCs and their carers
- Cost effective and efficient use of primary care resources
- Community focussed, diverse and responsive local provision

4.2 Design features of local integrated primary and community services

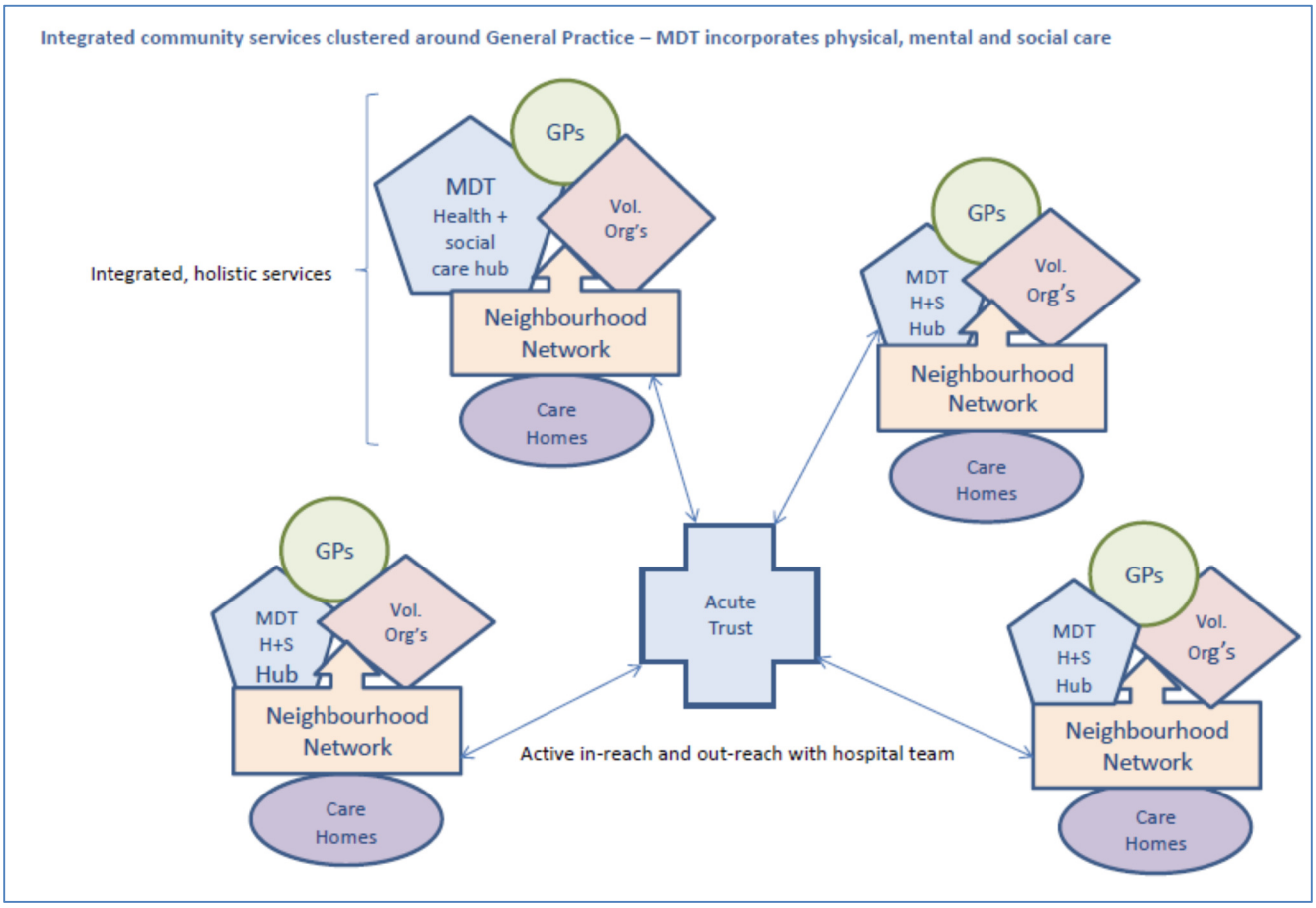
With the forecast increase in primary care activity and the necessary shift in activity away from acute setting, new models of primary care will be needed to deliver these integrated services at scale. The Five Year Forward View examples of Multi-Specialty Provider, Care Homes Pilot and Primary and Acute Care are not mutually exclusive and elements of each feature in various Norfolk and Waveney developments.

Much debate has been happening at both locality and county level around the type, size and number of integrated community care centres across the Norfolk and Waveney footprint and whilst there are differences in current thinking about 'form' there is consensus that they are a vital feature.

Possible design features to shape a Norfolk & Waveney integrated community service:

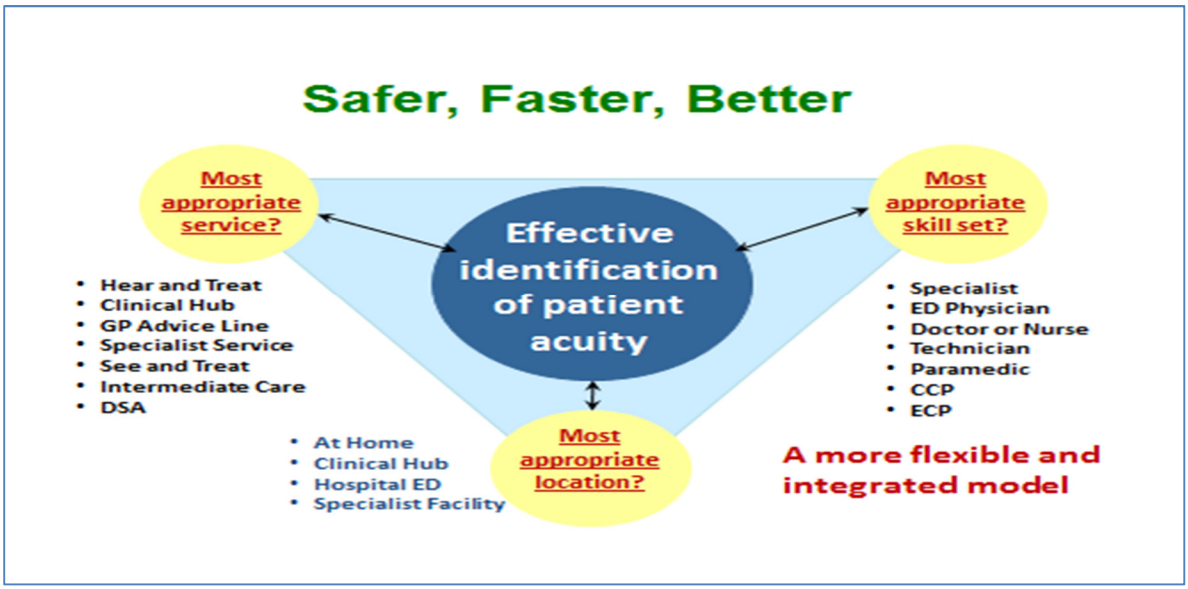
- Development of Primary Care at scale (variations of general practice models, no single approach but based on local determination) to ensure sustainability and achieve greater access to 7 day services across localities
- Enhancement of out of hospital integrated teams, health and social care, aligned to hub and spoke/cluster approach
- Shift of “acute” services into hub/spoke arrangements. The range of examples includes outpatients, diagnostic services, urgent care, diabetes, dermatology and community mental health services, social care and voluntary agency support
- Systems implementation of “Integrated Urgent Care Commissioning Standards”, contractual and service integration of NHS 111, out of hours and wider urgent care services aligning to local solutions
- Progression to “full delegated commissioning” of primary care in 2016/27, as mandated

The characteristics of one model are illustrated in the figure below:



Ambulance Service

The East of England Ambulance Service, which sits across 6 STP footprints, has a new operating model aligned to the Five Year Forward View which will contribute to the new models of community services across the Norfolk and Waveney footprint.



