Norfolk County Council

People and Communities Select Committee

Date: **13 September 2019**

Time: **10:00am**

Venue: **Edwards Room, County Hall, Norwich**

SUPPLEMENTARY
A g e n d a

7. Working with the NHS on integrated services in Norfolk and Waveney **(Page A2)**

Report by the Executive Director of Adult Social Services

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Date Supplementary Agenda Published: 6 September 2019

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Report to People and Communities Committee

Item No. 7

Report title:	**Adult Social Services – Working with the NHS on integrated services in Norfolk and Waveney.**
Date of meeting:	**13 September 2019**
Responsible Cabinet Member:	**Cllr Bill Borrett**
Responsible Director:	**James Bullion, Executive Director of Adult Social Services**
Is this a key decision?	**No**

Executive Summary/Introduction from Cabinet Member

The NHS Long-Term Plan sets out specific requirements of Health and Social Care Systems. This paper provides an update on Norfolk & Waveney's (N&W) response so far and how Norfolk County Council Adult Social Care (NCC ASC) services are working with Health organisations currently as part of the new Sustainability and Transformation Partnership (STP) developments. The paper builds on previous policy positions agreed in the Adult Social Care Committee and the Policy and Resources Committee. The Health and Well-Being Board has a key strategic role in overseeing integration at a system level and their Strategy leads on Prevention and Integration.

Recommendations:

a) **For the People and Community Select Committee to consider and support the progress on integrated commissioning and community-based models and policies for integrated social work services, and to comment on the risks and opportunities**

Actions required:

a) **To support further updates to Select Committee as required, and further action by the Executive Director of Adult Social Services, in consultation with the Cabinet Member for Adult Social Care, Prevention and Public Health, on revised agreements with the NHS to achieve improved outcomes**

1. Background

1.1 The Council's Policy and Resources Committee, in March 2019, agreed the Council's ambitions for integration between Adult Social Care and Norfolk NHS Services, delegating authority to the Executive Director of Adult Services to review and renew existing integration agreements with Norfolk's NHS in the light of the NHS Long Term Plan.

1.2 This report provides an update on progress with developing integrated arrangements including revised joint commissioning, the development of community-based models of social work and support at home, and stronger support within hospitals.

1.3 Alongside the Care Act 2014, the NHS Long-Term Plan January 2019 has reiterated the requirement for the 'whole system' to work collaboratively, with Primary Care Networks as a core new focus for shaping and delivering community integrated services.

1.4 The Plan requires systems to address long-standing areas for development. The focus is on prevention, wellbeing, workforce, quality care for all ages, innovative and integrated

working, tackling inequalities, making better use of data and technology and "getting the most out of taxpayers investment" (NHS Summary).

1.5 STPs and Integrated Care Systems (ICS), which are groups of local NHS organisations, local councils and other partner, are required to develop and implement their strategies over the next five years.

2. Working with the NHS on Integrated Services

2.1 The Norfolk & Waveney STP is assessed by NHS England as an "aspirant ICS" and is developing a plan for Autumn 2019 in order to become an Integrated Care System from April 2020.

2.2 The N&W STP has recently undergone significant re-organisation and alignment in order to be in the best shape to meet the new system requirements. Melanie Craig is the appointed STP Chief Officer with key senior posts working to her as outlined in the structure attached (Appendix 2).

2.3 In addition, the various Health organisations in Norfolk and Waveney are beginning to work more collaboratively, seeing the five CCGs aligning, blending and sharing staff and functions, the three acute Trusts working to one Urgent Emergency Care Board and Norfolk Community Health and Care (NCHC) and Norfolk and Suffolk Foundation Trust (NSFT) looking to work in partnership. (Appendix 3).

2.4 The STP has a number of Boards and workstreams that underpin these developments as outlined in the Primary Care Strategy (please refer to pages 66 and 67 of the Primary Care Strategy - Appendix 1).

2.5 We ensure that NCC staff are an active part of all relevant Boards, workstreams and developments both at a strategic level and through to locality operations. For example, James Bullion, Executive Director of Adult Social Services and Sara Tough, Executive Director of Children's Services, are members of the STP Executive and each Chair the Primary Community Care and Children's Boards and Louise Smith, Director of Public Health, is the Senior Responsible Officer across the system for Prevention.

2.6 Members of the Executive teams are involved in all key developments and lead core areas for the whole system. For example, Social Prescribing and Enhanced Services to Care Homes.

2.7 The financial context is well rehearsed and challenging across the N&W STP. The aspiration is the sharing of the problem and calculating the overspend as a whole, treating it as "the Norfolk pound" and developing whole system solutions rather than taking the traditional silo approach.

2.8 The Boston Consulting Group produced a detailed assessment of the N&W system in 2018. In response, a Demand and Capacity workstream exists to work across all partners to share intelligence and devise joint plans to address issues of demand, capacity and savings.

2.9 James Bullion, Executive Director of Adult Social Services, is the Senior Responsible Officer for the STP for Primary & Community Care and chairs the Primary & Community Care Board. The N&W STP Primary Care Strategy was developed as part of the workstream and is significant for the way Adult Social Care shapes its services. It has received very positive feedback from NHS England.

2.10 In summary, the Primary Care Strategy covers the following areas:

a) "Boosts out of hospital/care – finally dissolving the historic divide between Primary and Community Services"

b) “Reduce pressure on emergency services”
c) Give people “More control over their health and more personalised care when they need it”
d) “Digitally enabled care”
e) “Local NHS organisations will focus on population health – moving to ICS everywhere”

2.11 In addition to the STP workstreams, the five areas - North, South, GY&W, Norwich and West all have Local Delivery Groups (LDGs), where all key partners, including Districts and Borough Councils, come together to plan, develop and deliver joined up services. These are seen as “the engine rooms” for the system – the emphasis is on co-production with Primary Care colleagues. Each Primary Care Network has appointed a Clinical Director to lead from a clinical perspective to ensure the correct emphasis.

2.12 Adult Social Services ensure senior representation at these LDGs, both Operational Assistant Directors and Joint Commissioning senior leads, supported by an Executive level Officer. In addition, Children’s Services have a direct link via the NCC STP lead for community services.

2.13 Adult Social Services are actively aligning services and teams to work in Primary Care Network areas, co-locating where possible and are undertaking a review of NCC acute hospital teams to maximise the benefits of locality/Primary Care Network working. All Officers are expected to progress integrated working as outlined recently in the Six Principles to Achieve Integrated Social Care agreed between Association of Directors of Adult Social Services, Local Government Association, NHS Providers, Clinical Commissioners and Confederation. See section 6.1 for a link to more details.

They are:

a) Collaborative leadership
b) Subsidiarity-decision making as close to communities as possible
c) Building on existing, successful local arrangements
d) A person-centred and co-productive approach
e) A preventative, assets-based and population health management approach
f) Achieving best value

2.14 NCC continues to deliver services that avoid unnecessary hospital or residential care and to work in a multi-disciplinary way, including Norfolk First Support, Swifts, Night Owls and joint response services such as the Norfolk Escalation and Avoidance Teams and in co-located joint duty teams.

2.15 The “3 Conversations” model, which is an established part of NCC’s Promoting Independence Strategy, fits precisely with the NHS Plan Personalisation agenda. NCC Public Health colleagues lead on Population Health Management for the system in order to better inform how we use resources.

2.16 NCC Human Resources have been very involved in the workforce strategy both nationally and locally, ensuring the whole care sector is represented and leaders developed according to the considerable experience of integration to date.

2.17 The Section 75 between NCC Adult Social Services and NCHC Adult Services (covering joint senior operational posts) is being reviewed to evaluate the five years in operation and to make recommendations on best fit for the future joint working in system. The Primary Care Network (PCN) developments will be a major influence on the chosen model going forward.

2.18 Mental Health, Learning Disabilities and Children’s Services, whilst developing their own whole system strategies and specialist services, are also considering how to maximise the benefit of the evolving PCN approach. This includes working with NHS learning disability

providers to design and implement a new collaborative and integrated pathway to deliver on long term plan commitments to reduce specialist hospital placements and improve and increase preventative community provision.

2.19 Public Health colleagues are actively working with health colleagues in areas such as healthy ageing, end of life care, a tobacco strategy, and the healthy pregnancy agenda. Their Business Intelligence team is very active in providing modelling analysis, aligning intelligence to support plans and in producing the Joint Strategic Needs Assessment.

2.20 The Health and Wellbeing Board is core to overseeing the relationships and initiatives outlined in this paper and has very senior representation from all sectors.

2.21 In terms of financial alignments, the Better Care Fund and the Improved Better Care Fund arrangements overseen by the health and Wellbeing Board encapsulates many examples of the approach outlined in this paper.

2.22 In addition to this Officers have worked hard to achieve sensible integrated approaches. These include some joint funding of nursing and continuing care arrangements, a joint approach to health and social care debt, and a shared polled fund under the Transforming Care Partnership which deals with people with severe Learning Disabilities.

2.23 Following a review in August 2019 Adult Social Services have revised joint commissioning roles across the CCGs closely aligned on priority areas of focus. These include the commissioning of services for people with a Learning Disability and Autism, Transforming Care, Out of Hospital Care, the Better Care Fund plan, and other opportunities to work together on health and care market management, quality and housing. These joint staffing arrangements will be secured under a revised S75 agreement in 2020. This work is overseen by the Director of Commissioning in Adult Social Care Services.

2.24 We also have a number of jointly funded prevention and demand avoidance schemes such as the Integrated Equipment service, home based re-ablement, accommodation-based reablement, enhanced home support, District Direct services and Social Prescribing. All arrangements are within the legal framework of, and adhere to, the Care Act 2014.

3. Discussion Issues for the Select Committee

3.1 Achieving integrated commissioning and service delivery arrangements with Norfolk's NHS is key to achieving better outcomes for the citizens of Norfolk. Many people with a social care need also have a health care need where working together will achieve better care and coordination of support.

3.2 Social care also has its unique core statutory role of protecting and connecting people irrespective of health care needs; with community cohesion and support though a range of community and voluntary sector groups; with families and family carers so that people can be mutually supportive, receive respite, be more resilient and live well together; with housing suited to their needs, including through adaptations; and with adult safeguarding for people at risk of abuse.

3.3 In doing this statutory role the wider functions of the council play an important and integrated part which must be balanced with working closely with health services, but which also 'add value' to integrated working.

3.4 Being a good partner with the NHS means we will take into integrated working clarity about our principles which sit under the Department's overarching aim:

'To support people to be independent, resilient and well'

This includes:

a) A strong social care approach with strong leadership of social work
b) A standard and equal level of service across the county with delivery devolved locally
c) Strong links with primary care – we don't want to first meet people in hospital
d) Simple processes, swift solutions
e) Saving money and avoiding demand
f) Fewer organisations for the public to deal with
g) Providing for the local population within a clear local budget
h) Ensuring that social care does not become dominated by a medical model
i) A focus on person-centred care and personalisation, choice and control

4. Financial Implications

4.1 The N&W STP face significant financial challenge. NCC are part of this context. Officers have to balance supporting the 'bigger picture' whilst ensuring that NCC budgets, such as Purchase of Care, are not adversely impacted by initiatives.

4.2 Ideally, joint developments will deliver a more effective and efficient use of resource, including social care, particularly if the focus on prevention is successful. Officers should ensure that any benefit is also apportioned fairly.

5. Resource Implications

5.1 **Staff:**

5.1.1 The developments should mean opportunities for staff to develop their skills and work in satisfying multi-disciplinary teams. This should support job satisfaction and staff retention-as will the workforce strategy which allows flexible working across roles and organisations and sees a more joined up approach to staff recruitment and development. The Population Health Management approach may lead eventually to some necessary movement of teams which will need to carefully managed, as does any co-location.

5.2 **Property:**

5.2.1 The STP has an Estates Strategy and NCC play an active part in this. The aim is to make best use of all estates across the system.

5.3 **IT:**

5.3.1 NCC are very involved in developing joined up Information Technology solutions and innovation to support developments. In addition, the use of tele health and smart technology feature in the strategies and should serve citizens well.

6. Other Implications

6.1 **Legal Implications:**

6.1.1 Different mechanisms to ensure any new working arrangements are safe will need to be explored as matters progress.

6.2 **Equality Impact Assessment (EqIA)**

6.2.1 All services are underpinned by an ethos of fair and equal access. Any developments will have to be equitable.

7. Risk Implications/Assessment

7.1 In addition to the potential financial risk, there is a concern that the social care voice and ethos might be lost. This is mitigated by a clear set of professional social care principles underpinning our work, senior representation on key Boards and developments, by the NCC internal Integration Board, by the duties of the Director of Social Work role and other executive level staff holding each other to account on all initiatives. (Appendix 4, Risk Register).

8. Background Papers

8.1 Primary Care Strategy (Appendix 1)
Norfolk & Waveney CCG Exec Team Structure (Appendix 2)
Proposal to Merge the Five CCGs in Norfolk (Appendix 3)
Risk Register (Appendix 4)
Integration with the NHS & 10 Year Plan, Policy and Resources Committee March 2019 (page 151)
Better Care Fund and Integration Plan (p21)
Care Act 2014
NHS Long Term Plan
Norfolk & Waveney Mental Health Strategy, December 2018
ADASS Six Principles
Norfolk's Better Care Fund and Integration Plan 2017-19: Progress Report for 2017-18 (page 14)
Norfolk and Waveney bid to become an Integrated Care System (page 226)

9. Conclusion

9.1. Considerable review and renewal of integrated working with Norfolk's NHS is underway. The developments in the N&W STP are significant and NCC need to ensure maximum participation and influence in order to ensure joint approaches and benefits. Risks will need to be mitigated and support given to Officers working in complex partnership environments.

