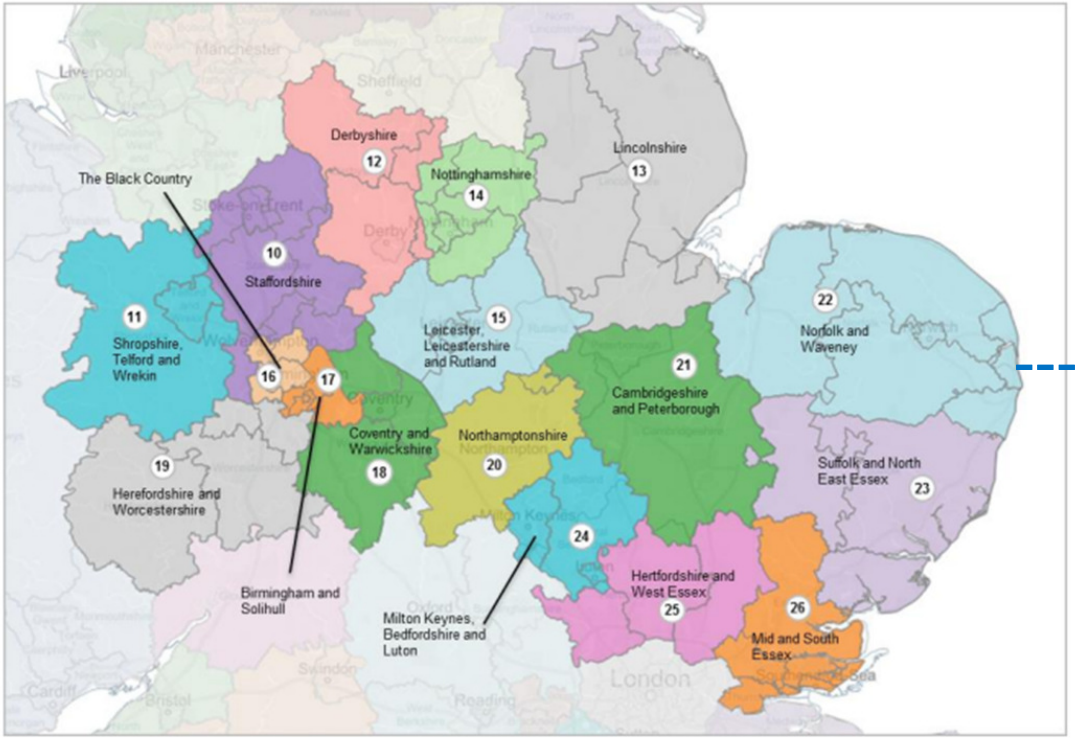
Norfolk & Waveney STP – Checkpoint Submission

Please fill in key information details below

Name of footprint and no: Norfolk and Waveney, No 22
Region: Midlands and East
Nominated lead of the footprint including organisation/function: Wendy Thomson, Chief Executive, Norfolk County Council
Organisations within footprints:



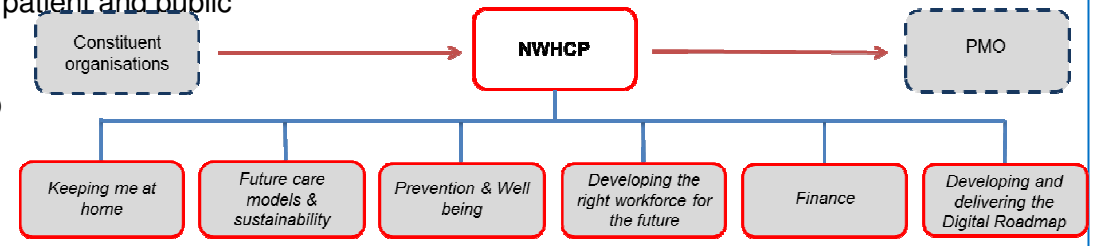
Great Yarmouth & Waveney CCG
North Norfolk CCG
Norwich CCG
South Norfolk CCG
West Norfolk CCG
East Coast Community Healthcare CIC
East of England Ambulance Service NHS Trust
James Paget University Hospitals NHS Foundation Trust
Norfolk County Council
Norfolk Community Health and Care NHS Trust
Norfolk and Norwich University Hospital NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
Norfolk Independent Care
Norfolk and Waveney Local Medical Committee