The functionality of this model is primarily designed to manage and service 999 demand which is growing year on year at an alarming and unsustainable rate. EEAST's approach is intended to integrate locally allowing for fully integrated community service.

The range of integrated community models are all designed to achieve common outcomes

- Improved coordination of local service delivery
- Increased collaboration between organisations, including statutory, non-statutory, care homes and voluntary partners
- Reduced avoidable emergency admissions to hospital
- Activity shifted from the Acute sector to Community
- Clinically and financially sustainable configuration of service providers
- For the STP footprint the opportunity is estimated to be c. £31m over 3 years

4.3 Mental health and LD

The Norfolk and Waveney Health and Social Care Partnership is committed to the principle of parity of esteem in mental health provision and therefore consciously rejects having a discreet mental health work stream. To do so arguably perpetuates the historical isolation of mental health as different and alternative to physical health and outside mainstream primary and secondary care.

The 5 Year Forward View for Mental Health, requires that Dementia is a priority. The CAMHS Local Transformation Plan pre-dates the STP but its delivery ensures that the needs of younger citizens are captured when considering system wide mental health provision.

Partners are committed to mechanisms to ensure the physical health needs of people with MH problems are addressed to reduce the life expectancy gap. Equally we will seek to better meet the needs of people with long term conditions where addressing their MH needs will aid their physical treatment programme '

The new standards, alongside existing national metrics, for mental health will continue to be managed via normal contractual processes informed further by the new mental health services data set.

And commissioners remain committed to the expectation that investment in mental health is commensurate with allocation growth as a minimum.

Learning from local and national experiences the following are being considered for scale-up and/or proof of concept. The opportunities listed are not finite and constantly evolving:

- Further roll-out, in number and scope, of Increasing Access to Psychological Therapies (IAPT), Children and Young Peoples IAPT, and Early Interventions in Psychosis (EIP) provision; to possibly include outpatient appointments
- A defined secondary care blueprint for mental health, to include meeting the 'core 24' standards as a minimum
- Mental health as a component part of community model/s of care (MCP/PACS/ etc). To include appropriate mental health crisis support and home treatment
- Mental health as a defined element within agreed urgent care integration - ensuring a better skill-mix and specialist expertise is routine in ooh/111/999 triage
- A singular planning round for the principal mental health provider; to replace the current model of 3 x commissioning intentions, 3 x contracts, and 3 x contract negotiations (dependent on decisions over organisational forms)
- The consideration of 3-5 year contracts (dependent on decisions over organisational forms)
- New payment approaches to mental health, looking at the outcomes associated with capitation, year of care, and episode based payments

In addition the STP recognises national expectations in relation to:

- Appropriate specialist perinatal mental health provision
- Effective eating disorder services for children and young people, building on the significant investment already received nationally
- Suicide reduction plans co-produced with local government and other local partners
- The role of education and employment in the wider parity of esteem debate
- The role of the third sector in delivering good mental health services
- Of the third sector in delivering good mental health services

Dementia

The national dementia strategy requires Norfolk and Waveney to achieve the diagnosis rate, improve treatment and support post diagnosis, and tackle unwarranted variation at a local level.

Locally the case for change evidences the prevalence of dementia and the impact of its diagnosis. There is a need to be more radical in how dementia is currently managed. The footprint will deliver this by placing a far greater emphasis on prevention, whilst at the same time recognising the need to maintain independence alongside good quality support of families and carers.

Recommendations from the Dementia Network are recognised; namely

Preventing Well

By 2020, every person will be aware of their personal risk of dementia which can be part of the NHS Health Check, identifying people at higher risk of developing dementia and relatives of people with dementia.

Diagnosing Well

By 2020, the overall diagnosis rate maintained at two thirds of the estimated number of people with dementia, every person who wishes a diagnosis will have that, where clinically appropriate, within six weeks of referral and 25% of people with dementia will have been given the opportunity to take part in research.

Supporting Well

By 2020, everyone person with a diagnosis of dementia will have a personalised care plan and their families and carers will be able to say that the support they received met their needs. In addition, all health and social care professionals should have a basic understanding of dementia in line with the core competencies published by Health Education England, with information reported by CQC and NHS England.

Living Well

By 2020, every person with dementia should be able to say that their communities and organisations with whom they have contact treated them with dignity and respect, every hospital will have signed up to John's Campaign.

Dying Well

By 2020: every person dying with dementia will have an Advanced Care Plan has been managed according to the NICE End of Life Care Guidelines.

A key priority area for immediate action will be to benchmark current local provision against best practice – including the 2020 recommendations as above, and national standards to develop a clear strategy for implementation.

Learning Disabilities - Transforming Care Programme

"Norfolk and Great Yarmouth & Waveney CCG are one of 48 Transforming Care Partnerships formed in December 2015, who will work together in the commissioning arrangements for people including children and young people with Learning Disabilities including Autism. It will bring together the commissioners responsible for funding health and social care for people with a learning disability and/or autism (CCGs, local authorities with their responsibilities for care and housing, NHS England specialised commissioning), with local budgets aligned or pooled as appropriate.

The Norfolk and Great Yarmouth and Waveney Transformation Plan sets out to deliver the ambitions of the Learning Disability Transforming Care programme, which aims to significantly re-shape services for people with learning disabilities and/or autism with a mental health problem, or behaviour that challenges, to ensure that more services are provided in the community and closer to home, rather than in hospital settings.

This plan covers 2016/17, 2017/18 and 2018/19.The plan describes how we will shape the transformation of learning disability services locally in Norfolk (West Norfolk CCG; North Norfolk CCG; South Norfolk CCG & Norwich CCG) and Great Yarmouth and Waveney, including:-

- Deliver the national trajectory for the reduction of in-patient beds and in-patients through discharge and repatriation and by commissioning robust health and social care community support as a viable alternative to admission to hospital care;
- Empowering people and their families by giving them the means to challenge their admission or continued placement in inpatient care through an admission gateway process and Care and Treatment Reviews, reducing the number of admissions and speeding up discharges;
- Getting the right care in the right place by working with local authorities and other providers to ensure that high quality community-based alternatives to hospital are available, meaning more people can get the support they need close to home and Increasing workforce capability by working with patient and carer groups to address gaps in skills, best practice and staff awareness of learning disabilities and mental health problems,
- Driving up the quality of care by working with providers and commissioners; strengthening accountability for improving outcomes by reforming contracts, including giving commissioners the ability to fine providers who fail to meet care standards or an individual's personal objectives and improving the amount of data and information collected and shared by public agencies to ensure that a person's outcomes and destinations are monitored, and that local public services can be held to account for their progress.