10. Recommendations/Actions

10.1 **Recommendations:**

a) **For the People and Community Select Committee to consider and support the progress on integrated commissioning and community-based models and policies for integrated social work services, and to comment on the risks and opportunities**

Actions required:

a) **To support further updates to Select Committee as required, and further action by the Executive Director of Adult Social Services, in consultation with the Cabinet Member for Adult Social Care, Prevention and Public Health, on revised agreements with the NHS to achieve improved outcomes**

Officer Contact

If you have any questions about matters contained in this paper, please get in touch with:

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in good health
The Norfolk and Waveney Health and Care Partnership

Norfolk and Waveney Sustainability & Transformation Partnership

2019/20-2023/24 Primary Care Strategy

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Version Control

Version Number	Date	Author	Details of Update
1	30 May 2019	Sadie Parker	
1.1	5 June 2019	Sadie Parker	Amends to sections
1.2	5 June 2019	Sadie Parker and Emily Arbon	Rewrite to some sections
1.3	7 June 2019	Sadie Parker	Finalise draft for PC&C workstream board
2	12 June 2019	Sadie Parker	Revisions following PC&C board
2.1	17 June 2019	Sadie Parker	Draft for STP Exec
2.2	18 June 2019	Emily Arbon	Formatting and editing
2.3	19 June 2019	Sadie Parker	Revisions following JSCC and LMC
3	20 June 2019	Sadie Parker	Version submitted to NHSE
3.1	25 June	Sadie Parker	Updates following STP Exec and North, South, Norwich GB meetings
3.2	31 July	Sadie Parker	Updates to maps and response to NHSE feedback

Authorisation

Date	Name	Position

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Norfolk and Waveney Sustainability & Transformation Partnership

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1 Executive Summary

The overarching aim of our partnership is to build healthier communities in Norfolk and Waveney. We are creating an Integrated Care System (ICS) where we will work in partnership at three levels to achieve our aim: Neighbourhood, Place and System. General practice is the foundation of our developing PCNs and our ICS and while our PCNs are relatively new, they build on years of GP practices and community partners working together through existing relationships.

At neighbourhood level, our 17 Primary Care Networks (PCNs) will be the fundamental building blocks of our ICS and enable us to deliver the new service model for primary and community care set out in the NHS Long Term Plan. These multi-disciplinary teams will help to ensure that people receive more joined-up and coordinated care, near to where they live, from primary and community health services. They will be responsive to the characteristics and needs of their local populations.

Over the next five years we will be aligning some of our current workforce to our PCNs, for example mental health teams, adult social care and community services. We will also be expanding our PCNs by adding new roles, such as nursing associates, physician associates and advance paramedic practitioners, as part of the investment we are making into primary and community health services.

We have established five local delivery groups, one in each ‘Place’ (CCG area), that bring together a broad group of providers and key stakeholders. At this level there is greater involvement from our district councils, particularly housing, leisure and community development. These groups are accelerating the development of new relationships between all of our “out of hospital” provision. Over the next five years they will continue to ensure we maintain a focus on local delivery.

At System level we are working together to set the strategic direction for primary and community care across Norfolk and Waveney. At this level we will take decisions for the whole of Norfolk and Waveney to eliminate unwarranted variation and implement transformation at scale, for example workforce planning, digital and information governance, which will support the implementation of the new service model for primary and community care and the delivery of the General Practice Forward View.

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Our approach to population health management will support all three levels of our integrated care system to make more intelligent decisions that improve the health and wellbeing of local people and reduce health inequalities. Building on our experiences of using population health management techniques across Norfolk and Waveney, over the next five years we will refine our approach and embed it as a fundamental part of how we plan services and deliver care to patients. It will enable us to move to providing more proactive care, by using data and evidence of what works to prevent people from getting ill, diagnose problems earlier and help people better manage their long-term conditions.

Together we are working to reduce pressure on emergency hospital services. Our plans include developing our multidisciplinary Clinical Assessment Service so that it is typically the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.

The service will help to make sure that people directed to the most appropriate place to get the care they need, first time. As a partnership we will continue to reduce avoidable admissions by establishing acute frailty services, as well as reduce delayed transfers of care when people do have to be admitted. Patients will also benefit from same day emergency care at our three main hospitals, 12 hours per day, seven days per week.

We want to make care more personalised; providing individuals with support tailored to their needs, rather than a one-size-fits-all approach which can fail to engage with the people most in need of support, leading to inequalities in access and health outcomes. Our “three conversation” approach to adult social care and health coaching approach in provider organisations set strong foundations for providing personalised care.

Our social prescribing model is also predicated on a life/health coaching model to provide a more rounded and focussed offer for individuals. We are working towards increasing the use of personalised health budgets, and not just in the traditional areas such as Continuing Health Care, but we are looking at other innovative ways of supporting people using this approach. Underpinning all the changes we will be making will be the better use of technology and modernisation of care.

Primary care will exploit new technology to increase the number of appointments available online, ensure a seamless journey for the patient from 111 to out of hours and primary care, promote wellness and self-care and ensure that clinical time is focussed and available for patients who need it most by the deployment of efficient triage and signposting methods. These changes will enable us to provide easier and more convenient ways for people to get the care they need.

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2 Vision

Our system leaders across the Norfolk and Waveney Sustainability and Transformation Partnership (STP) and Norfolk and Suffolk County Council's Health and Wellbeing Boards have a shared commitment to supporting people to be healthy, independent and resilient throughout life and when help is needed to offer it early to prevent and reduce demand for specialist services.

We want to empower people to understand and manage their health and wellbeing through coordinated care and support networks and improve population health and wellbeing in the longer term throughout Norfolk and Waveney. As far as possible we want people to be able to manage their health and wellbeing where they live in their homes and communities and this means tackling structural deficits and health inequalities to improve healthy life.

As a system we have set out a series of vision statements to help shape our health and care services for our population. We aim to communicate and adapt this vision further over the coming months.

- Together we will build **healthier communities** in Norfolk and Waveney
- We will provide **high quality and responsive** health and care services for Norfolk & Waveney. We will be there for our people when they are vulnerable, regardless of age or ailment
- We will make it easier for people to **access our services** to enable people to lead happy and healthier lives
- Working in partnership we will provide **sustainable services** through an empowered workforce

The NHS Long Term Plan describes a triple aim of better health for everyone, better care for patients, and sustainability, both for the local NHS system and for the wider NHS. This requires transformation of our health services and removing organisational barriers to integrated patient-centred health care with seamless efficient care pathways working across primary, community and secondary care services. Even this on its own, however, cannot achieve these aims. This will require breaking down organisational boundaries and rearranging services around individuals where they live. This will include services which target the root causes of poor health and promote the health of the whole individual, not just treating single acute illnesses. We want to deliver a quadruple aim through our strategy which will also increase staff joy and meaning in service delivery in order to improve integration of services, culture and recruitment and retention of staff. General practice will provide the foundations at the centre of our Primary Care Networks (PCNs) and strengthening these services will be a key focus for our system.

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We have created 17 Primary Care Networks (PCNs) in Norfolk and Waveney which will see primary, community, social care, mental health teams, pharmacy, public health and the voluntary sector working together to provide coordinated, joined up care for patients. Every single practice has signed up to the new Directed Enhanced Service (DES) contract and is part of a Primary Care Network.

Our approach to developing PCNs is wholly aligned with the NHS Long Term Plan and provides the building blocks for an integrated care system (ICS) for Norfolk and Waveney.

Our vision for PCNs and community services is that:

We will **empower people** to understand and manage their health and wellbeing through **coordinated care and support networks** and **improve population health and wellbeing** in the longer term throughout Norfolk and Waveney.

In developing our PCNs, we will improve the resilience of general practice and deliver the General Practice Forward View (GPFV) and will shift our focus to prevention and proactive care as an enabler to improve outcomes for our populations and ensure the resilience and sustainability of services for the future.

We can only achieve our ambition for PCNs with a solid foundation in General Practice. We know GPs and General Practice continue to face growing pressures due to the changing needs of our population and workforce and workload challenges. We continue to work closely with wider partners, including the five GP Provider Organisations (GPPOs) in Norfolk and Waveney, to develop ways to address these issues.

We will build on the good progress already made in establishing Place level leadership through the five clinically led Local Delivery Groups to drive the development of our PCNs across our STP. Our Place level governance will be complemented by new senior CCG locality director roles with additional senior roles dedicated to supporting the development of our PCNs in conjunction with our partners' Place-based leadership.

Our service provision will be driven by a thorough understanding of population health and wellbeing and we will therefore continue to develop a robust population health management capability developing a range of tools to enable segmentation and risk management of all registered patients.

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3 Introduction

Norfolk and Waveney STP is a partnership of local health and care organisations working together to build healthier communities. We provide services to more than a million people. Norfolk and Waveney STP's priorities are as follows:

- Preventing illness and promoting well-being– supporting people to live longer, healthier lives by targeting lifestyle risk factors. Aligning community services with local authorities and the third sector, supporting people to live independently;
- Care closer to home – people living independently with better access to primary, and secondary care, as well as the third sector, thereby reducing demand on hospital and residential services;
- Integrated working across physical, social and mental health, delivering holistic care, improved patient experience and better outcomes. Services focusing on social care and mental health parity of esteem;
- Developing sustainable hospital services;
- Delivering cost-effective, high quality services within the funds available;

3.1 A map of the area indicating the main areas of population

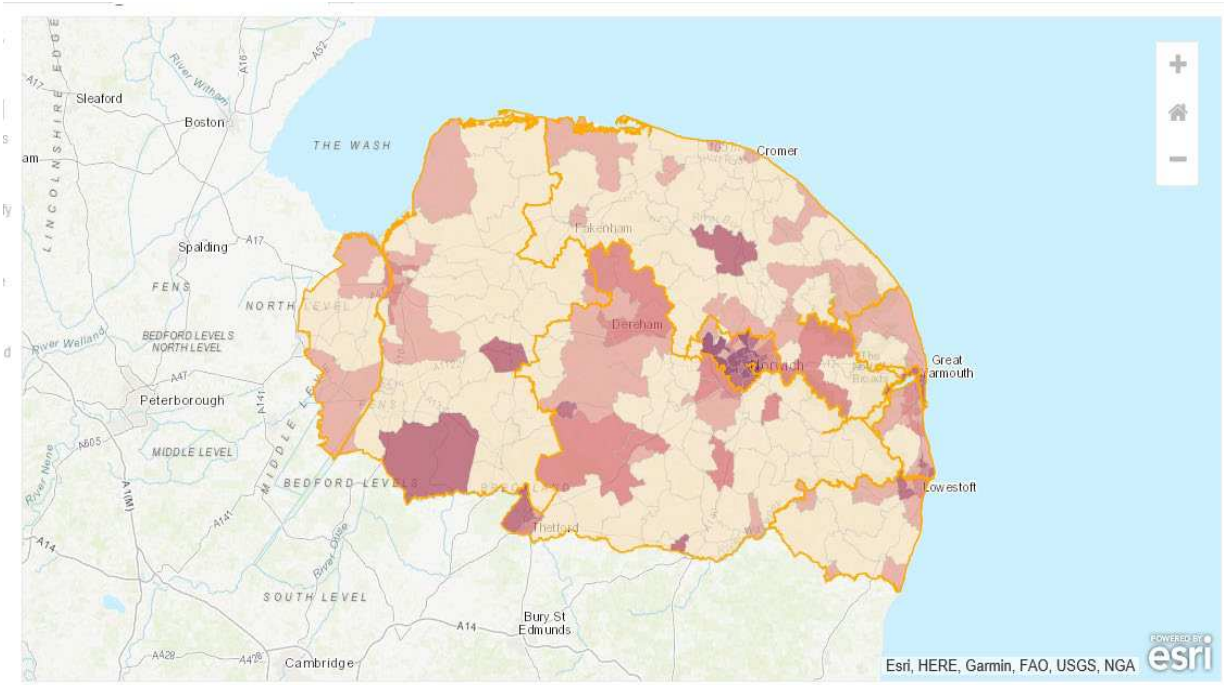

Figure 1: Map of area indicating main areas of population. Source: https://www.norfolkinsight.org.uk/population/map/Source: https://www.norfolkinsight.org.uk/population/map/

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3.2 Population covered by Norfolk and Waveney STP

The resident population of Norfolk and Waveney is estimated to be 1,016,287 (ONS, 2017) and the population registered with General Practices in Norfolk and Waveney STP was 1,059,363 (approximately 43,000 more) in January 2019.[1]

Figure 2: Population figures for Norfolk and Waveney at a glance

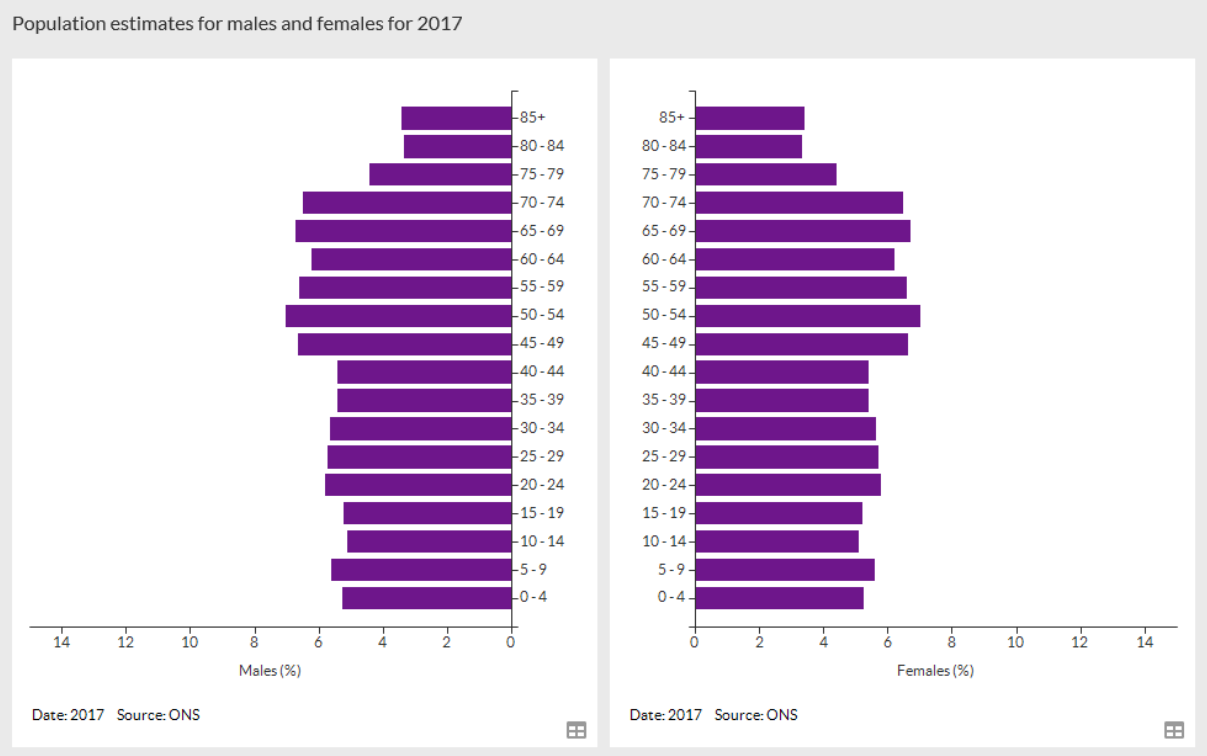

Figure 3: Population estimates for males and females for 2017:

Source: Norfolk Insight: Norfolk and Waveney STP Population estimates ONS 2017
https://www.norfolkinsight.org.uk/population/report/view/d6fbe2869a3f4dcfbdaeca5c52deae12/E54000022

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3.3 The main NHS organisations, local authorities and third sector organisations

The following is a list of the main NHS organisations, local authorities and third sector (infrastructure organisations) covered by Norfolk and Waveney STP.