Section 1: Leadership, governance & engagement

Please discuss progress you have made (and any challenges) in the following areas:

Collaborative leadership and decision making

The Norfolk & Waveney STP is an overarching plan that draws together three systems across the footprint area. They came together in October 2015 as the Norfolk and Waveney Health and Care Partnership (NWHCP) and began developing whole system leadership and a shared vision to drive transformation and resilience across health and social care. This was through Chief Executive involvement from all the partner organisations. The NWHCP involves the 5 CCGs, 3 Hospital Trusts, Norfolk Community Health and Care, Norfolk and Suffolk (Mental Health) NHS FT, East Coast Community Healthcare CIC, East of England Ambulance Service, Norfolk Independent Care, the Norfolk and Waveney Local Medical Committee and Norfolk County Council (NCC). The NWHCP has created a pooled fund, commissioned support from an external facilitator (Sir John Oldham) and been supported by the programme office from Norfolk County Council. These arrangements will continue with the additional role of supporting development and implementation of the STP. The governance arrangements and workstreams (as well as overview of the Digital Roadmap delivery) are illustrated below and overseen by the CEX group. Each workstream and system is already involving clinicians and the public in their work, for example through workshops or established patient and public engagement groups. Leadership of the STP development is with the MD of NCC. They will be supported by CEXs leading the workstreams, a PMO managing the projects and will be supported by a dedicated programme lead, analyst and writing capacity.



An inclusive process

Involvement of patients and our wider communities in the development of STP will be undertaken via collaboration of our existing organisational arrangements. There is a plan to hold a large 300 attendee event, the Norfolk and Waveney Health and Care Summit, with the objective to widen awareness of and engagement with the case for change, and develop consensus on the vision and timetable of next steps and roles going forward into implementation.

Local government involvement

As described above partnership arrangements are already in place and the LA is fully engaged in this. The STP is the priority item on the Health and Wellbeing Board's (HWBB) agenda in April. The HWBB's goals are integration, prevention and reducing inequalities. District Councils are represented on the HWBB. Public Health support includes membership of the strategic partnership meeting, sponsor of the prevention workstream and Joint Strategic Needs Assessment.

Engaging clinicians and NHS staff

Clinicians and practitioners from across all fifteen organisations were involved in shaping the five workstreams and take an active role in leading their delivery. In line with this, in all localities joint work led by clinicians and practitioners is taking place to transform current practice and widen ways of working, with clinical dialogue in designing pathway change.

Section 2a: Improving the health of the people in your area: Key Challenges

Health gap due to our ageing population

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 2014 and 2025 to be in those aged 65 and over. Although some will be undiagnosed this means that due to age alone between 2014 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.** 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.

Health gap due to inequality

In 2015 more than **150,000** people in **Norfolk and Waveney** lived in areas categorised as the **most deprived 20%** in England. These are mainly located in the urban areas of Norwich, Great Yarmouth, Lowestoft, Thetford and King's Lynn together with some identified pockets of deprivation in rural areas, coastal villages and market towns. However, some of the smaller areas of rural deprivation, which make delivery of services more difficult and reduce accessibility for the population, remain hidden. 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. 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.