The plan also demonstrates how we will fully implement the national service model including alignment to the Transforming Care principles and expectations starting with the national planning assumptions set out in Building the Right Support.

The planning assumptions describe what local commissioners need to use as we enter into a detailed process of planning. Local planning needs are both challenging and creative but are intentionally ambitious based on a strong local understanding of the needs and aspirations of people with a learning disability and/or autism, their families and carers, and on expert advice from clinicians, providers and others. We are working towards a model of care that uses fewer inpatient beds both in NHS settings and those in the private care sector. We will go further still to support people in out of hospital settings above and beyond these initial planning assumptions.

The Transforming Care Principles and expectations are supported by a new Service Model for commissioners across health and care that defines what good services should look like.

4.4 Actions

- Prioritising areas by shifting resource – as services move into a community setting there will need to be a like for like reduction in investment in Acute/specialist settings. Opportunities will exist to repatriate current provision provided out of Norfolk into any capacity released into acute settings as a result
- Opportunities will be sought to access the System Transformation Fund to allow for double-running/pump priming of initiatives
- Contractual models – Learning from the Vanguards as well as from the local models outlined above, discussions will need to evolve to agree what single prime provider contracts for locality areas may look like. There is the potential to evolve into ACOs "Accountable Care Organisations". And the opportunity to adopt the new MCP contracts as they are published. This may result in having secondary care commissioning budgets which will incentivise the community provider to retain care in the community and make fewer secondary care referrals
- Cultural and behaviour change – To create the emerging models of care we will need to align incentives and responsibilities; to identify "what is in it" for clinical groups, community, primary care, mental health, social care as well as patients.
- Stabilising the system through the period of change – ensuring there are robust shared local and operation plans that allow the system to change at pace without adversely disrupting services to patients and the community.

5 Acute care

5.1 The challenges

There are three acute Trusts in Norfolk and Waveney, Norfolk and Norwich University Hospital Foundation Trust, with c1,000 beds, James Paget University Hospital Foundation Trust, c440 beds and Queen Elizabeth Hospital King's Lynn NHS Trust, c400 beds. In combination, these three Trusts deliver the vast majority of secondary care for the population, with some tertiary referrals to neighbouring Trusts in Cambridgeshire. Each of the Trusts is in financial deficit and therefore under directions from NHS Improvement to address their financial gap.

Due to the dispersed geography and distances between the hospitals, a careful assessment of the essential requirements to support local delivery of acute care at each of the sites is vital. This does not just involve a conversation about local access to A&E, maternity and paediatrics; it is a complex task to determine the inter-relationship between certain core services, the impact that has on personnel and local skills required and the resultant configuration of services necessary to support them. Before this can be undertaken, all three trusts will initiate a clinical dialogue about 'best practice', National Guidance and local quality standards. This requires the continued close collaboration with commissioners as well as other health and social care partners. As described later in this document partners have agreed to undertake an Acute services review to inform local decision making.

It is also essential to commence early engagement with the public, to ensure there is an awareness of the size of the challenge and the difficult nature of some of the potential decisions ahead.

In 2015/16, Norfolk and Waveney as a geographical patch has experienced inconsistencies in the delivery of the NHS Constitutional standards, particularly A&E targets, ambulance handover and 18 week Referral to Treatment Times. There is a financial consequence of this difficulty in achieving sustainable performance; a ripple effect on elective care income due to cancelled elective cases and loss of income through fines for poor performance. This places the acute trusts under further pressure to perform, creating pressure on already stretched staff.

It is therefore essential that the driving central force for any acute care review and reconfiguration is access to high quality care and the maintenance of safe standards in hospital.

5.2 Priorities in addressing the challenges

Acute care organisations collaboration

The three acute trusts in Norfolk already have close working relationships. The Eastern Pathology Alliance formed over 3 years ago and reconfigured pathology services across the 3 Acute trusts ensuring “Hot Lab” services at JPUH and QEH with all other laboratory functions being undertaken at NNUH Pharmacy services are coordinated between NNUH and JPUH and across a wide range of other clinical services such as vascular and ENT services.

In December 2015 the three hospital trusts and community trust agreed to work together more formally to explore and accelerate options for greater collaboration. Together with the Community Trusts in Norfolk and also Great Yarmouth & Waveney, the Norfolk Provider Partnership was formed underpinned by a signed Memorandum of understanding December 2015. More recently, Norfolk & Suffolk NHS FT has indicated via a Board agreement the intention to join the Norfolk Provider Partnership.

The objectives of NPP are:

- Establish clinical networks to ensure that best practice and most effective patient pathways are in place
- Review any services which are difficult to sustain in the longer term either collectively or for an individual Party, in order to explore solutions at service level
- Seek to maximise economic benefits, with a focus on the realisation of benefits, not least by injecting pace and seeking ‘quick wins’ where possible
- Establish high level joint strategic intentions for Information Technology and related platforms and infrastructure
- Review elective and non-elective capacity across the Parties’ services to establish where opportunities exist for balancing capacity and demand
- Establish a relationship with appropriate legal and /or other partners to support the Parties in taking forward new provider relationships and service models as required
- Consider the development of a Joint Venture Company or other organisational model to enable the Parties to jointly pursue new commercial opportunities
- Share appropriate information regarding the commissioning landscape for mutual benefit; and
- Consider the constraints and opportunities of the Parties’ estate and where appropriate any options for developing it

The work programme will focus on:

- Consolidate further Pharmacy across Norfolk & Waveney footprint
- A strongly networked Radiology service across Norfolk & Waveney footprint to reduce workforce costs and enable closer clinical interdependencies

- Review the current business model for the Eastern Pathology Alliance developing a robust business plan for the future whilst consolidating the IT platform and aligning systems to enable greater efficiency
- Exploration of opportunities at pace arising from the Carter review to plan to consolidate back office functions e.g. Procurement, payroll etc.

Within the STP process the NPP has recognised that a more ambitious agenda should be pursued to ensure clinical services are placed on a sustainable footing across Norfolk and Waveney and opportunities for improving efficiency realised at pace.