- NHS North Norfolk CCG
- NHS West Norfolk CCG
- NHS Norwich CCG
- NHS South Norfolk CCG
- NHS Great Yarmouth & Waveney CCG
- Norfolk & Norwich University Hospitals NHS Foundation Trust
- The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- James Paget University Hospitals NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- East Coast Community Healthcare CIC
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk County Council
- Suffolk County Council
- Breckland District Council
- Broadland District Council
- Great Yarmouth Borough Council
- King's Lynn & West Norfolk Borough Council
- North Norfolk District Council
- Norwich City Council
- South Norfolk District Council
- East Suffolk Council
- East of England Ambulance Services NHS Trust
- OneNorwich and Norwich Practices Limited
- Coastal Health GP Provider Organisation
- North Norfolk Primary Care
- South Norfolk Healthcare
- West Norfolk Health
- Norfolk Independent Care
- Integrated Care 24 NHS
- Arden and Gem CSU
- Community Action Norfolk
- Community Action Suffolk

[1] Source: NHS Digital https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/january-2019

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- Voluntary Norfolk
- Healthwatch Norfolk
- Healthwatch Suffolk

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The map below illustrates Norfolk and Waveney's health and care organisations at a glance.

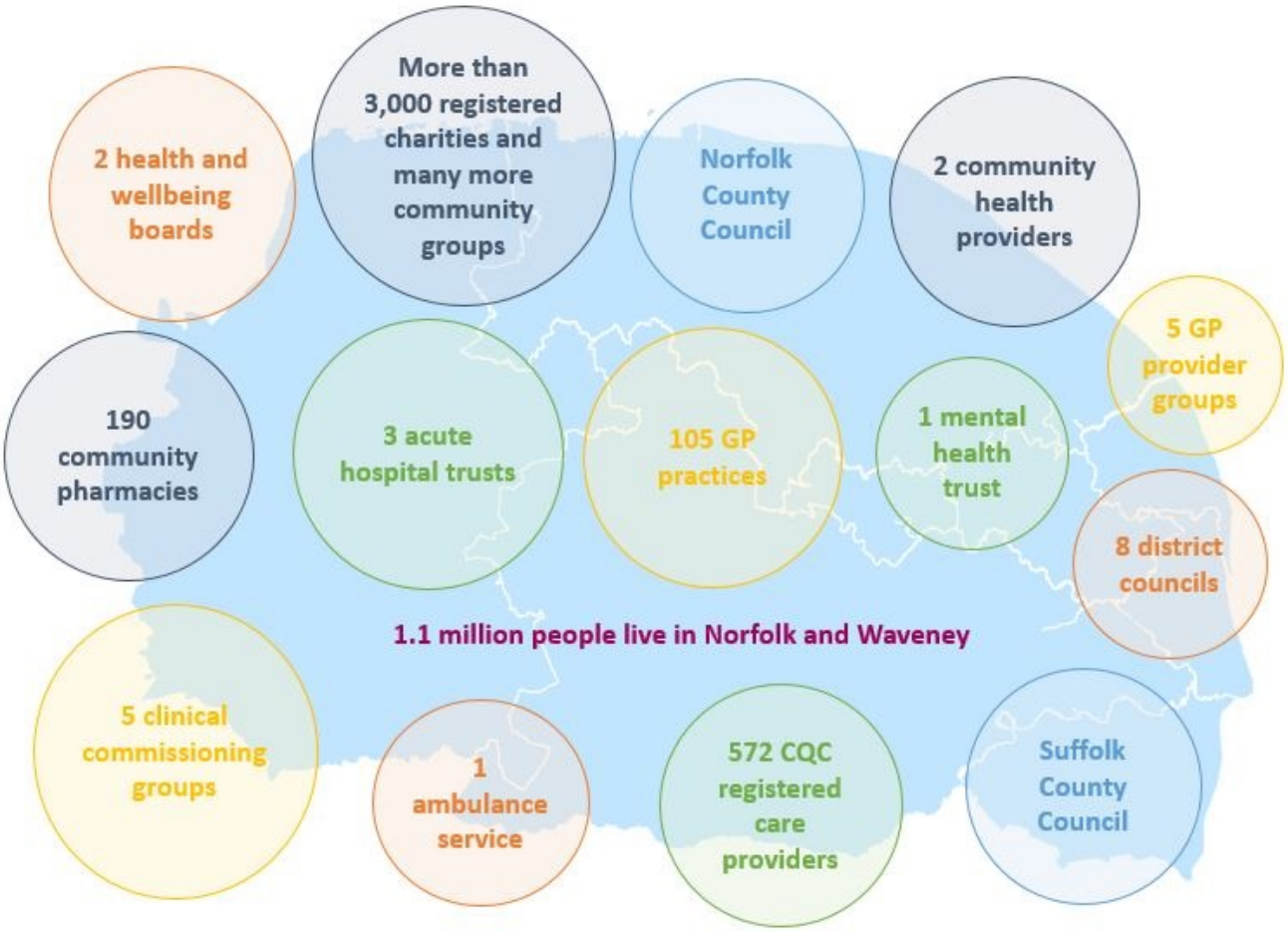

Figure 4: Norfolk and Waveney's health and care organisations at a glance

3.4 Our GP provider organisations and number of practices

There are five GP provider organisations (GPPOs) in Norfolk and Waveney, one in each Place (CCG area), and 105 GP practices. The GPPOs have been commissioned to support the development and delivery of PCNs to meet the national GP contract deadlines and to further support the development of our integrated care system.

3.5 A list of local Primary Care Networks

There are 17 PCNs in Norfolk and Waveney, four in each CCG with the exception of Norwich which has formed a single city PCN with four sub-neighbourhoods. Each PCN has a clinical director, including Norwich which will also be supported by a clinical lead in each sub-neighbourhood.

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A map of Norfolk and Waveney's PCNs can be seen below:

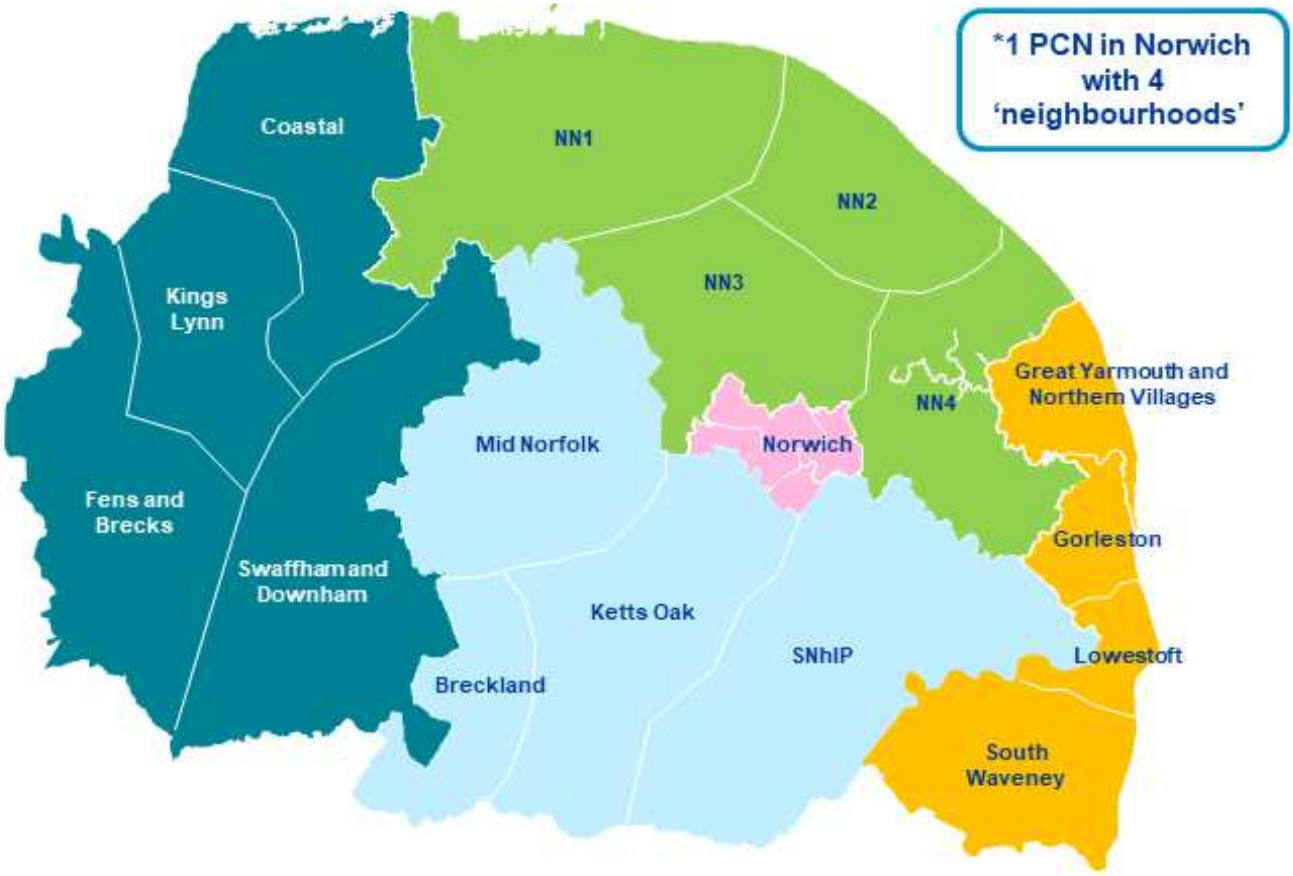

Figure 5: A map of Norfolk and Waveney's Primary Care Networks

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Details of our PCNs and constituent practices are set out below:

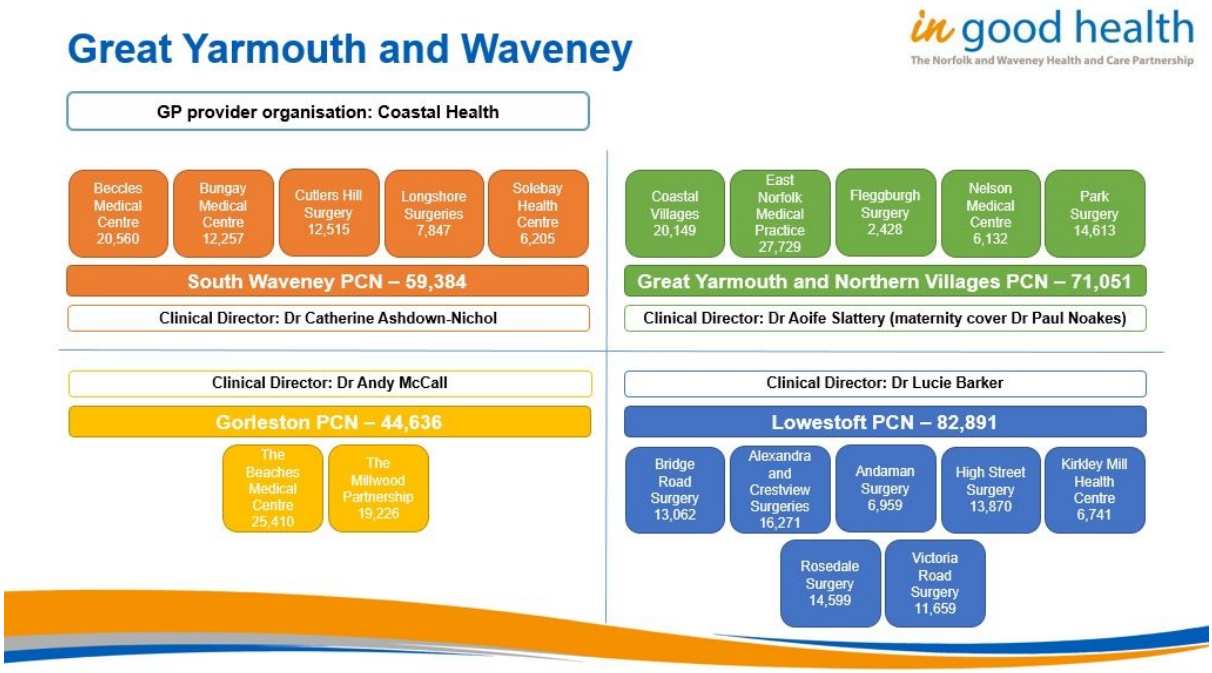

Figure 6: Great Yarmouth and Waveney PCN

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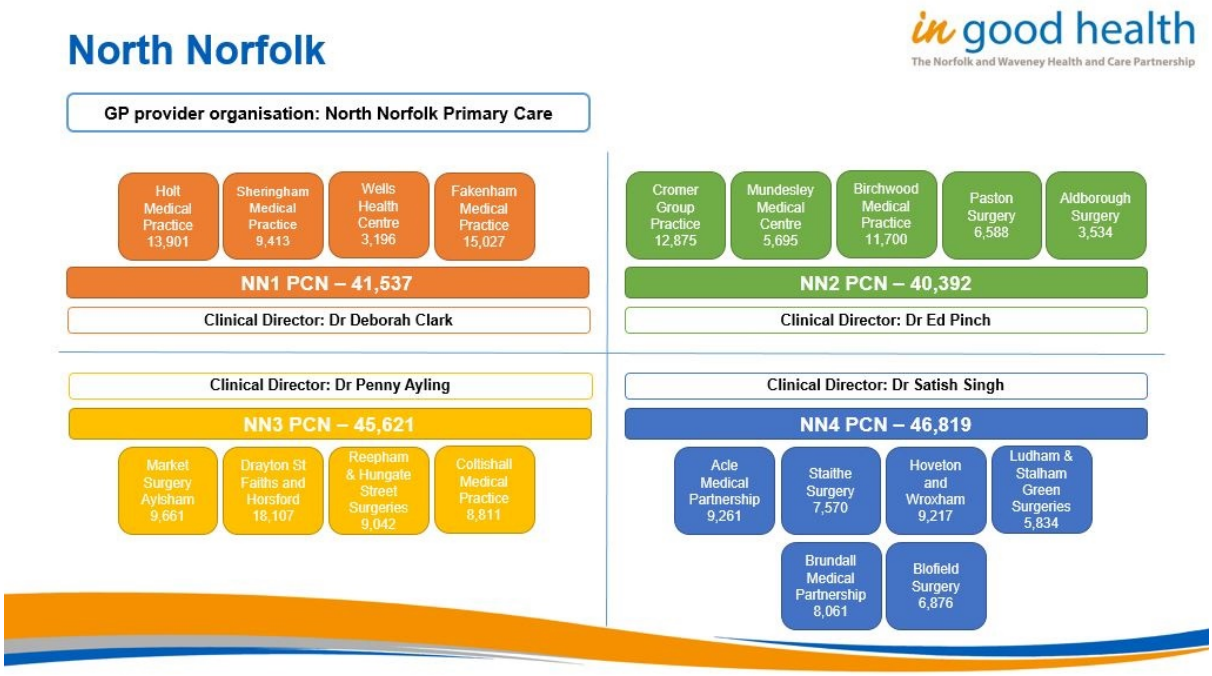

Figure 7: North Norfolk PCN

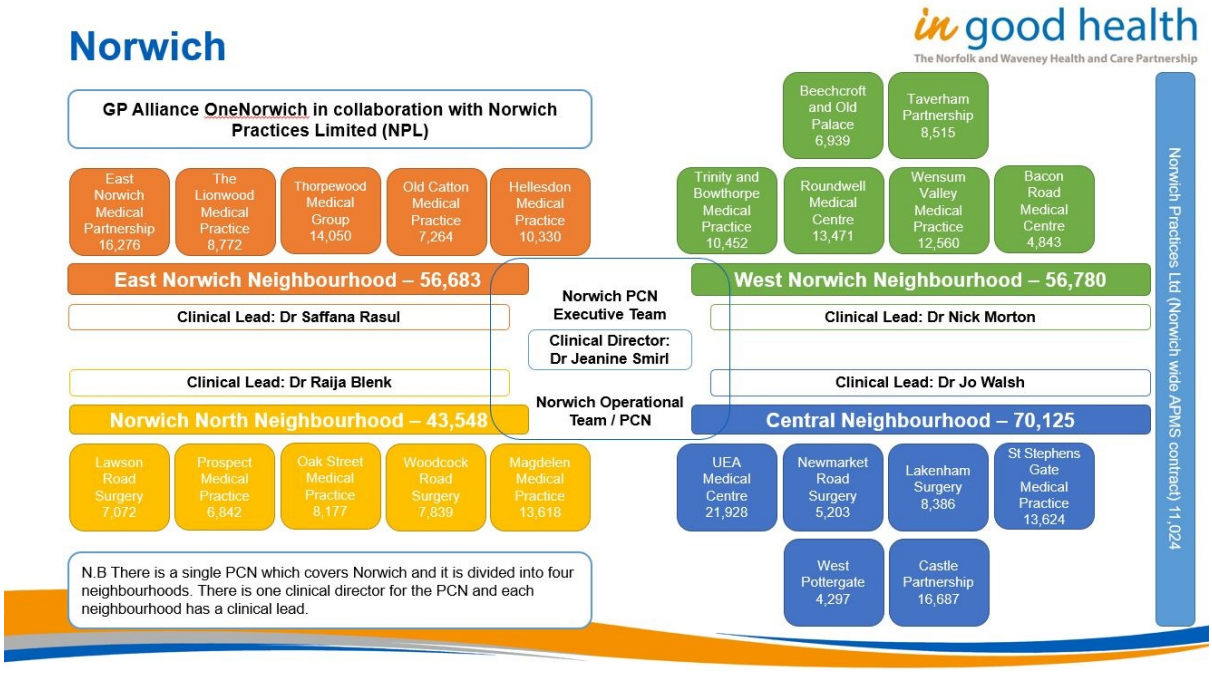

Figure 8: Norwich PCN

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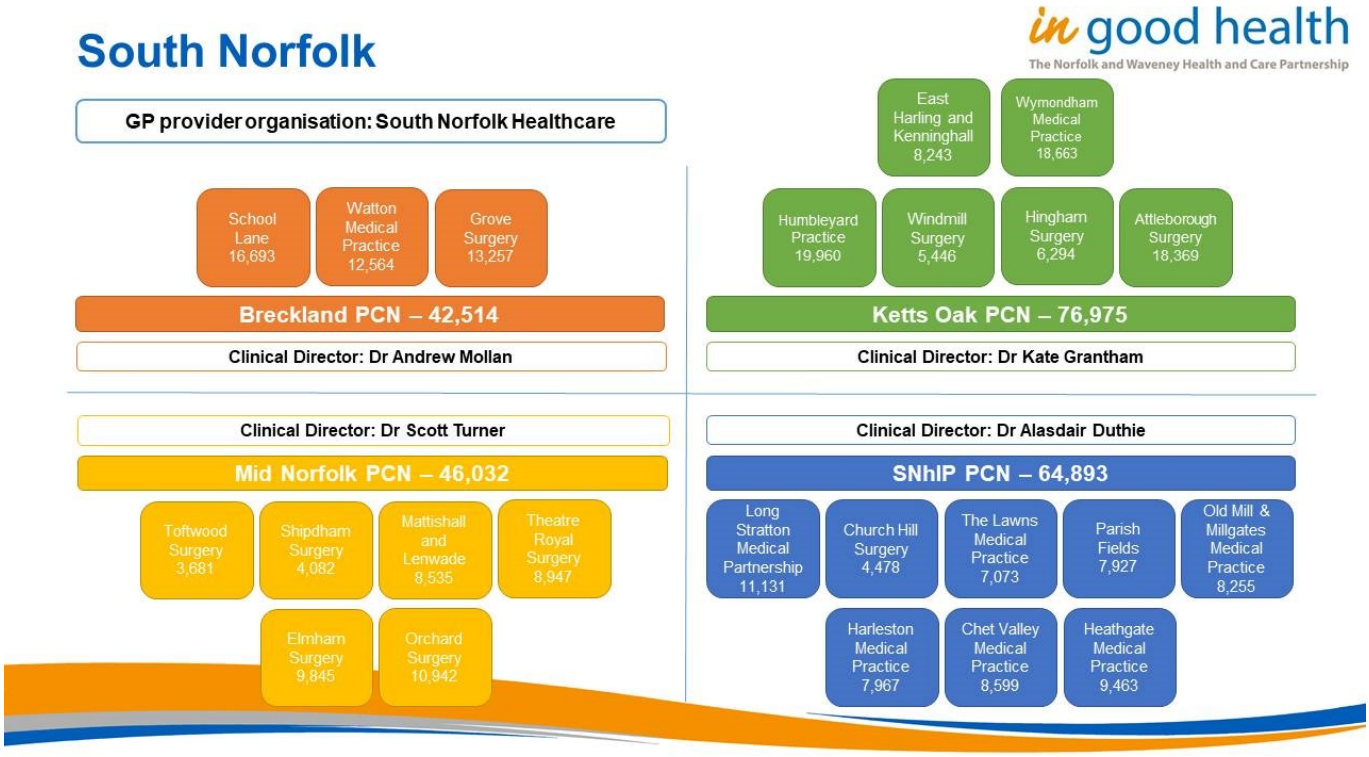

Figure 9: South Norfolk PCN

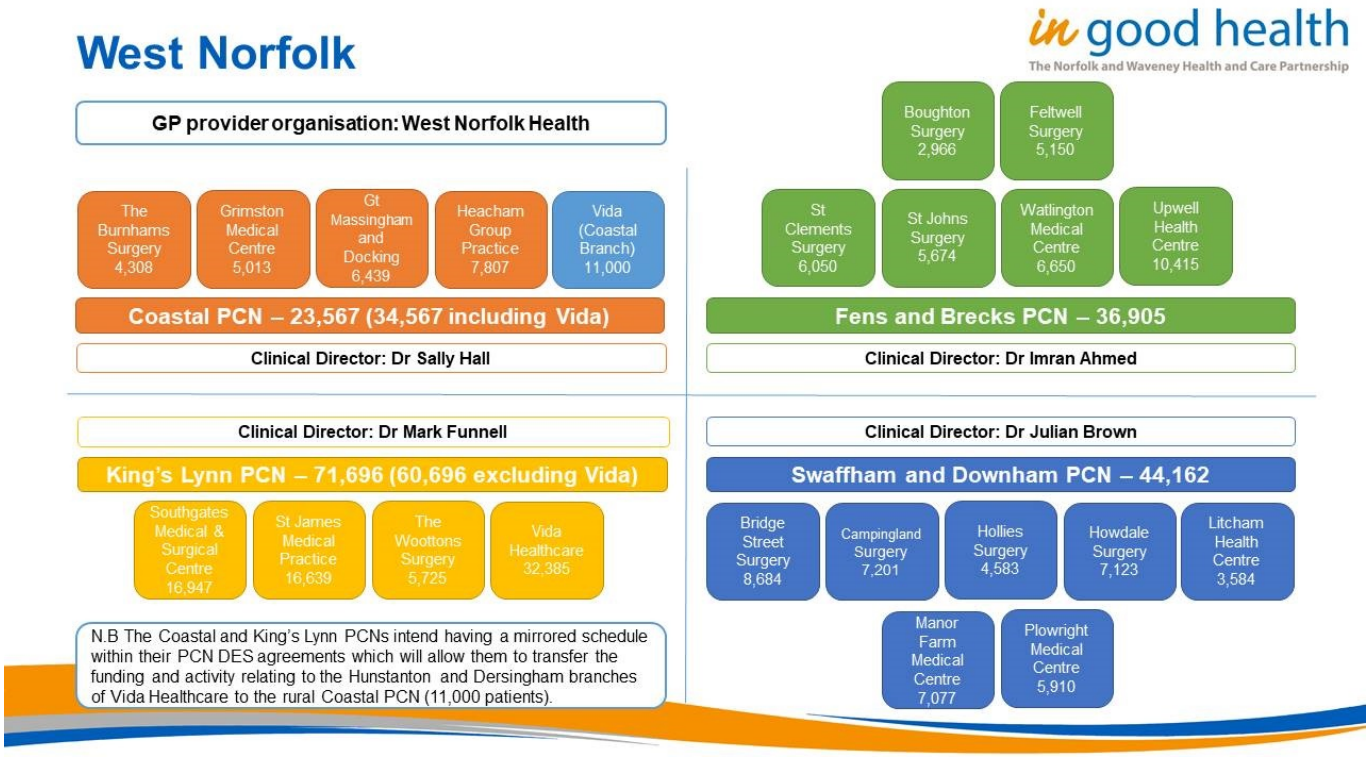

Figure 10: West Norfolk PCN

3.6 Key general practice workforce statistics

Mirroring the national picture, the biggest challenges facing GP practices in Norfolk and Waveney are workforce (recruiting and retaining staff), increasing demand for services and access.

As at 31 March 2019, Norfolk and Waveney STP general workforce statistics are as follows:

	GPs	Nurses	Direct Patient Care	Admin/Non-Clinical
Norfolk and Waveney STP	**737**	**567**	**630**	**1982**
NHS Great Yarmouth and Waveney CCG	144	130	98	439
NHS North Norfolk CCG	137	115	172	407
NHS Norwich CCG	164	89	59	327
NHS South Norfolk CCG	170	126	149	420
NHS West Norfolk CCG	134	109	152	390

Table 1: Key general practice workforce statistics. Further information can be found at: https://digital.nhs.uk/data-and-information/areas-of-interest/workforce/workforce-minimum-data-set-wmds

These figures do not contain workforce information on primary care staff providing services at prisons, army bases, educational establishments, specialist care centres including drug rehabilitation centres and walk-in centres. However, work is ongoing to build an understanding of primary care staff in these alternative settings.