Health gap due to lifestyle, long term conditions and mental health

Obesity leads to many long term conditions. In Norfolk and Waveney there are about **250,000** obese adults and about **34,000** obese children. In 2014 obesity is estimated to have contributed to an **additional 5,800** patients with CHD, **41,000** patients with diabetes, **84,000** patients with hypertension, **2,600** strokes, **260** incidences of cancer. It is estimated that this is costing the local health economy more than **£100 million** per year. In Norfolk smoking contributes about **11,000** hospital admissions per year at a cost of about **£21.9 million** and about **4,400** deaths per year. In contrast to other conditions where mortality is decreasing, alcohol related mortality is showing an upward trend and is estimated to be responsible for over **6,700** hospital admissions per year at a cost of about **£13.3 million.** Deaths from suicide are also increasing in the Norfolk and Waveney system. Between 2012 and 2014 there were almost **300** deaths from suicide, the majority of these in men. In 2013/14 the mortality rate for those with a serious mental illness was more than 3 times higher than the rest of the population. For those aged 15 to 74 the years lost to life due to suicide is also significantly higher for Norfolk at 37.5 yrs per 10,000 population compared to England 31.9 yrs per 10,000 population (2012-2014, Office for National Statistics).

The EPIC 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. The next slide identifies the targeted interventions we will deliver.

Section 2a: Improving the health of people in your area Priorities

Potential areas of focus for improving health and wellbeing

Across Norfolk and Waveney we are ambitious about **preventing** people from becoming ill, **reducing** the impact of their illness and **minimising** their need for formal care services. The challenge through the STP development and delivery will be to shift to prevention at scale and not just focussing on care delivery.

Though the benefits will be realised over a longer period than this plan, we will ensure that every child has the best start in life through the Healthy Child Programme. This is a high quality health visitor and school nursing service linked with other key services for children and young adults. The programme includes health improvement to address obesity, ensuring child development is monitored regularly and that the health needs of our most vulnerable children are met.

For adults we will target early intervention programmes to reduce smoking, reduce harmful drinking, reduce obesity and inactivity to lower the burden of preventable disease. This includes scaling up local implementation of the National Diabetes Prevention Programme by building on the first wave of projects underway across North Norfolk, Norwich and South Norfolk; focusing tobacco control and stop smoking services on reducing smoking rates in key vulnerable groups and deprived areas; working with district councils to address the wider issues that affect health such as housing; and taking a multi-agency approach on issues such as mental health, domestic abuse and substance misuse.

To promote and improve our workforce's health and wellbeing we will be rolling out a workplace health offer to medium sized employers to address issues such as stress, smoking and MSK problems. This will build on successful initiatives already in place, including NHS health checks delivered through major employers, to reduce sickness absence, improve productivity and enable healthy workplaces in general.

To address these lifestyle issues we will scale up behaviour change approaches such as; using behavioural insights; making every contact count and patient activation to improve patient knowledge and confidence.

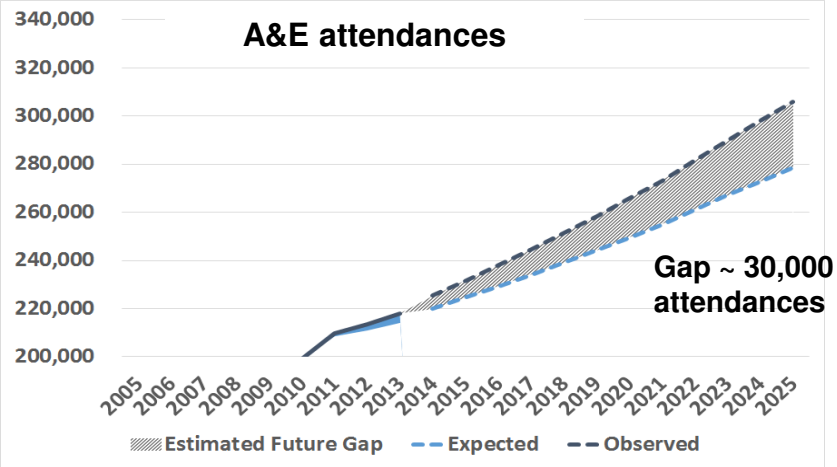
Treating disease early and well can prevent further complications and need for urgent care such as heart attacks and strokes. Using the Right Care approach to reduce inequalities and variation in care and quality we will increase the value that the patient derives from their own care and improve population health. We want to reinforce the credibility of community provision in its widest sense (pharmacy, voluntary sector provision, adult learning, district provided leisure services, warm and well initiatives) and make every one of these contacts count, encouraging people into self-care and to recognise early warning signs.