Proposals are:

a. Independent review of acute services

This work will concentrate on the clinical transformation required to:

- Improve quality and the ability to meet clinical standards
- Improve recruitment and retention of high quality and appropriately skilled staff
- Ensure best practice across sites in developing common protocols and pathways
- Sharing further staff and facilities across the three organisations
- Ensure each hospital retains a viable clinical infrastructure and portfolio of services including the identification of those fragile operational elective services where further consolidation, transformation or transfer are needed e.g. dermatology and neurology

This will be achieved by the following work programme:

- Mapping and review of the clinical interdependencies between the three hospitals.
- A demand and capacity analysis to identify gaps and potential surplus physical capacity
- A focus on 'big ticket' items:
    a. Maternity
    b. Cancer
    c. Radiology
    d. Cardiology
    e. Stroke

b. Reduced time spent in hospitals

We will reduce the time spent in hospitals by patients through the development of out of hospital services. There is a need for a single plan covering Norfolk and Waveney which sets ambitious targets for reducing the length of stay.. Numerous schemes are in place across the five CCGs and it will be important to build on these where solid evidence exists.

The plan to reduce time spent in hospital across would seek to cover:

- Telehealth, which prevents acute hospital attendances and admissions by providing 24-hour remote support and triaging through a video link
- Enhanced step-up, which prevents acute hospital attendances and admissions by treating all adults in crisis not suffering hyper-acute episodes in a community hospital day-case setting
- Rapid response and early supported discharge, which provides treatment in patient homes to patients entering crisis or recovering from inpatient stays to reduce attendances and admissions and length of stay for patients
- Reablement, which helps patients with complex needs to recover at home and live as independently as possible again after an illness or hospital admission, as well as reducing ongoing social care costs, through regular visits for up to six weeks

In developing the plan consideration should be given to:

- The ability for the system to target the intended patients
- The need to build credibility and scale
- The potential impact on reduced length of stay and unplanned admissions
- The ability for hospitals to save money given the semi-fixed costs of ward based care
- The scale of investment required
- Collecting data to evaluate effectiveness and payment mechanisms

c. Organisational form

The scale of change required across Norfolk and Waveney is unlikely be delivered without reform in organisational form in both providers and commissioners, changes to delivery models and payment for activity.

NPP wishes to explore:

- Exploration of different provider models. Acknowledging the output from the national Vanguard sites.
- One set of agreed Health & Social Care commissioning intentions across the N&W footprint (pooled allocations)
- One contracting process across the Norfolk & Waveney health system
- Agreed position across N&W on Commissioner Requested Services to help inform the parameters of potential service changes
- Design of a model for distributing funding differently, to take account of the changes in funding flows needed to support the service changes required

An assessment of the right acute Trust configuration has to be based on sound evidence about the 'trade-offs' between implementing guidance and the practical implications in a rural geography. For example, implementing recommendations from a national review are likely to have very different applications when the next nearest hospital is 40 miles away as opposed to 4. Similarly, acute mental health needs have to be considered very differently in a large rural geography with dispersed teams and limited acute in-patient facilities. Several important national reviews also inform this analysis; maternity, urgent and emergency care, cancer care, 7 day working, stroke care, making it all the more important to conduct a methodical and careful review and analysis of the inter-dependencies between local services and personnel.

5.3 Actions

1. A review of the three acute Trusts will be commissioned, in the context of the whole Norfolk and Waveney health and social care landscape, including mental health, to determine the right configuration of secondary care services to ensure sustainable, safe care into the future
2. The Norfolk Provider Partnership will continue with the existing work programme to consolidate clinical support services such as pharmacy, and radiology using a similar approach to the development of the Eastern Pathology Alliance
3. Also in line with National requirements to review Urgent and Emergency care, Maternity, Cancer, 7 day working, and stroke services against recently published strategies
4. An implementation timetable and detailed delivery plan will be developed during July

Urgent Care

In addition to the work outlined there is a need locally to progress the integration of urgent care provision, not least to ensure better delivery of national standards and much improved patient care.

Norwich CCG is leading on a clinical hub that will bring together current services and offer an alternative triage in real time for non-urgent ambulance dispositions.

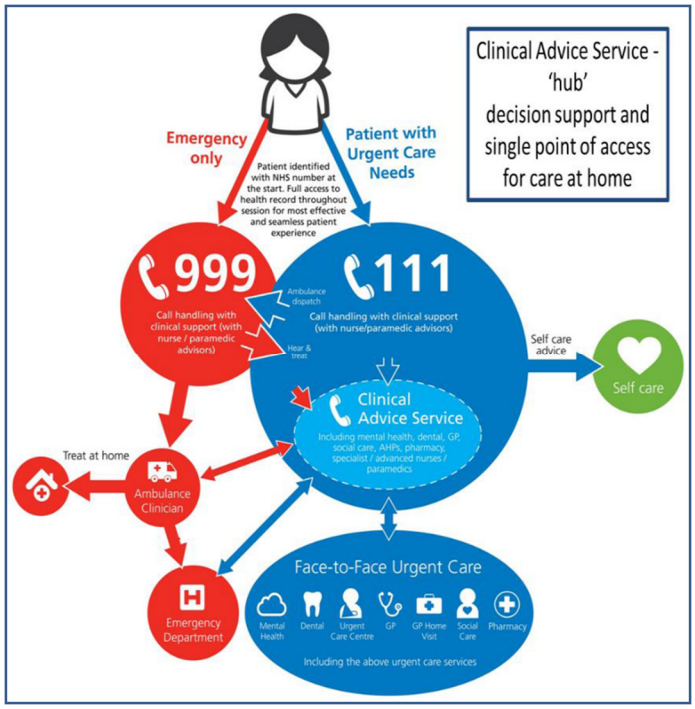
2 routes in – 999 (emergency and life threatening) and 111 (urgent care/same day)

Ability to transfer between the two, and a link back into planned care to pick up residual ongoing need (i.e. de-escalate)

Centred around robust triage, clinical assessment and advice and access to local services

Clinical assessment and advice = clinical hub (physical and/or virtual)

Clinical hub needs access to range of clinicians for triage plus a single point of access for each service (NSFT, NCH&C, NFS, in hours GP, NNUH, etc.)



Progress to date includes:

- Procured and mobilised an integrated 111 and Out of Hours service with effect from 01/09/15
- Established a 'Clinical Hub Development' Group consisting of input from 111 and 999 providers and CCG clinicians from central Norfolk and GYW CCGs
- Focus on non-urgent ambulance dispositions ('green' calls). First step to identify where there are opportunities for the 111 and 999 providers can place some confidence on each other's triage processes to minimise duplication
- Commissioned a clinical hub pilot via CQUIN with a key purpose of assisting the management of increasing demand and patient expectation as to which is appropriate for their need. It will engage seamlessly with partner providers, for example 999 services, to minimise duplication, identify and maximise use of resources to ensure pathways are clear for patients and clinicians. The clinical hub will need access to multi-disciplinary clinicians consisting of, for example, Advanced Nurse Practitioners, Urgent Care Practitioners, GPs, Dentists and Pharmacists with Mental Health support. There is an expectation that the need for access to additional specialists may be identified and included going forward to aid the treatment, advice and signposting for patients effectively and safely

6 Communication & engagement

The Norfolk and Waveney STP partners are clear that the Plan can only be developed with the people and organisations of Norfolk and Waveney.