3.7 Key budgetary numbers

A breakdown of primary care budgets in Norfolk and Waveney for 2019/20 is provided below. This is regularly monitored and reported through individual primary care commissioning committees in each of the five CCGs.

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Delegated co-commissioning	£m
Contractual (global sum MPIG etc)	103.7
Enhanced services	4.3
Other - GP Services (dispensing, locum fees etc)	13.4
Premises cost reimbursements	14.6
QOF	15.2
New PCN staff & funding	3.7
PMS to GMS release	4.1
Total Delegated Planned Spend	**158.9**

Other Primary Care	£m
Prescribing	166.3
Improved Access	6.4
Locally Commissioned Services	8.5
£1.50 per head PCN development	1.6
GPFV (Workforce, online consultation etc)	2.6
GPIT (core business as usual spend)	4.0
Total Planned Spend	**189.3**

Table 11: Breakdown of primary care budgets in Norfolk and Waveney for 2019/20

4 The case for change

4.1 Our population and the impact of anticipated demographic changes

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Our population in Norfolk and Waveney is generally older than the rest of England and it is projected to increase at a greater rate, which creates a challenge for the health and care system. Almost all of the population increase over the last five years has been in the over 65 age groups and we anticipate the largest increase between 2014 and 2025 to be in those aged 65 and over.

These changes will increase the need for health and social care support as multi-morbidity, frailty and risk of emergency admissions increase with age, which will impact on primary and community care provision. This means that due to age alone between 2014 and 2025, we will see about **9,000** additional people with **diabetes**, more than **12,000** additional people with **CHD**, more than **5000** additional people who have suffered a **stroke** and almost 7**000** additional people with **dementia** (ref: local modelling, Public Health Information Team).

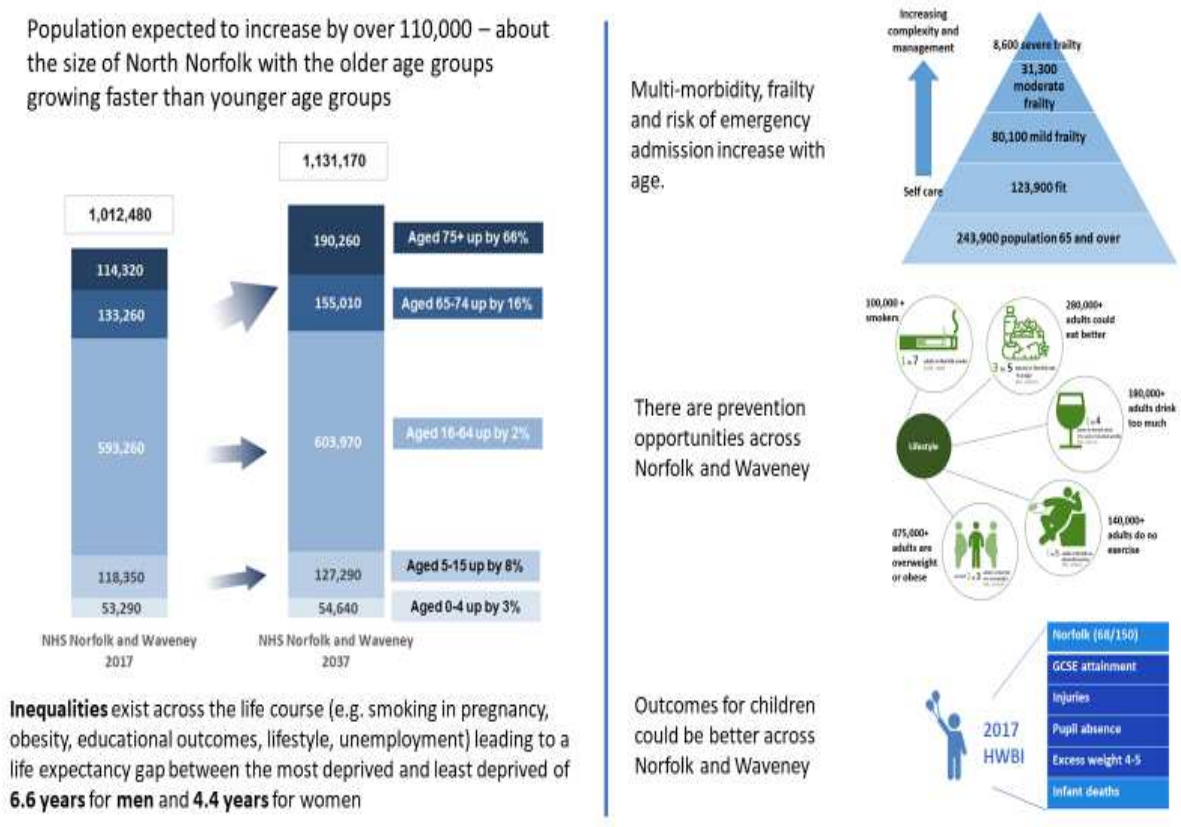

Figure 11: Anticipated demographic change and opportunities to improve outcomes in Norfolk and Waveney. Source Population change: ONS population projections (https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2016basedprojections)

Our System does not always deliver the joined-up care that people need to help them with the daily challenges they face living with multiple long-term conditions. Our services are also faced with responding to illnesses associated with the more sedentary lifestyles many of us now have. The impact of smoking-related illness has fallen as fewer people smoke, but the long-term impact of obesity and the increase in disease related to this, such as diabetes, continues to grow.

For example, by 2020 based on current trends and forecasts, obesity will be responsible for more than 7,000 people with heart disease, 100,000 people with hypertension and 50,000 people with diabetes. All of these conditions are likely to increase the risk of acute care.[2]

The diagram below illustrates the predicted growth in demand for hospital services.

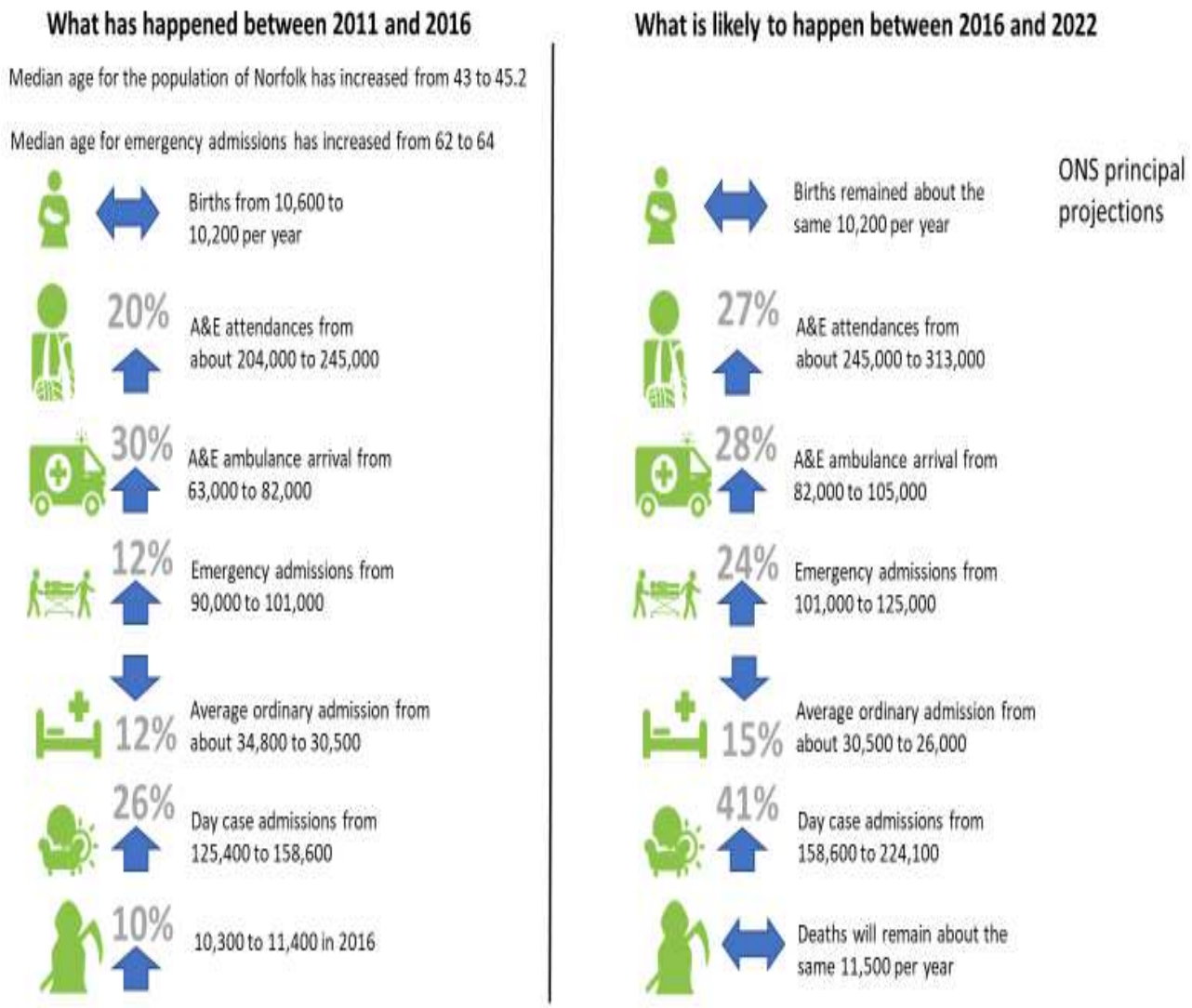

Figure 12: Diagram illustrating predicted growth in demand for hospital services. Source ONS principal projections

Overall Norfolk and Waveney is a relatively healthy and safe place to live, with life expectancy for men and women slightly above the national average. However, there are areas of significant deprivation particularly in parts of Norwich, Great Yarmouth, Lowestoft, Thetford and King's Lynn. There are also significant pockets of deprivation in rural areas, particularly in the Brecks and the Fens, in coastal villages and market towns. In 2015 more than **150,000** people in Norfolk and Waveney lived in areas categorised as the **most deprived 20%** in England. This has a significant impact on health, wellbeing and life expectancy.[3]

Inequalities exist over the life course (e.g. smoking in pregnancy, obesity, educational outcomes, lifestyles, unemployment) and life expectancy is lower in more deprived areas. In our STP there is nearly 14 years difference in life expectancy for women (between 77.7 years in areas of West Norfolk to 91.3 years in areas of Broadland) and just over 12 years difference for men (71.9 years in areas of Great Yarmouth to 84 years in areas of South Norfolk).[4] In the most deprived 10% of areas of Norfolk life expectancy for women has declined from 81.2 to 79.9 years between 2010-12 and 2014-16. Over the same period for men life expectancy has increased from 74.7 to 75.1 years.[5]

The reasons for such differences in life expectancy associated with deprivation are higher rates of cancer, respiratory disease and heart disease. In men we also see higher numbers of deaths linked to external causes such as trauma. We have estimated that if the most deprived areas experienced the same rates as the rest of Norfolk and Waveney then each year more than **400** more children would be of healthy weight, there would be **1000** fewer emergency admissions for older people and there would be **60** fewer deaths due to preventable causes. Some of the smaller areas of rural deprivation that exist across Norfolk and Waveney make delivery of services more challenging and reduce accessibility.

4.2 Workforce challenges in Norfolk and Waveney

We aren't just faced with an increase in demand for our services. Like many other parts of the country, Norfolk and Waveney also faces challenges in recruiting appropriately qualified staff across health and social care services, with vacancies in a variety of jobs, from consultants to care assistants.

A significant number of experienced staff will reach retirement age in the next few years. Unless we change how staff are deployed and jobs are designed, it will not be possible to continue to provide the same quality of service to our population.

Our system faces a number of workforce challenges:

- General practice has difficulties recruiting GPs due to higher retirements and lower local training fill rates

[2] *Public Health Information Team and https://fingertips.phe.org.uk/profile-group/cardiovascular-disease-diabetes-kidney-disease)*

[3] *Ref: ONS 2017 mid-year LSOA population estimates https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates*

[4] *Ref: www.localhealth.org.uk (for the period 2013-2017)*

[5] *Ref: https://public.tableau.com/profile/population.health.beta#!/vizhome/InequalityinlifeexpectancydashboardDev/SIIv2Story*

- Social care is facing recruitment problems, especially in domiciliary care where 12% of posts are vacant and there is a shortfall of registered nurses
- NHS vacancies are increasing – currently 8.9%, including over 500 nursing and 200 medical posts
- Nursing and medical workforce supply shortages are predicted to continue over the next 5 years based on current service and supply models
- We have an ageing workforce, imminent retirements and loss of experienced staff and clinical leadership as staff retire with limited succession planning
- Medical retirement hotspots over the same time period: Psychiatry (30%), Obstetrics & Gynaecology (27%) and Medicine (19%) Consultants and GPs (23%)
- Shrinking pool of potential young employees with different expectations ("Generation Z"). The number of 15-24 year olds is predicted to reduce by -4% over 5 years, whilst the total population is expected to grow by + 3%
- There is a need to use the workforce more effectively to deliver savings, review skill-mix to bridge supply gaps and clarify future service delivery models and join up plans
- We have previously had a fragmented approach to workforce development across health and social care. There is a need to join up conversations around apprenticeships across the system
- Norfolk and Waveney STP also has particular challenges around the mental health workforce, with significant challenges around retention of staff and recruitment in a trust in special measures

4.3 Current and anticipated challenges to the delivery of primary care services

In Norfolk and Waveney we have a good understanding of the current and anticipated challenges to the delivery of primary care following a Demand and Capacity Review, published in 2019.