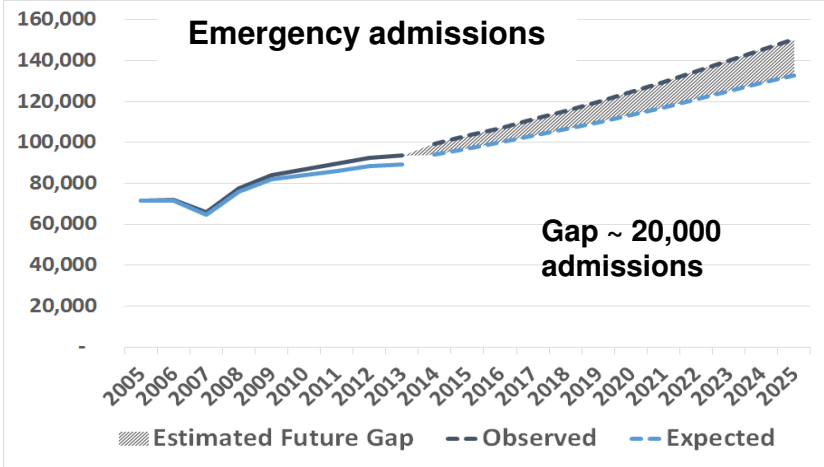
As people get older this will lead to holistic person centred prevention and enablement to keep people in their own homes and prevent increasing dependency through, for example, programmes that prevent falls, keep people independent, and support carers.

We have a dedicated STP workstream focussing on *Prevention and Wellbeing.*

Section 2b: Improving care and quality of services
Key challenges – demographic pressures

Increasing A&E attendances and increasing emergency admissions highlight the increasing pressure the Norfolk and Waveney system is under. Under a do nothing scenario the gap in what we observe and what we expect to see if the change is due to demographic pressures alone is widening.





If rates continue to change as they have done in the past and population increases as projected then by 2025 we can expect an increase in population of about 65,400 people and:

About 7,100,000 primary care consultations per year
About 547,000 first outpatient attendances per year
About 1,460,000 follow-up outpatient attendances per year
About 30,000 ordinary inpatient admissions per year
About 250,000 day case admissions per year

About 10,600 births per year
About 27,000 maternity admissions per year
About 310,000 A&E attendances per year
About 250,000 ambulance call outs per year
About 120,000 ambulance conveyance to A&E per year
About 150,000 emergency admissions per year

About 6000 housing with care units, about 6000 nursing beds, about 8000 residential beds and about 7,700 deaths with a palliative care need.

Section 2b: Improving care and quality of services
Key opportunities

We will use the RightCare approach to tackle unwarranted variation through a focus on value to address some of the funding challenges faced by the Norfolk and Waveney system. NHS Great Yarmouth and Waveney CCG is a member of the first wave of CCGs to implement RightCare. We will use the learning from NHS Great Yarmouth and Waveney CCG across the system to understand where to look, what to change and how to change so as to improve population outcomes.

RightCare shows that there are some common areas of headline spend and outcome opportunities across the footprint. If the five CCGs in Norfolk and Waveney were to have the same spend and outcomes as the top five of their similar CCGs then for each year:

- **Circulation spend and outcome opportunities**: over 3,100 people with CHD or hypertension would have their blood pressure under better control, there would be 16 fewer early deaths from stroke and the system could save over £5 million in non-elective admissions.
- **Cancer spend and outcome opportunities**: more than 1,900 additional people screened, more than 130 people receiving 1st treatment within 2 months of urgent GP referral, 64 fewer early deaths and the system could save over £2 million in non-elective admissions.
- **Respiratory spend and outcome opportunities**: more than 2,400 Asthma patients with a review within 12 months, more than 1,300 COPD patients with a review within 12 months and the system could save over £4.5 million in non-elective admissions
- **Mental Health spend and outcome opportunities**: almost 500 fewer admissions for self-harm, 84 fewer early deaths in people with serious mental illness and savings of almost £5 million in prescribing costs.
- **Avoidable ACS admissions opportunities**: The Norfolk and Waveney on the whole manages avoidable admissions well. However, each year across Norfolk and Waveney there are on average more than 18,000 potentially avoidable non-elective ACS admissions. 23 practices have significantly higher than expected non-elective ACS admissions contributing more than 900 additional potentially avoidable admissions per year at a cost of about £1.8 million.