There are two clear phases of engagement:

- With stakeholders to continually develop and review the Plan
- Engagement and consultations to facilitate service changes

A Communications and Engagement Strategy has been agreed by HealthWatch Norfolk and the fifteen STP partners; this is an evolving document and will naturally change over time as the STP matures.

Engagement and dialogue has already commenced with stakeholders:

- A milestone event on 7th June 2016 for non-Executives and invited partners from across the footprint
- Bulletins issued to staff in health and care and MPs
- Information published on all of the partners' public websites
- A feedback mechanism via HealthWatch Norfolk's website
- Health and Wellbeing Boards and public Overview and Scrutiny Committees have examined the STP development

6.1 Actions

How the footprint will communicate and engage going forward:

Partner Boards: Communications to partnership staff, updates to Memberships, Boards, Governing Bodies, and leadership groups.

Scrutiny: Briefings/challenge meetings with Health and Wellbeing Boards and Overview and Scrutiny Committees.

Workstream Expert Panels: To inform the process to November. One-off events aimed at engaging up to 20 or 30 specialists by subject matter. Their expertise and insights will directly challenge and inform the continuing evolution of the STP and also serve as preparation for the Health and Care Summit (below).

Learning Sets: To inform the role out of the STP once approved. These will be panel-style events drawing in local leaders, including clinicians, to sense-check specific areas of implementation, finesse ideas and act as a critical friend to the process. These will commence in 2017/18.

Norfolk and Waveney Health and Care Summit: An engagement event to bring together patient and service user groups, MPs and other elected representatives, staff, and the media, as well as some of the key opinion formers from our communities. It is anticipated between 300 and 400 delegates will be invited to attend. Provisional date: December 2016.

Statutory consultations: Where formal consultation is required CCG engagement leads will take these forward in a timely manner.

Public Engagement: HealthWatch Norfolk will lead public engagement, supported by CCG engagement staff, in the development of the STP. The suite of methods to be deployed are contained in the Communications and Engagement Strategy. There will also be conversations with members of the public, patient groups, MPs, councils, staff, clinical groups and the media to develop the STP.

7 Our key questions

The review of the previous sections leads us to conclude that our system faces these key decisions. We do not yet have sufficient analysis to decide and plan.

1. What is the quantified, evidenced level of shift out of hospital care into the community? And what investments are needed to facilitate this?
2. What is the optimum model of delivery for sustainable, integrated community care (Primary, community and social care services) to better manage demand?
3. What is the optimum pattern of acute secondary care for both physical and mental health services across the footprint and beyond?
4. What is the most effective configuration of organisations – both commissioner and provider - to effectively deliver these changes?
5. How do we ensure that we fully engage the citizens of Norfolk and Waveney in resetting the health and care offer?
6. And, to what extent do each of the above close our identified gaps in terms of health outcomes, workforce, and finance? And what is the system ask in terms of the total value and timing of Transformation Funding?

8 Our actions

8.1 6 month plan

1. Complete the diagnosis of our system

To accelerate the development of the Norfolk & Waveney STP, and inform the key decisions facing the Norfolk & Waveney system, we are seeking the resources to employ consultants. A Statement of Requirements has been prepared drawing on work done by the NPP and the Essex success regime. The Statement of Requirements forms part of the STP submission for consideration. This will be a two-phased project, with procurement beginning immediately and reporting phase 1 in mid-September and phase two in December.

2. New models of primary and community care

We have outlined the design principles for a locally integrated primary and community service. These principles will be developed by the STP Executive, informed by the analysis undertaken by the consultancy and through engagement with the clinical leadership across Norfolk & Waveney. Detailed work will be done as set out in section 4.4.

3. Provider Trust configuration

Building on the acute services review that is covered as an element of the proposed consultancy work, we will have a robust plan for ensuring sustainable specialist services across Norfolk & Waveney. The configuration of the provider trusts across the footprint and the role of social care provision within any revised configuration will be designed and executed.

4. CCG configuration

Alongside the review of acute services we will also consider the optimal future configuration for our 5 CCGs and the integrated social care commissioning units. This will form part of the consultancy work and will be an early priority for the STP Executive to address. As of June 28th 2016 South Norfolk CCG and North Norfolk CCG have agreed to establish shared Chief Officer and Chief Finance Officer roles.

5. Further develop the partnership and system-wide relationships

We will continue to develop as a partnership, building on the progress achieved since we first came together as system leaders in October 2015. We will also look to extend this to ensure that we develop effective collaborative relationships and foster the required cultural changes with wider partners and stakeholders across the Norfolk & Waveney footprint. This will build on our initial June 7th STP engagement event. Sir John Oldham had helped facilitate this to date and we will be seeking further support from him to progress this.

6. Communications & Engagement

The success of our STP is not just dependent on effective programme delivery. Sustainable change must be underpinned by meaningful local buy-in. To this end, we will deliver our Communications & Engagement strategy culminating in the short term with our Health & Social Care Summit in December 2016.

7. Governance

We need to move from informal collaboration to more effective decision-making and governance. While we cannot overlook the statutory roles and responsibilities of the many organisations involved we recognise that we will need to streamline this to work effectively and that the STP will form the “system plan” that all organisations sign up to and the agreement on which we hold ourselves collectively and individually to account.

We have established a working group tasked with identifying the key barriers to effective governance and oversight of the STP, and to bring forward:

- Proposals to address the key issues in formalising the decision-making capacity and the authority of the Executive
- Recognition of governance needing to change depending on where we are in the STP lifecycle; Design – Planning – Implementation
- An assessment of the key statutory requirements that will need to be addressed to allow good governance to evolve
- An assessment of the governance impact of the organisational forms or models of care agreed for local development
- Development of a managed risk register

The Governance process will evolve over time and include formalised decision making arrangements; defined voting processes inclusive of any powers of veto and escalation routes; mandated authority to sign off material spend in a timely manner and clear lines of accountability back to membership organisations and named stakeholders.