The review, which can be found in appendix 3, concluded that our STP has key challenges:

- A growing and ageing population
- Primary care working to capacity, with a shrinking GP workforce
- Acute inpatient bed capacity cannot meet demand
- Community services cannot meet demand from acutes
- Social care and home care capacity is not keeping up with demand
- The system has significant financial challenges

We also understand the resilience challenges facing general practice in our STP. Our work needs to support the resilience and sustainability of general practice. Of our e have one practice rated inadequate by the CQC and in special measures and four more rated as requires improvement. Significant numbers of general practice find themselves with fewer partners with

increasing numbers of GPs wanting to work more flexibly which doesn't always fit within a traditional partnership model.

Whilst these challenges were not unknown to us, the review has helped to quantify them so that we understand more about the scale of the challenges facing us, the causes and some potential solutions.

The recommendations are consistent with the work we have been doing over the past two years to integrate services, provide care closer to home and to develop PCNs. To consider ways to address and meet these challenges, we have established a Demand and Capacity workstream to take forward the findings from the review to develop system-wide short, medium and long term plans.

An important element of this work will centre on strategic estate planning across General Practice, which is essential to provide the change and integration required to enable the delivery of patient centred care closer to home. This is being led by the STP Estates workstream which also has a strategic primary care estates sub-group. A structured and targeted approach is vital to:

- Improve the ability to meet the increasing population growth and capacity required for the provision of primary care services
- Integrate service provision with community and acute service providers and deliver new service models
- Increase efficiencies , through the better use of high quality primary and community shared estate
- Support the development of primary care at scale
- Improve service resilience at a local and system level

With 17 PCNs in place across Norfolk and Waveney the estates strategy for primary care needs to incorporate their varied requirements and plan to provide the capacity required in the most effective way, with best value for space to enable the delivery of high quality services.

To enable all of the above the Norfolk and Waveney System is investing in estates expertise and individual pieces of work to ascertain:

- Current capacity in the local general practice sites
- Condition surveys to allow an overview of the potential risk of cost to the system if buildings are not maintained
- Schedules of accommodation
- Parking and wider travel arrangements

- Percentages of clinical, support and ancillary accommodation
- Commentary on building fabric, including observations on mechanical and electrical services
- Tenure / leases / ownership / notional rent position
- RAG style ratings for compliance with premises clinical standards, including infection control, fire safety, accessibility, clinical waste
- Soft/hard facilities management contracting position

This work will allow the System to have a clear view of the current state of general practice estate as part of our whole estate and to allow the ICS to make informed decisions and prioritise new builds or refurbishment of existing premises.

4.4 Key funding issues facing the health economy

The Norfolk and Waveney STP finished the 2018/19 financial year with a combined deficit of £98m. The vast majority of this deficit was incurred at our acute hospitals. Before any regulator sustainability funding, the combined 2019/20 financial plan for the STP is an £86m deficit, which includes the delivery of £113m of efficiencies schemes. The deficit again will sit primarily with the acute providers.

Even if the regulator sustainability payments are triggered, the STP still has a considerable financial gap of £11m that needs to be closed before the combined control can be achieved. In order to close the gap the STP financial steering group has taken ownership of the challenge and has identified some high level opportunities to deliver the necessary efficiencies.

In addition to the financial pressures, there has been a significant number of operational pressures, including:

- An annual increase of 7% in A&E attendances (of the total A&E attendances 40%, or 105,000 are for ‘minor’ conditions) and an annual increase of 5% in emergency admissions
- Consistent failure of the 4 hour A&E target across our three acute hospitals
- An historic waiting list high of >40,000 patients at the largest acute provider in the STP
- Consistent failure of the 18 weeks RTT target
- Significant clinical variation across the STP including variable performance at an acute hospital level for cancer targets and a wide range of dementia diagnosis rates across practices and the CCGs

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It is very clear from both the financial challenge and the performance pressures above that the historic methods of patient flow, efficiency schemes developed in isolation and organisational barriers must be transformed.
In order to meet the increasing and changing demand, the STP must look to new ways of working, which facilitate:

- Joined up care for patients
- Earlier intervention to avoid health issue escalations
- Improved transfer of cares times
- Sharing of optimal clinical decision making and expertise

To transform care in Norfolk and Waveney and to meet the requirements set out in the GPFV and the Long Term Plan, the STP has invested heavily in the formation of GPPOs as part of the £3 per head transformation in 2017/18 and 2018/19 and will further support the development of PCNs via the £1.50 per head funding and the £1.76 per head practice engagement funding in 2019/20. In addition to this, further funding has been included in community provider contracts to assist with the establishment of PCNs. Individual CCGs are also providing support for the devolvement of specific deliverables to meet the nuances of their local population.

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5 Fulfilling the NHS Long Term Plan

5.1 How we intend to fulfil the ambitions of the NHS Long Term Plan for primary Care

Primary Care in Norfolk and Waveney is ready to take on the challenge of delivering the Long Term Plan. Our 105 GP practices serve a wide demography in both rural and urban environments. Our Places deliver services for some of the most condensed elderly populations seen nationally and we also have areas with high deprivation.

By 15 May 2019 all general practices had indicated preference to join and be an active member of a PCN and the creation of GPPOs at each Place level has supported more cohesive primary care input to the system and the wider STP. Our five Local Delivery Groups (LDG) are developing work programmes that align to the Long Term Plan and local system initiatives. We place strong emphasis on clinical leadership in our system and this is demonstrated through our STP governance with GPPO representation on all key STP groups and the creation of our new Clinical and Care Reference Group bringing together clinical leaders from across the system. We have developed strong working relationships with Norfolk and Waveney Local Medical Committee as the statutory representative body for general practice and we have committed to engage with them formally through a memorandum of understanding. The LMC also form part of the membership of our Primary Care Commissioning Committees.

Work is now progressing at pace across the STP as plans develop at a PCN and Place level and examples are described in each of the following sections. The STP workstreams are driving the system work forward as we progress to forming an ICS. Relationships and a willingness to support one another is a bedrock of how we are developing our cultures and working practices to meet the demands that are placed on our system.

Developing integrated work plans for PCNs are expected to be underpinned by shared principles and locally agreed priorities. Local Delivery Groups, under the STP Primary and Community Care workstream are the natural home for robust, data-driven discussions to agree underpinning values at Place level and are a forum where there is strong representation from general practice through GPPOs and in the future, clinical directors. Network plans will naturally be aligned to both Place and ICS ambitions whilst reflecting local nuances and ownership from the ground up. PCN plans, which are in their infancy, will continue to develop as local partnerships evolve but there is already a clear commitment to working collaboratively together.

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The five CCGs in Norfolk and Waveney are currently undertaking a management restructure. A single executive and senior leadership team will be in place by mid-July and it is anticipated that the new single management structure for the five clinical commissioning groups will support this approach. The structure will bring new locality directors and PCN delivery associate directors, along with their teams, focused on Place level outcomes and development of PCNs. These posts will be ideally placed to facilitate new models of care which support primary care resilience, address local needs and are aligned to ICS ambitions. Shared principles, brought together under the ICS umbrella and driven by PCNs will support the five GPPOs in galvanising general practice to develop new ways of working which are sustainable in the longer term through access to specialist resource and supporting their ethos of a shared purpose and culture at different levels of the system.

We will deliver a system that fully supports identified patient needs with community services wrapping around local populations, using existing resources innovatively and GPPOs, through their membership have the commitment and system relationships to develop and implement a better future.

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6 Key element 1 - We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services

6.1 Summary of the current situation

As a System we have already made good progress towards the twin goals of increasing capability and capacity to support more people in the community and breaking down the divide between primary and community health services.

We have a good understanding of our capacity gaps following our review into Demand and Capacity, published in 2019, as set out in the previous chapter – Case for Change. We know there is already a shortfall of around 9% in GP appointments across the STP and as demand rises and our GP workforce declines, this is projected to worsen if nothing is done. We know there is currently minimal capacity in our A&E departments, community services and social care, however we know with our predicted demand in a do-nothing scenario, we are predicting capacity gaps of between 18% and 24% in our A&E departments, around 7% in our community services, 12% in community beds and 5% in social care by 2023/24. Our focus on demand and capacity is at system level and Local Delivery Groups and STP workstreams are accountable for their part in delivering the transformation needed to provide high quality, integrated services which are sustainable for the future.

General practice is the foundation of our developing PCNs and our ICS, and we use the term 'primary care' to represent all professionals and teams supporting people in the community. We recognise the importance of prevention and our ambition for prevention is in line with the NHS Long term plan to support people to live longer healthier lives through helping them make healthier lifestyle choices and treating avoidable illness early on.

Our integrated approach to prevention is to focus on actions that are evidence-based and will have the biggest impact for our population, targeting and supporting those most at risk, to reduce health inequalities and to reduce the demand for health and social care services. Wellbeing and preventative services, including social work, social care, public health, housing and a wide range of community provided wellbeing services from local authorities and the voluntary and community sectors are key to realising an effective prevention offer into the PCNs.

Our five Local Delivery Groups have already brought together this broader group of providers and key stakeholders which is accelerating the development of new relationships between all of our "out of hospital" provision and we had already begun to join up these emerging networks as early adopters of social prescribing.

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The Norwich Community Fully Integrated Care & Support service (CFICS) is an excellent example of enabling access to a wide range of community based services through Integrated Care Coordinators. The coordinators organise monthly practice based multi-disciplinary team meetings which help to identify people with complex or chronic conditions and link them to a wide range of providers that are able to meet health and wellbeing needs, enabling the person to continue to live as independently as possible at home.

There are other examples of boosting community based capacity and capability through a range of initiatives including:

- Virtual wards (Norwich and West Norfolk)
- Supported care (North and South Norfolk)
- Palliative care advice line (24hour)
- Care at home teams (West Norfolk)

In Great Yarmouth and Waveney, the new adult community services contract which commenced on 1 April 2019 has an emphasis on integrating services through PCNs along the Primary Care Home model and in improving the resilience of general practice.

We have established home and accommodation-based reablement services across Norfolk and Waveney which work closely with health services and other providers. The vast majority of people receive these services within two days of referral and our ambition is to further develop and join up these services.

We have already developed an Enhanced Health in Care Homes (EHCH) programme which has strengthened care quality in a number of our care homes and builds on locally commissioned services from general practice. We will fully develop the programme so that it builds on the PCN DES and is fully rolled out to all care homes by 2021.

6.2 Description of how services will be integrated

There is a history of joint working across Norfolk and Waveney, which provides strong foundations for development of a collaborative community provider model, and progress has already been made in co-producing this. In addition, the four main organisations providing adult community services (Adult Social Care Norfolk and Suffolk County Councils, Norfolk Community Health and Care and East Coast Community Healthcare) have already clustered their operational teams around our PCNs.

Our community-based providers will work within PCNs to develop their integrated service models over the coming months using population health data to ensure that services are aligned to meet the needs of local communities. We will learn from our own innovations and

what has delivered impact elsewhere in the country, for example through the Vanguards, and we will explore how this can be implemented in Norfolk and Waveney.

We know that continuity of care improves outcomes for patients and through our work on population segmentation, we will pilot new approaches to managing patients in primary care. We will support PCNs to roll out successful ways of working once pilots have been completed. This will focus the skills of our general practice workforce where they can make the most difference to patient outcomes. For example the 5% of a practice list that have the most complex needs with more than five long term conditions will always see a GP in a longer appointment, whereas the 25% of a practice list who have no long term conditions will usually see a paramedic, physician associate or nurse when presenting with an urgent need. In their PCNs, community providers will also build on how they respond to population segmentation in the same way.

The STP mental health workstream is progressing the development of a new model of care with Norfolk and Suffolk Foundation Trust, aligned with PCNs. This is in line with our Norfolk and Waveney mental health strategy published earlier this year.

We are creating multi-disciplinary mental health teams to deliver better support and services to meet the multiple needs of PCN populations, the exact composition of which is still to be confirmed. We will test elements of the mental health model from October 2019 with the expectation that this will be rolled out to all PCNs within six months.

Work is ongoing to explore how best to ensure that both community based physical and mental health can work together with social services to become fully integrated at Neighbourhood, Place and System level. We want to ensure that we develop the best possible arrangements through a co-productive process with clinical directors and senior provider leads which we will agree within the development year for roll out thereafter. The process will include some piloting of early ideas shortly after the PCNs go live on 1 July.

In addition to supporting practices to implement the ten High Impact Actions, we will boost capacity in primary and community care through our prevention strategy which has four key strands:

Healthy Lifestyles in Communities

We will do this by:

- Developing key interventions at points where service users may be most motivated to change e.g. smoking quitting advice and support
- Supporting the delivery of the NHS diabetes prevention programme
- Moving to a community approach (upstream from General Practice) - developing integrated working with community resources such as libraries, leisure centres etc.

- Promoting a positive view of ageing encouraging continued activity, healthy eating, limiting alcohol, volunteering and physical activity.

- Developing strategies to reduce air pollution in the key areas affected by poor air quality
- Developing joint strategies with local care homes to optimise infection control, and support delivery of the NHS five year action plan to reduce anti-microbial resistance.

Population Health Management
We will do this by focussing on interventions that can prevent or delay loss of health, targeting clusters of conditions where management and care can be optimised, and reducing unwarranted variation, for example:

- Implementing the primary care elements of the diabetes strategy
- Respiratory disease – diagnosis and management of Asthma and COPD
- CVD secondary prevention – including the roll-out of a Community Pharmacy based project to support the early identification and treatment of AF and Hypertension in conjunction with the Public Health "Get Checked" campaign.
- Improving flu vaccination uptake in 'at-risk' groups such as COPD patients

Developing Health Coaching skills in our workforce.
We will do this by training staff across disciplines in Health Coaching approaches to increase their ability to engage service users in their own care and embedding a 'making every contact count' approach to use contact opportunities to promote self-care.