For these areas alone, targeting variations in need, access and treatment could save more than £13 million per year, a significant proportion of which would materialise in the non-elective element of the NHS activity gap of 30,000 A&E attendances and 20,000 emergency admissions. A detailed RightCare approach across the system would highlight further care and quality opportunities to improve population health and system efficiency.

Section 2b: Improving care and quality of services - Priorities

Potential areas of focus for improving care and quality of services

Extending from our focus on preventing illness we will seek to minimise the impact of illness and the need for care. Our focus will be on rebalancing the Norfolk and Waveney system to treat and support more people in a community setting, reducing reliance on procured beds and time spent in institutional settings. This will particularly be for people with complex care needs including mental health and those with LD. We will achieve more consistency in delivery and core standards across the footprint and ensure services are sustainable over the longer-term, which will involve difficult commissioning choices but a commitment to building on successful innovation and co-operation between providers e.g. the Norfolk Provider Partnership (NPP) which is collaborative working between the 3 Acute Trusts and the NHS Community Trust.

New models of care identified in the 5 Year Forward View are being explored at pace to determine the best fit for our footprint and local communities. The STP has a dedicated workstream for *Future care models and sustainability* (including both acute and primary care). Our initial priorities are :

- Developing an integrated primary health and wellbeing system centred around General Practice within communities, that encompasses a broad spectrum of agencies including voluntary, home care providers and those promoting positive lifestyle choices, making these more joined up and accessible
- Work towards implementing the mental health priority of the Health and Wellbeing Board across the Norfolk and Waveney system; reducing stigma by creating a more open and accepting culture; shift to earlier intervention and community support by commissioning better pathways into and through services; improve support to people with long term conditions by improving access to self-help resources; making mental health everyone's' business by building links across the system through schools and employers
- Building on existing work across Norfolk and Waveney to integrate health and social care services, creating joint roles like care coordinators
- Working with care homes to enhance health outcomes for individuals, including developing a more proactive health and social care model within and around homes
- Developing stronger and more ambitious plans for improving urgent and emergency care, learning from Vanguard models. A focus will be on reducing confusion of the various emergency care services – A&E, walk-in centres, urgent care centres, GPs, pharmacists and out of hours services
- Developing an integrated approach to end of life care to achieve a more consistent approach across the whole footprint, using best practice and co-design with the third sector

A number of key enablers are necessary to support our overarching workstreams. These include infrastructure – such as use of estate and IT, through delivering the Digital Roadmap and common access to information – as well as workforce change. We will develop new roles that flex across an integrated system and work with education and training providers to develop innovative schemes to attract and retain good quality staff. We will strengthen links with the independent sector, working with them to foster a more sustainable home care market across the footprint, particularly in rural areas.

Section 2c: Improving productivity and closing the financial gap

The NWHCP executive group has committed to accurately establishing the gap between our finances as a system in Norfolk and Waveney and the costs we will actually face. We will provide a system-wide response that ensures equality of risk share and long-term sustainability.

Of the pressures identified so far, over the 5 year period, inflation is the largest driver (circa 40%). Demand for services (volume) and local cost pressures (non-volume) combined with inflation make up about 90% of the pressures. 62% of the solutions are assumed to be delivered from QIPP / CIP / efficiencies. The bulk of the remaining solutions (32%) are related to funding changes.