8. PMO and workstream development

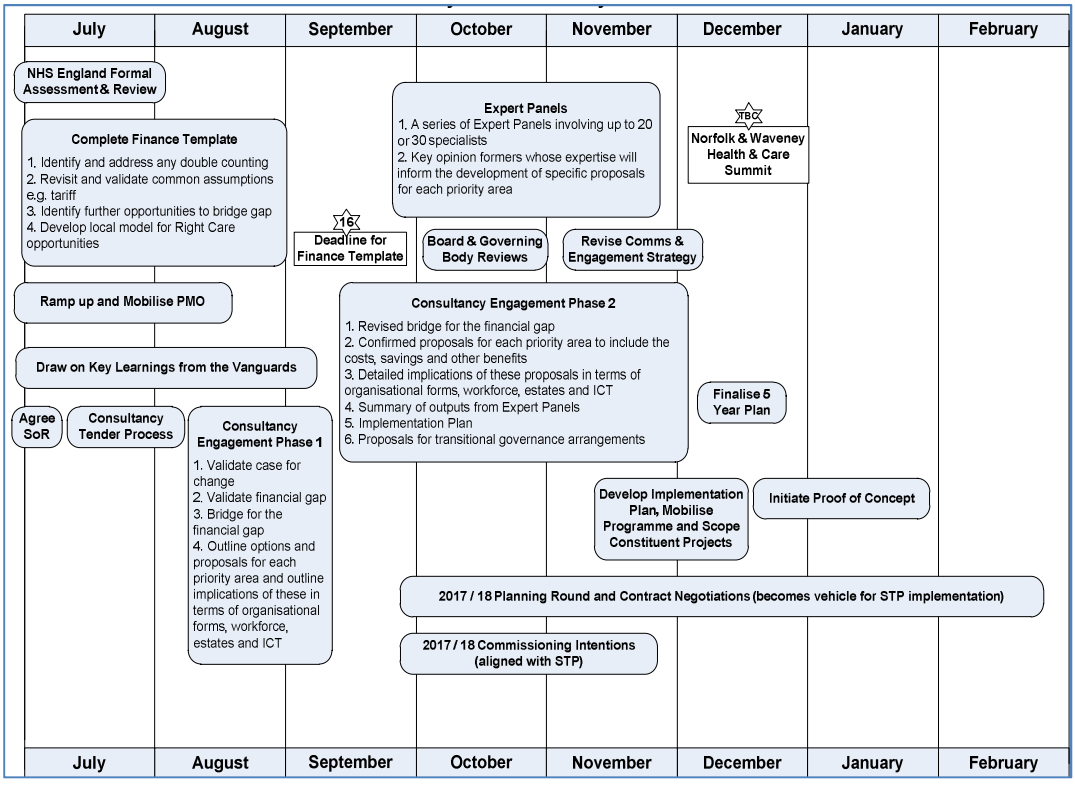
Delivery of a bold STP will require more PMO capacity and adequate dedicated resources to deliver the workstreams. We are strengthening the PMO function to ensure that it has the capacity to develop and produce the next STP supporting the SRO and workstreams.

We are also reviewing the number and scope of the workstreams to make sure they are fit for purpose and we are strengthening the capacity and capability of the programme delivery team to ensure that dedicated lead resources to manage each of the key workstreams are identified and formally co-opted onto a redefined core team located in the PMO.

The STP Exec has approved in principal a revised workstream structure, and a strengthened PMO inclusive of dedicated resources to enhance the delivery team. The ability to resource this to the required timescales depends, in part, on the ability to draw down on the STF.

8.2 6 month timeline

The timeline below provides a high-level summary of scheduled activity for the next 6 months.



8.3 Our ask

In the short to medium-term we are seeking financial support to fund the proposed consultancy engagement as detailed in the Statement of Requirements at Appendix A. We are seeking to fund this as a draw-down from the STF.

We are also seeking financial support to fund the extended dedicated PMO and core team as described at Appendix B. We are seeking to part-fund this with a draw-down from the STF.

The STP plan also assumes full utilisation by 20/21 of Norfolk & Waveney's "fair share" of Strategic Transformational Funding. Whilst 2016/17 funding has in-part been allocated to acute providers to underpin underlying deficit positions there is an urgent requirement to provide support for dedicated management capacity to translate agreed system wide ambitions into robust delivery plans.

Delivery of the STP change programme will require all organisations to accept significant change in the way services are currently delivered and it is therefore important that the plan is underpinned by a robust, credible and evidence based programme which traditionally external consultancy has a track record of mobilising jointly with the full support of partner organisations. From year 2, Transformation funding will need to help kick start investments in services and where appropriate meet the recurrent and non-recurrent costs of provider reconfiguration as the key work-streams within the STP document are implemented.

9 Appendices

9.1 Appendix A – Consultancy statement of requirements

9.2 Appendix B – Proposed programme structure

9.3 Appendix C – Enablers

Norfolk & Waveney STP

Norfolk & Waveney (Footprint #22)

STP Submission

APPENDICES

30 June 2016

Appendix A – Consultancy Statement of Requirements

A Statement of Requirements has been drafted in response to the agreement by the STP Executive to secure consultancy support for the next stage of the development of the STP. The Statement of requirements is Commercial in Confidence and has therefore not been included in this version of the STP Appendices.

Proposed Timeline

- Exec agree Statement of Requirements – June 28th
- Submit Statement of Requirements as appendix to STP submission – June 30th
- ALBs Review Meeting – July 8th
- Issue to market – July 11th
- Tender deadline – July 29th
- Award contract – August 12th
- Engagement start date – August 22nd
- Phase 1 end date – September 16th
- Phase 2 end date – December 16th