Tackling inequalities and wider determinants.
We will do this by:

- Using data on health needs and population heath management analysis to prioritise future investment and undertaking health equity audits to identify unmet need
- Developing multi-disciplinary team working with staff from wider services, and provide training to increase NHS wider staff knowledge and skills in referral to other agencies
- Increasing proactive referral for benefits advice and warm homes grants
- Continuing to commission our social prescribing programme

6.3 How the workforce will be configured

As we co-produce our wrap around services with PCNs, working with clinical directors we will determine the number and type of community health and care roles needed as core staffing reflecting population health data and health inequalities.

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Our aim to increase staff joy and meaning in service delivery will be supported through the development of our STP workforce strategy. Freeing up staff to work in self-directed teams will allow them to build a workforce model suitable for local health need and staff can focus on quality improvement by reducing handoffs and delivering services that are personal and tailored to individual need. As community and primary care staff come together, supporting conversations that develop the local service model will help staff to integrate and form local teams.

We will agree which services are best arranged at PCN, Place and System level and our ambition is to have the new arrangements operational by April 2020 and to continue to develop them as the additional staffing through the DES comes on line and we evaluate the impact of the transformation.

We have clear workforce plans in place to boost the numbers of GPs and practice staff and to support them to work in new ways as part of PCNs. Our trajectories can be seen at appendix 5 along with a description of our planned approach to retention. Some of the new roles include:

Trainee Nursing Associates
162 TNAs have commenced their 2-year work-based learning programme since September 2018. Our ambition is to implement the role within PCNs, with one TNA per Primary Care Network by March 2023.

Advanced Care Practitioners
Further expansion of the ACP role will increase by one per Primary Care Network by March 2023.

Clinical Pharmacists
We are expanding the number of clinical pharmacists to one per PCN across Norfolk and Waveney STP by March 2020. Further expansion of the clinical pharmacist role within primary care networks will increase to an estimated one per practice, subject to PCN population size.

Social Prescribers
We will expand the number of SPs to one per PCN by March 2020. Further expansion of the SP role within primary care networks will increase to three SPs per primary care network by March 2022.

Physician Associates
Further expansion of the PA role will increase to two per PCN by March 2024.

Advance Practice Physiotherapists (First Contact Physiotherapists)
Further expansion of the APP role will increase to three per Primary Care Network by March 2024.

Volunteer workforce

The valuable contribution that volunteers make in health and social care sectors is well known and recognised to be one of the key focus areas within the Long Term Plan. The Kings Fund report, 'Volunteering in General Practice' (2018) identifies specific ways in which volunteers can engage and support general practice. There are over 300 volunteering NHS role types within the STP and we have well established volunteering programmes across our provider trusts and STP organisations, embedding volunteers as a core part of our workforce

A pilot commenced in 2018 to develop volunteers within general practice. So far, we have recruited a Volunteer Coordinator and nine volunteers working in practices in North Norfolk and Norwich with more currently going through the recruitment process. Our ambition is to continue to grow our volunteer workforce in primary care and expand the remit of roles to more skills-based roles and social prescribing. We aim for one volunteer per PCN by March 2023

6.4 How services will be delivered and new technology

PCNs are the foundation of our STP, we are developing our integrated services around registered patient lists and want to provide services as close to the patient as possible. Where people need more support from health and care services, services should be available wherever possible in people's own homes including care homes where this is a person's principal place of residence.

We will continue to promote and accelerate the extensive use of technologies to support independent living at home and ensure that capital investment through disability facilities grant funding is invested in the most effective equipment and technologies. We will ensure that our integrated community equipment services are readily available and used by all who would benefit.

We already have a programme in place to support this ambition and some examples are set out below.

- Expand the use of NHS Mail for care homes
- Support people in care homes to benefit from assistive technology

We will strengthen the programme through the PCNs going forward. Further detail on our digital plans can be seen in key element 4 on page 50.

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Norfolk and Waveney CCGs will continue to invest in general practice facilities and technology using the Estates and Technology Transformation Fund (ETTF). The main aim has been to develop more modernised infrastructure in general practice to improve and expand services for patients and to accommodate developing new models of integrated care.

Some examples of the existing and planned use of the £4.5m fund we have secured are:

- New consulting and treatment rooms to provide a wider range of services for patients and so more patients can be seen
- Improved reception and waiting areas
- Building facilities to deal with minor injuries
- Creating better IT systems to improve the way information is shared between health services in the area
- Extending existing facilities to house a wider range of health staff including GPs, nurses and clinical pharmacists.
- Building new health centres which have a greater range of health services for patients in one place.

6.5 Governance and operational requirements

Our STP governance arrangements can be seen in appendix 1. Our five Local Delivery Groups are supporting the development of PCNs and are currently accountable to the STP Primary and Community Care Workstream, which is in turn accountable to the STP Workstream Delivery Group.

The five Primary Care Commissioning Committees have oversight of Place-based arrangements for investing in the PCN DES through the GP contract. The PCCC in each CCG reports to its respective CCG Governing Body and NHS England. It is planned that our Joint Strategic Commissioning Committee (JSCC) of the five CCGs will be delegated oversight for the strategic commissioning of primary care during 2019.

6.6 Resourcing of the proposed changes

In Norfolk and Waveney we will look at resourcing on a system-wide basis and this will respond to our strategy and plans over time.

We also expect to see a shift from where funding is currently spent, towards PCNs and community care to enable additional investment to support the development of PCNs. We know there is unwarranted clinical variation across our STP, with funding sometimes being spent in an inefficient way. Through our work to develop consistent quality of services across Norfolk and Waveney we expect to see a release of funding which will support delivery of the plans outlined in this strategy.

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CCGs have committed funding to the delivery of the new PCN roles and the requisite engagement of local GPs. Where these costs are likely to generate cost pressures over and above the specific allocations received, CCGs have integrated the impact into the Norfolk and Waveney-wide Finance Recovery Plan (FRP).

In future years, developments and investments will form part of the Medium Term Financial Plans (MTFPs) at a CCG and a wider Norfolk and Waveney level. This will ensure funding requirements are secured and resource planning can be completed in a timely manner that coincides with the STP strategy.

It is important that the limited financial resources available are used effectively. In order to achieve this Local Delivery Groups (LDGs) will be the initial forum for discussing opportunities and funding requirements. LDGs will then make recommendations and these recommendations will be assessed by delegated decision making forums, which will include finance representation and will ensure decisions are made in conjunction with MTFPs and FRPs.

We will use our General Practice Forward View funds to improve the resilience of general practice and to support delivery of our workforce plans. We will review the Training Hub model and with the investment received from Health Education England will work closely with PCNs to ensure it supports transformation across primary care.

We will review the use of our Better Care Fund and ensure that it is fully aligned with the priorities of our PCNs. We will ensure through our governance arrangements that our key partners in local government are fully engaged and sighted on PCN priorities so that they too can seek to align their investment in care and wellbeing with our investment in health services.

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7 Key element 2 - The NHS will reduce pressure on emergency hospital services

7.1 Summary of current situation

Primary care manages the majority of urgent demand on a daily basis, however we know there is unwarranted clinical variation between practices across the STP and that our A&E attendances and emergency admissions activity has been growing on an annual basis. Some practice populations have seen higher levels of growth than others and we are working to understand this across the PCNs.

We have tested various approaches to reducing activity across the STP, for example we have seen emergency admissions in care homes reduce as a result of locally commissioned services which align practices with care homes and ensure a proactive approach. We will evaluate these approaches and roll out successful schemes across the STP.

Whilst pressure on emergency hospital services continues to grow over the winter period we are also experiencing year round pressure requiring further transformation of primary and community care services both to tackle pressure on admissions and to get people out of hospital as soon as they are fit enough to do so. We have also made significant progress in putting in place arrangements to address unplanned urgent need through our multi-disciplinary escalation avoidance teams (NEATs) at each Place level. The original pilot NEAT based in Norwich has now been in place for two years and has shown success in avoiding emergency admissions.

Norfolk and Suffolk County Council provide further planned and urgent response services through their Night Owls, Swifts and Waveney Response services and there is an emergency duty team within the adult social care system. Our ambition is to build on the success of the NEAT approach.

We will also continue to improve capability by formalising links to independent care providers and voluntary and community providers to benefit from the full range of support available to respond to urgent care need and assist with timely discharge. We are forming a Care Association for Norfolk and Waveney independent providers including all care homes and home care providers through which our ambition to agree more effective and efficient arrangements involving their services can be developed and agreed. We see the PCNs as critical in providing leadership into this area at Neighbourhood level.

We are already consistently exceeding the NHS111 target that 50% of people calling the service receive a clinical assessment and are working towards the target that 100% of people are able to access urgent and emergency care advice through the NHS111 online service.

We are advancing with our programme of achieving urgent treatment centre (UTC) capability in all of our current walk in and similar centres and will have assessed the need for any further UTC capacity required by 2020.

A key development will be the implementation of a comprehensive CAS fully integrated with our NHS 111, ambulance dispatch and GP out of hours service by 2023. The ambition is that the service will become the single point of access and preferred channel for the whole population and will be linked to acute and community based services that are the most appropriate to meet a person's needs including our community urgent response, reablement services and mental health services. We will also explore how to integrate the CAS with general practice and PCNs.

7.2 A description of the role primary care will play in reducing pressure on emergency service

We already have multiple local initiatives targeted at reducing the pressure on hospital emergency departments. We will review these with PCNs and will refine and roll out the most successful approaches. Some examples of these initiatives are set out below and demonstrate the role primary care will play in reducing the pressure on emergency services.

We have developed High Intensity Service User Support Services which provide support and positive intervention to people who frequently attend Emergency Departments (ED), GP practices and are also known to system partners such as the police and mental health services. This approach involves a multi-disciplinary and multi-agency case management meeting to agree a management plan and to share risk. Most recently general practice has been included in these meetings. These are at the early stages of implementation and will be refined over the coming year.

In North Norfolk an Enhanced Care Home Team has been established (delivered by North Norfolk Primary Care) to support care homes and general practices and is evidencing excellent early outcomes. The service is reducing admissions to hospital and is reducing the number of GP visits by offering a more tailored and organised service for care homes. Through our enhanced health in care homes programme we will evaluate and roll out the most effective services for residents of care homes.

In Great Yarmouth & Waveney an emergency hotline was introduced at the end of 2018 so that GPs can call for clinical advice for potential emergency admissions. GP urgents follow a transport pathway for patients who do not require a paramedic crew to support the best use of system resource by reducing ambulance conveyance and improving patient experience.

On the day teams are in place across many practices, providing same day triage and access to general practice services and practices are piloting weekly MDT meetings which identify and proactively manage those identified as at risk from emergency admission with a view to expand this approach across their PCNs. In Norwich and Lowestoft a shared home visiting service is being piloted to both reduce emergency activity and to support the resilience of general practice. This will be evaluated and learning used by the PCNs to develop their services. Great Yarmouth and Waveney PCNs are also implementing a population segmentation approach to managing patient demand and improving outcomes. This will also be piloted in PCNs across the STP. If a person has complex needs (eg five or more long term conditions), they will receive continuity of care from a regular GP. If they have one to five long term conditions, their care will be coordinated by a named professional working within a GP-led team. If a person has no long term conditions and there is no need for continuity of care, practices will ensure that rapid access to a healthcare professional is available to deal with their urgent care need. This may be a physician's associate, paramedic or nurse.

West Norfolk Health is working closely with PCNs to ensure that emerging PCN transformation projects reflect the needs of the local community. Projects will be enabled through the West Norfolk population health management approach utilising NHS Pathways to facilitate targeted prevention. For example a frailty project is underway in the Coastal PCN.

In South Norfolk an integrated approach is being provided with Norfolk County Council adult social services and Norfolk Community Health and Care Trust, working closely with the Norfolk and Norwich hospital to offer a community geriatrician to support care homes and complex needs patients in their own homes. This model is designed to offer a pro-active approach and avoid unnecessary admissions to hospital. If patients go into hospital they are tracked by the geriatrician to help expedite a planned discharge to the home. This is augmented by the joint supported care service.

As a system we have been delivering Improved Access in addition to Extended Access since September 2018. We have delivered over 70,000 extra GP/Nurse appointments to patients and each Place has tailored a service to meet patient and practice expectations and this is continually evolving. As this service evolves further and becomes part of PCN delivery models it will be able to target patients that are accessing hospital services (such as A&E) and further reduce demand on emergency services.

All practices have been offered training in signposting and care navigation. This links well with the development of our social prescribing model with PCNs and should support in reducing the numbers of GP appointments being used for non-medical needs thus increasing capacity.

7.3 How workforce will be configured

We will agree the best arrangements for deploying and developing the workforce needed to realise our ambitions through a co-productive process with PCNs driven by high quality data and evidence of need. For example, as part of our workforce planning, we are working with the East Anglian Ambulance Trust and our community providers to develop the new role of advanced paramedic practitioner.

This new role over the next three years will work autonomously within the community, using their enhanced clinical assessment and treatment skills, to provide first point of contact for patients as an alternative model to urgent and same day GP home visits for the PCN.

We will expand the number of APP/CP to one per Primary Care Network by March 2024.

We are in the process of developing our STP workforce strategy which will be published in the autumn and will support delivery of our primary care strategy and the development of PCNs.

Some PCNs are taking advantage of the Productive General Practice programme and are working with NHS IQ to develop their teams and their models of care and we plan to expand this.

7.4 How services will be delivered and what role technology might play

We are implementing an online consultations system across Norfolk and Waveney, which will be available to all GP practices. The system will provide a digital front door to primary care and give better opportunities to sign post patients to the right care and ensure GP time is focussed where it is most needed. In line with the national roadmap, the online consultations system will be linked into the NHS App.

GPIT Futures will bring better opportunities for interoperability across care settings and GovRoam will provide clinicians with seamless access to the clinical data they need to deliver care in any location.

Our digital strategy for primary care shows that we intend to harness new technology to move clinical activity such as post-operative, long term condition and symptom monitoring away from hospitals and practices and into the patient's home, using telehealth tablet prompts and devices. We have discussed with our network provider the ability to put short term wireless access points into patient's homes, where they have no broadband solution, which can be re-used.