The emerging priorities for returning the system to aggregate balance include:

- Upscaling prevention and early intervention and moving towards new models of care as a system as described in 2a and 2b
- Improving management of unplanned care pathways and urgent care system, limiting growth in emergency admissions & reducing delayed discharges
- Removing unnecessary duplication and variation
- Providing more active management of patients with long-term conditions to avoid episodes of acutely unwell (primarily through population management and risk stratification)
- Building on work of the Norfolk Provider Partnership to establish common clinical guidelines and services, develop networked clinical teams and develop telemedicine to support out of hours provision
- Simplify and integrate commissioning and contracting arrangements to tackle variation in provision and reduce the number and complexity of contracts
- Establish an approach to achieving one estate and ICT infrastructure, with increased emphasis on co-locating services as a key feature of further integration
- Proactively use the data within the Right Care Programme and Carter review to help focus priorities for savings programme

These drivers for financial balance are incorporated within the workstreams focussing on sustainability, new models of care and workforce change. The STP also has a dedicated workstream to focus on the financial impact of the wider plan.

Section 3: Emerging priorities

Based on the work undertaken by the NWHCP so far and extending from the summary analysis on previous slides, the following table summarises our emerging priorities.

	Key areas for focus	System priorities
1	**Prevention at scale**	• Ensure every child has the best start in life through the healthy child programme • Tackle the preventable causes of ill health in older people and those with mental health conditions • Deliver targeted early intervention programmes that support people to remain independent and well in their own homes and communities
2	**New/sustainable models of care at scale**	• Determine at pace which models of care are a best fit for our footprint to achieve our aspiration of returning to aggregate balance and supporting more people in a community setting • Adopt learning from the Vanguards and local initiatives to integrate primary, community and social health and care provision and work jointly across the acutes • Determine an approach to sustainability of all sectors including Domiciliary Care and Primary Care
3	**Workforce change**	• Achieve a healthy and productive workforce by stepping up existing workplace initiatives • Focus on attracting and retaining high quality staff across the health & care sector, including independent providers
4	**Enabling culture & behaviours**	• Address cultural and behavioural issues among the public and staff, with the ambition of creating greater credibility for community provision and reducing confusion about the use of emergency care
5	**Structural enablers and infrastructure**	• Establish an approach to achieving one estate and ICT infrastructure • Developing and delivering the digital roadmap so that all heath and care records are digital by 2020, Information is shared between organisations in a way which is core to them and resources are optimised through standardisation
6	**Commissioning & contracting**	• Simplify commissioning and contracting arrangements to adopt a greater one system perspective for commissioning and reduce the number and complexity of contracts • Achieve greater consistency in provision and core standards across the footprint through standardisation

Section 4: Support we would like

Please discuss your emerging thinking in the following areas:

Areas for regional or national support

- Transformation funding and acceptance that dual running of old and new services are often required for a period of time
- External health economics support to help understand future activity and financial scenarios across the whole system
- Flexible planning horizons to enable longer-term transformation and less emphasis on short-term performance issues
- Flexibility around departure from tariff and support for development of local models for financial management e.g. one system control total

National barriers/action

- Current regulatory model and performance monitoring regime a barrier in terms of the focus on an organisation's local targets and short-term performance; leads to entrenchment of silo working
- Current system still places too much emphasis on transactional issues (e.g. quarterly monitoring) rather than transformational
- To tackle the above we would like to explore alternative performance monitoring regimes in keeping with the NHS Constitution

Sharing good practice

- Build on the experience from NHS Great Yarmouth and Waveney CCG as part of RightCare wave one with greater sharing of learning from and access to leaders of the Vanguard sites and elsewhere internationally

Key risks

- Scale of financial challenge presents significant risk, no clear consensus yet that this can be overcome within existing financial envelope and STP timeframe
- Failure to transfer funding within the system (e.g. prevention, social care) to rebalance where care takes place
- Entrenchment of locality perspective over system perspective for both commissioners and providers
- Relative newness of system working and relationships within the footprint and its leadership, combined with the timeframe present a significant challenge and risk to the development of an effective STP for a new footprint area
- We underestimate the effort required to address cultural and behavioural issues among our workforce and citizens
- Workforce shortages hamper implementation of new schemes e.g. geriatricians, GPs
- Engagement of clinicians who are becoming weary of new initiatives
- Failure to galvanise political support around the case for change and decisions required to achieve sustainability
- The nature of the rurality and geography of the STP footprint may limit the models of care and options available