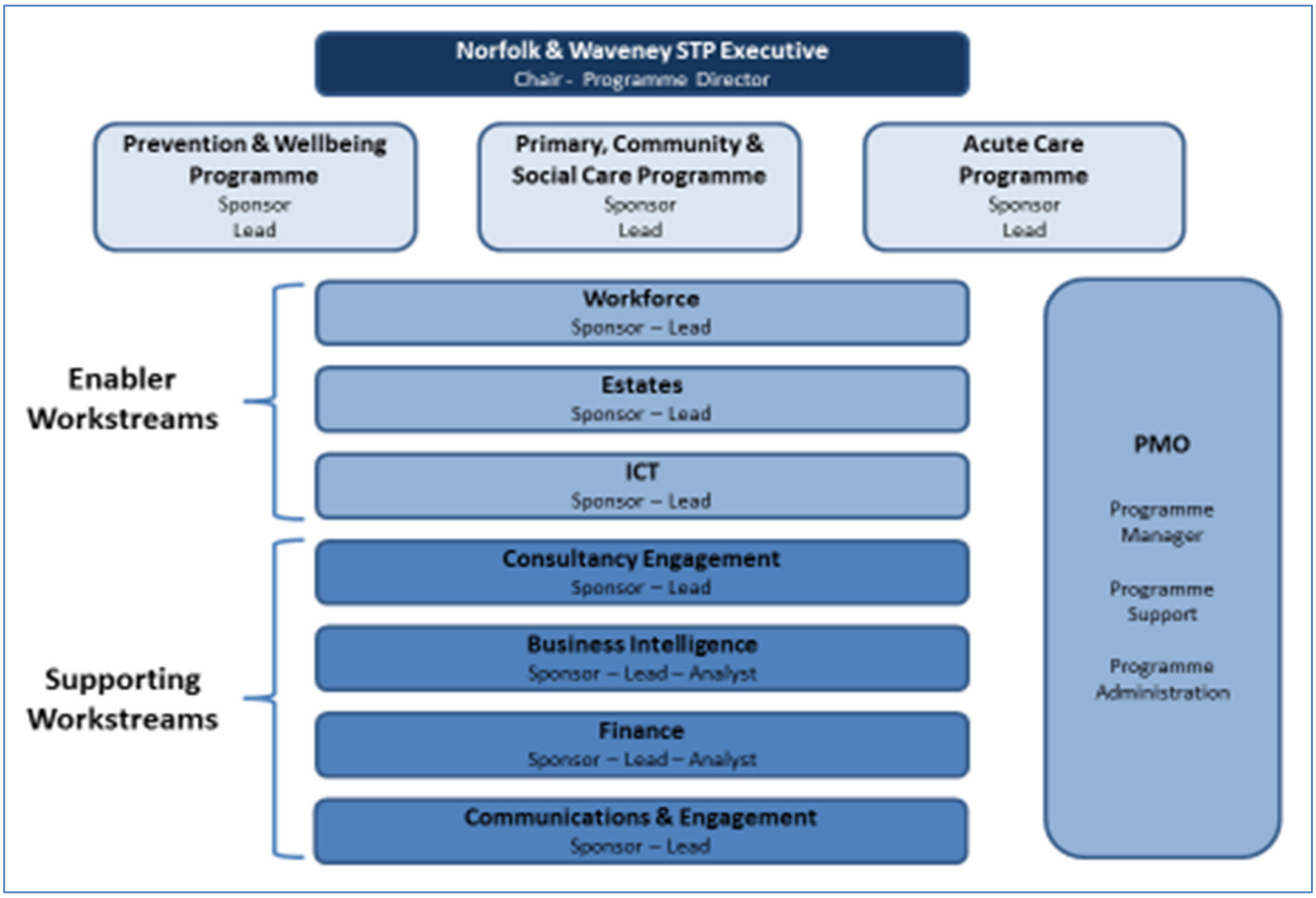
Risks

This is an aggressive timeline targeting the September / October timeframe for the next iteration of our STP. Risks to delivery include the following

- Delays to agreeing the Statement of Requirements
- Delays to securing the funding
- Any delays that impede the ability of the consultants to deliver to the timescales including the selection process and kick-off taking place during the summer holiday period
- The possibility that consultancies with the required skills and experience do not tender for the work – there may be several other footprints who are pursuing a consultancy route at the same time
- The possibility that consultancies with the required skills and experience do tender for the work but are unable to release high calibre resources
- The risk that the system is unable to implement the changes recommended by the consultancy and/or bridge the gaps identified by the STP.

Appendix B – Proposed Programme Structure

For the next stage of our STP development, we are looking to expand our PMO and core teams to inject the required capacity through formal secondments or recruitment. The diagram below sets out the programme structure and the resources required.. .



Appendix C – Enablers

Workforce

As a STP footprint we have a workforce challenge facing us now with significant numbers of vacancies in a variety of professions and care settings; an ageing workforce in some areas and insufficient supply into a range of key roles.

This requires us to take action in order to protect our workforce supply as we move to the emerging models of care as well as prepare our existing workforce for the changes in their working patterns that they will have to adopt as we move towards a more integrated "wellness" based service.

There are 3 key considerations as we prepare for our system to deliver this STP.

- 70% of our budgets is spent on staffing
- 70-80% of our existing workforce will still be in post over the next 5 years
- Any change in model will require the mobilising and energising of our existing workforce if it is to succeed.

There are 4 pillars to our strategy.

1) Protect our workforce Supply
2) Skill Mix – Think whole workforce
3) Integrating Commissioning – HR & Back Office Functions
4) Leadership

In order to address the issues against each of the 4 pillars above we are adopting a "laboratory" style approach that will allow us to test new ways of working to increase, protect or remobilise the workforce. Our system already has a number of these "laboratory" sites in the early stages of mobilisation which is a legacy of the HEE Workforce Partnership structure. Therefore as a system we consider ourselves to be in a state of readiness to adapt to new ways of working and to use education and training as a positive disruptor for change to support the emerging models of care.

<u>1) Protecting our Whole Workforce Supply</u>

As our models of care develop we need to protect our existing workforce supply pipeline to ensure that those students already in training are encouraged to complete their courses and take up employment within our system. We plan to create the right environment to attract potential employees into Norfolk & Waveney by thinking more broadly and more innovatively as a system with our LA and LEP partners.

Norfolk & Waveney is well served by high quality HEI provision from, primarily, 2 institutions; the University of East Anglia (UEA) and University Campus Suffolk (UCS) with Norwich Medical School situated in the centre of the patch. UCS's strength lies in their range of non-medical work-based and primary care provision for nursing and healthcare science whilst UEA's strength lies in a range of non-medical courses for nursing, AHPs, scientific & technical and non-medical Masters provision. UEA have also been leading the development of new roles through their Physician Associate Programme with our first cohort starting in February this year.

We already have a number of "laboratory" sites identified that are beginning to test a number of workstreams: "Grow your Own"; "Attract New Workers"; "Recruitment"; "Newly Qualified Academy / Preceptorship"; "High Quality Learning Environment"; "Our Future Workforce".

<u>2) Skill Mix – Think Whole Workforce</u>

The Nuffield Trust research states that the largest proportion of our workforce across the NHS is our non-medical registered workforce. This profile presents opportunities to look at 3 significant areas of opportunity to improve the productivity and effectiveness of our workforce to support the emerging models of care:

1. Develop skills of and expand our support workforce with clarity around role definitions and role boundaries
2. Extend Skills of non-medical workforce to work to top of licence
3. Expand number of advanced roles to take on tasks and roles traditionally undertaken by Doctors

When we compare our STP health and then health and social care workforce we see a very different profile. This highlights the opportunity to develop an already large support workforce.

We have a number of "laboratory" sites identified to test: "STP led CPD"; "Apprenticeships and Foundation Degrees"; "Health & Social Care Integration"; "New Roles".

3) Integrating Commissioning – HR & Back Office Functions

As a system we have opportunities to create economies of scale by looking at back office functions supporting workforce and education. This will help us to improve efficiency and reduce cost.

Our STP has already begun work as a result of the Lord Carter Review in each of our Trusts and through the Norfolk Provider Partnership. In addition we have begun to scope opportunities to develop shared services across the STP where we can deliver further financial savings and improve efficiency. The Workforce Leaders Group are working as a system across Norfolk and Suffolk to drive collaborative working, agreeing systems approaches and ensuring a consistent HR approach to address workforce issues.

We already have a number of "laboratory" sites identified: "Model Hospital Data Pack"; "Shared Services cross STP"; "Common recruitment process for NQHPs".

In addition there are a variety of roles in health and social care which are currently undertaken by volunteers. However, these are an area of workforce that has historically received little attention or development. Concentrated recruitment efforts, combined with developmental opportunities and career pathways for access to Bands 1-4 and professional roles could further enhance our health and social care workforce (including mental health and learning disabilities).

Retired health care professionals will be encouraged to consider volunteering as a useful way of maintaining a clinical contribution whilst working more flexibly and with less demanding roles. For example, the experience they can offer students and newly qualified staff, whilst fulfilling a supernumerary role, would release other supervisory staff for a more clinical function.

4) Leadership

Service providers across Norfolk, Suffolk and North East Essex have a mature governance system with leadership roles for Directors of Nursing (setting CPD and educational strategy), Workforce Leaders (setting HR, recruitment and retention and employability direction) and Primary Care Group (determining Primary Care priorities and setting workforce direction across the PC system) – all under the governance of the CEO Board.

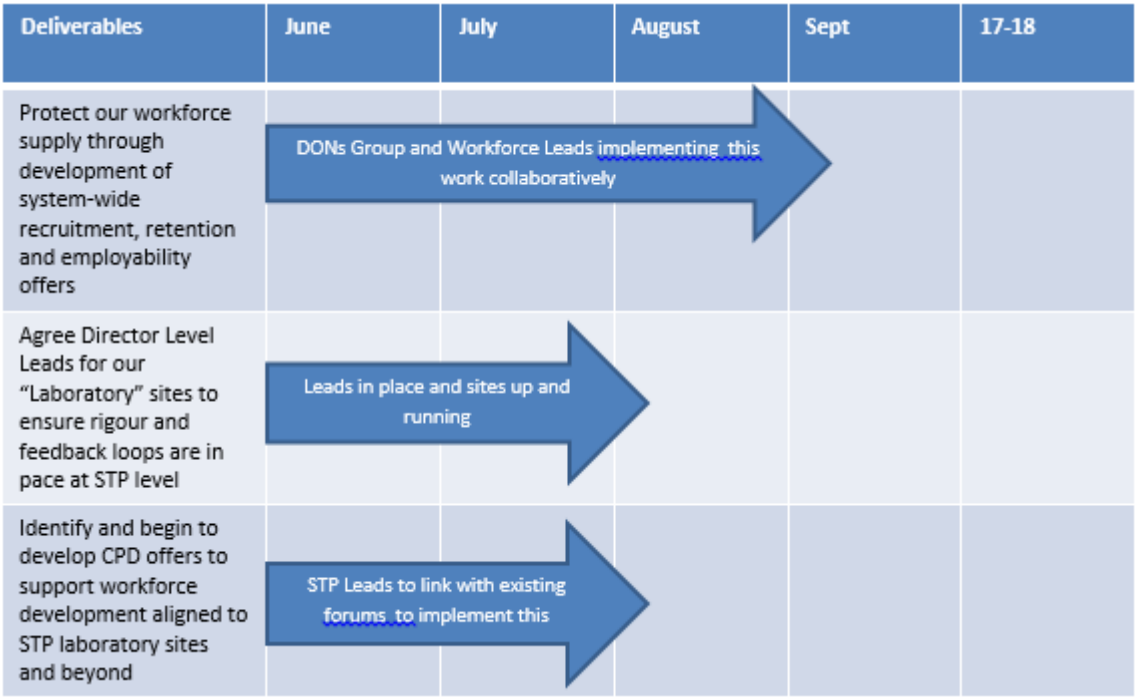
This has led to service providers who are able to address system priorities and target the "greater good" in decision making over individual need and a system which is sufficiently mature and capable of underpinning the implementation of the STP.

Examples of our successes include: development of the Physicians Associate model, Guaranteed Minimum Offer for Newly Qualifieds and the development of innovative CPD to reach more of the critical mass of existing staff (including e-learning packages and work-based learning).

Within our leadership workstream we have developed 4 strands to support the STP:

- A set of agreed operating principles across our STP
- The management of our talent as a system
- Staff engagement to support the changes we need to make – developing resilience
- Demonstrator or "Laboratory" sites to test our workforce approach

Initial Draft Delivery Plan and Timeline



Estates

The second of the 3 Enablers in Norfolk & Waveney is Estates. Early work has been done on the opportunities to realise efficiencies and cost savings as set out below and will be underpinned by system-wide Local Estates Forums. The overarching objective is to deliver an approach to achieving one estate and ICT infrastructure, with increased emphasis on co-locating services as a key feature of further integration and a fit-for-purpose estate to align with the transformation model.

1. Flexibility across boundaries: Health estate in Norfolk and Waveney comprises in total 404.2k sqm of space across 243 properties and 101.8k ha of land. The three Acute hospitals account for 120k sqm of space and 61.6 ha of land.
2. Interoperability: Running costs account for circa £150m (based on ERIC data 2014/15). Norfolk and Norwich (PFI) estates costs £61m and the three hospitals combined account for a total of £104m of costs.
3. Optimisation: Opportunities identified include:

    - Potential release of land for around 800 homes.
    - Dec 2016 SEPs estimated disposal proceeds of £13.3m from NHSPS estate and estate cost savings of £18.4m over 5 years.
    - Trust and FT potential disposals receipts and cost savings to be added to this.
    - Capital investment and revenue consequences have yet to be fully estimated.

The STP Estates strategy will ensure system-wide collaborative working to identify and deliver optimum estates solutions aligning individual Estates Strategies to the overarching STP Strategy. This STP Estates Strategy must be led by the clinical and health and well-being strategies and objectives and supported by transparent information sharing.

IM&T: Local Digital Roadmap

The third of the enabling workstreams focuses on IM&T identifying our universal capabilities (see table below) and setting out progress in developing our local digital roadmap. The Five Year Forward View makes a commitment that, by 2020, there would be "fully interoperable electronic health records so that patient's records are paperless." This was supported by a Government commitment in Personalised Health and Care 2020 that "all patient and care records will be digital, interoperable and real-time by 2020."

Universal Capabilities	Capability Tool
Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions	Summary Care Records
Clinicians in urgent and emergency care settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)	Enhanced Summary Care Records
Patients can access their GP record	Patient Online
GPs can refer electronically to secondary care	Electronic Referral Service
GPs receive timely electronic discharge summaries from secondary care	E-Discharge
Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care	E-Comms
Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly	Child Protection Information Sharing
Professionals across care settings made aware of end-of-life preference information	Electronic Palliative Care Coordination Service
GPs and community pharmacists can utilise electronic prescriptions	Electronic Prescription Service
Patients can book appointments and order repeat prescriptions from their GP practice	Patient Online

The STP guidance stated that, in developing STP content and ensuring delivery of transformation, local health and care systems should harness the opportunities that digital technology offers. The best plans will be coherent across all elements, including 'digital'. The development of a Local Digital Roadmap is a clear opportunity for local communities to articulate how they will harness technology to accelerate change.

Progress on Development of LDR for Norfolk and Waveney:

- NEL CSU facilitating the development of LDR
- Stakeholder meetings to identify and develop intelligence required to create LDR
- Operational meetings to identify project requirements to deliver universal capabilities
- 1:1 meetings with CCG and providers

- First draft created as collation of all information gathered from DMA, organisational IMT strategy, CCG operational plans
- LDR being revised in line with recent release of further guidance

Indicative timelines and key actions are identified below in the development of the local digital roadmap.