The advent of 5G will mean increased coverage in Norfolk and Waveney, which already has the second highest rate of patient sign up to online services in the country showing that the population has an interest in using technology and online services, which will be

harnessed. GP practices already offer patient Wi-Fi, and we plan to introduce access to tablet devices in waiting rooms so that patients can access online consultations and advice, and self-monitoring tools, supported by digital navigators.

PCNs will continue to develop their plans through 2019/20 as their development year.

7.5 Governance and operational arrangements

Our STP governance arrangements can be seen in appendix 1. Our five Local Delivery Groups are supporting the development of PCNs and are currently accountable to the Primary and Community Care Workstream, which is in turn accountable to the STP Workstream Delivery Group.

The STP Urgent and Emergency Care Workstream is accountable for the work to reduce pressure on emergency hospital services, working closely with the Primary and Community Workstream and through Local Delivery Groups.

Our STP A&E Delivery Board, supported by local strategic operational resilience teams oversees the performance of our emergency system.

7.6 Resourcing of the proposed changes

STP partners routinely work together in the development of new initiatives designed to reduce avoidable emergency activity and to reduce untimely transfers of care. These work streams will include co-produced business cases, which amongst many other things, will set out the financial resources required and what the anticipated impact on emergency activity will be.

CCGs have established governance routes for the ratification of these business cases which results in the financial resource being secured and being incorporated into future financial plans. In addition, deep dives into the efficacy of these schemes are regularly scheduled and the impact of the service is reported monthly.

Many of the schemes already exist in parts of the STP, so plans can be developed using experience of delivery and lessons learnt. This also gives a strong basis for financial and resource planning.

Due to resourcing shortages within the STP, not least workforce issues, it is crucial that a system approach is employed when planning schemes. The STP will ensure that, where appropriate, resources are interchangeable across organisational barriers and that financial flows are open and predicted in order that partners are not financially destabilised.

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8. Key element 3 - People will get more control over their own health and more personalised care when they need it

8.1 Summary of the current situation

Our STP partners are committed to increasing the personalisation of care for Norfolk and Waveney people. We have a number of initiatives currently underway.

Currently we have a model of social prescribing linked to all 105 GP practices and which is funded until July 2020. Grants have been aligned so that we can run all the funded services until July 2020 at which point we will transition services into the next stage of this offer to deliver services until at least 2023.

Social Care have wide experience in delivering personal budgets and have a strong ethos of an enabling and self-determining approach, the CCGs also offer personal health budgets in line with the Personal Health Budget strategy. Through our partnership working, we have the opportunity to share these skills and experience around the areas of assessing risk and mental capacity.

The “three conversation” approach in Social Care has had an accelerated implementation across the STP and the health coaching approach in provider organisations mirrors it very well, meaning the foundations for personalisation are well placed. Over 500 staff have already attended a two-day health coaching programme with many more training days planned. This is delivering positive results around shared decision making, empowered individuals, improved self-management in reduced follow ups. Alignment of health coaching and social prescribing will be reviewed over the next year.

There are a number of schemes primarily within the voluntary sector that are commissioned by our local CCGs or in conjunction with partners to support primary care in providing personalised health and care. Examples include West Norfolk Carers, Carers Matters Norfolk, Care Navigator Scheme and the LILY scheme.

Acute Clinicians regularly attend the monthly General Practice Forums to provide a platform to facilitate effective communication to support consistent approach to early, open discussions and implementation of care plans. An example of the topics discussed include PEACE and RESPECT.

We are increasing the number of personalised health budgets for our population, and not just in the traditional areas such as Continuing Health Care but looking at other innovative ways of supporting people with this approach. We will work towards developing a workforce plan to upskill staff in this approach and also how we support individuals to manage their budget. Personalised care plans are recognised widely across all PCNs as key to enabling patients and their carers/families in managing their wellbeing and long term conditions.

8.2 A description of the role primary care will play in personalising health care services

In personalising care, we are building on our online offer to individuals. As well as the existing ability to book appointments online at GP practices and view medical records, general practice will support patients in using Apps, such as the NHS App, MyCOPD App and Mapmydiabetes App. Online therapies will be offered as part of our mental health service offer and we will offer online consultations from the summer of 2019 as part of our overall delivery of the General Practice Forward View.

Primary care has a key role in the diabetes care pathway as approximately 90% of patients can be effectively managed in the community without requiring hospital services. A key priority outlined in the STP Diabetes strategy is to establish holistic, person centred care across the STP. To achieve this;

- Technology is being explored to better support self-care
- Services will be developed to wrap around primary care networks
- Primary care pilots will be initiated in 19/20 to explore population health management and integrated care approaches to delivering diabetes services

PCNs are developing their approach to population health management and segmentation. This approach will be piloted during 2019/20 in a number of PCNs before plans are finalised to roll out across Norfolk and Waveney.

Our recently published Adult Palliative and End of Life Care Strategy sets out how we will work with PCNs by utilising population needs assessment and learning from Mortality Reviews to understand the needs of our communities including people living with dementia, learning disabilities and non-cancer conditions, older people, BAME communities and other hard to reach groups. We want to ensure that care is personalised around the needs of each patient, and their

carers / family. In the coming year, the Collaborative Group will further develop Advance Care Plans to include ReSPECT and IPOC (Individual Plan of Care).

We have commissioned appropriate training and support for the PCN workforce to help them have what can potentially be a difficult conversation with patients and carers about planning for end of life.

We will also explore adoption of Personal Health Budgets for patients eligible for Fast Track Continuing Health Care, to support people to take control of their care. We wish to empower individuals, families and communities which will support system sustainability.

8.3 How the workforce will be configured

As part of the ongoing development of new roles and new models of care, PCNs will use data through population segmentation to understand how to configure their workforce. Our work to develop our overall STP workforce strategy will build on the PCN plans when they are available in July.

In the first year of the GP contract, additional pharmacists and social prescribing coordinators will be appointed by the PCNs (please see page 37 for the breakdown of the workforce numbers) to provide more personalised support to individual patients. PCN teams will be enhanced by further roles of physiotherapists, clinical paramedics and physicians associates as the delivery of the GP contract progresses over the next five years.

Our community health and care services are committed to reconfiguring the workforce around PCNs to provide seamless care to patients. Staff, working in integrated teams will be focused on quality improvements by reducing handoffs and will deliver services that are personal and tailored to individual need.

We will continue to invest in health coaching training for staff working in the community. 30 staff have already been trained as trainers and we will ensure all staff across all sectors can access health coaching training within two years with one integrated approach.

8.4 How services will be delivered and what role new technology might play

We are developing a social prescribing model which is predicated on a life/ health coaching model to provide a more rounded and focussed offer for individuals. The connector role will be extended to life/coaching and additional support to include an element of support for people with mental health issues to support management and recovery.

Services will make the connection with population health data and risk stratification increasing the strength of the current integrated care coordinator roles to support effective triage.

Social Prescribing Connectors will have a caseload of individuals, providing onward support to realise effective change with people. The model will increase the capacity available to support more focused interventions and will link closely with new PCN social prescribing coordinator roles. Care will become more holistic following the ethos of 'what matters to me' with shared decision making at its heart, rather than the traditional 'what is the matter with me' approach.

New technology is currently being introduced to the care pathway to ensure everyone with a diagnosis of diabetes has access to digital diabetes structured education, even if they cannot attend face to face sessions. This is being launched in June 2019 as a 12 month pilot across Norfolk and Waveney.

There are other technology developments which we are investigating to bring improvements to the care pathway, in particular:

- **Low Carb Program** – developed in collaboration with the RCGP and provides access to online education, peer support, recipes and meal plans and behaviour change mentorship. More than 40% of people with type 2 diabetes who start the program on medication eliminate a medication from their regime at 1-year

- **OurPath** – 12week programme which offers digital access to a health coach, remote monitoring of physical activity and peer support. The intervention has an 85% completion rate, with people using the programme achieving an average 8.2% weight loss at 6 months (about 7 kilos), equivalent to a 50% reduction in their risk of developing type 2 diabetes.

8.5 Governance and operational arrangements

The Diabetes Transformation programme is already underway and reports through a monthly Diabetes Programme Board and into the STP Primary and Community Care Workstream Board.

Our Prevention programme is making good progress against its priorities and reports into the STP Primary and Community Care Workstream Board.

Our End of Life and Palliative Care programme has recently published its strategy and this group also reports into the STP Primary and Community Workstream Board.

8.6 Resourcing the proposed changes

CCGs already have a dedicated business unit to manage PHBs. The unit comprises a multidisciplinary staff base ranging from market experts to clinicians. In addition to managing

the current caseload of PHBs, the unit is leading the system in the rollout programme. This agenda is underway to be able to grant the right of individual patients to be offered the option of a PHB.

In order to be able to extend the PHB offer beyond the existing levels, the business unit (in conjunction with NHS England) has sourced a bespoke virtual banking system. This system will considerably reduce the administration burden, thus freeing up resources to enable the increase of packages within the current funding arrangement.

The banking system will allow patients considerably more freedom and flexibility to procure their own care and it will remove the unnecessary engagement of agencies, which will improve continuity of care as well as giving better value for money.

Whilst much of the current personalisation agenda in Norfolk and Waveney has been funded from non-recurrent bids or investment reserves, evaluations are routinely enacted. Business cases will be produced in conjunction with providers, commissioners and the voluntary sector as appropriate. Decisions will then be made on the ongoing delivery of the schemes, including any required alterations, which will lead to the schemes being included in the future financial planning of the CCGs. As the personalisation agenda progresses all STP partners will need to be involved in the redesign of the care offer for Norfolk and Waveney.

This will ensure that the evolution to patient personalised care is delivered in the most effective way in accordance with the system wide financial plan.

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9. Key element 4 - Digitally-enabled primary and outpatient care will go mainstream across the NHS

9.1 A summary of the current situation

Norfolk and Waveney was the first area in the East of England to launch the NHS App on 15 April 2019. The App includes a symptom checker, ability to book appointments or order prescriptions through the practice and also indicate personal preference on the organ donation register. Access to a patient's summary care record is also provided through the App.

We were also part of the first of type programme for GP Connect, where local practices, the NHS111 and out of hours provider and NHS Digital worked together to develop the technology for clinicians in NHS111 and out of hours to view a patient's GP record.

The procurement process has just been completed for an online consultations system for all practices in Norfolk and Waveney. The product purchased will provide a consistent website feel and content across the area, improving the patient experience and saving time in general practice. The new system will give patients a digital first option to access general practice services and communicate with their GP Practice.

Over 350 GPs across the patch in around 50 practices are implementing voice recognition technology which will increase time available to spend with the patient during consultations. Patients can access self-care and monitoring technology in many practice waiting rooms and the use of self-care telehealth technology is being explored and pilot projects are being formed. Practice IT equipment and networks are being updated and patient Wi-Fi is available in all surgeries.

West Norfolk already has one practice delivering care to patients using an online consultation solution. Access to the practice has transformed enabling patients to see a GP, or appropriate clinician, either the same day or next day. 2-4 week waits for appointments have ceased. As part of the STP online consultation procurement, West Norfolk has 12 practices who have requested early sign up.

Our implementation will range from fully digital access (ie all appointments being filtered through the online consults solution) to part digital (only same-day appointments will be filtered through the online solution) to provide an additional channel for patients to access their practice. Timing and levels of implementation will be formalised following a pre-readiness questionnaire to practices, expected to be in June. We are planning for 75% patients to have access to online consultations by March 2020.

Our online consultation solution also provides an option for practices to transfer their practice websites through to a standardised format which fundamentally integrates the online triage and consultation solution. Our local system is being offered support from Footfall, who have recently won our online consultation tender.

GPPOs are currently working with practices to create a secure intranet for the sharing of common policies, pathways and processes, enabling the clear communication of information to be provided through to practices. It is expected that these will be live within 3-6 months across at least two Places.

Through ETTF funding, West Norfolk enabled the roll-out of the Ardens and QMaster suite of clinical system templates throughout 2018/19. These templates enable all practices to work on the same format, based on best practice resources. This consistency enables a higher quality provision of healthcare with clinicians being enabled to spend more time interacting with the patient, and less time inputting. Updated changes to pathways also only need uploading to one platform, as opposed to individually to practices. This is being rolled out across the STP in 2019.

ETTF funding in North Norfolk has also seen the local GPPO purchase a range of technical solutions for practices such as Surgery Pods to release time back into practice and begin to digitise some aspects of patient care.

GP Connect is currently being tested in Norwich between SystmOne practices and IC24 which enables live record viewing by out of hours clinicians. It is intended that this solution is offered to all practices in by March 2020, where it is also anticipated that direct appointment booking will be enabled between out of hours and practices. The testing for Emis practices is taking place outside of our STP, but with the same out of hours provider; we expect this will be available for Emis practices by the end of the year.

Primary care is at the heart of the developments above. The delivery of high quality healthcare, supported by the digital developments available, is intrinsic to working smarter with patients. Work is being undertaken to enable access to an integrated patient record which will allow access to live records by the community and ambulance agencies. This record will enable all those involved in the healthcare provision to that patient to be both well-informed and personalised in their approach.

Working with NHS111 and out of hours services, the CAS (clinical assessment service) aims to signpost people and provide information to patients with clinical advice. The aim will be to connect patients to advice and support which is fully integrated using an enhanced 111 service. Escalation and avoidance teams are working with NHS111 to develop a pathway for CAT3/CAT4 dispositions to prevent avoidable admissions.

A number of our Places are piloting WHZAN as part of the locally commissioned care home services. The majority of practices also have MJOG messaging services that are proving to reduce DNAs and be an important communication tool with local patients.

North Norfolk practices are implementing a pilot scheme called 'TekiHealth' that is hoped can start to revolutionise the way practices conduct home visits, particularly in a rural setting. The pilot will involve a small dedicated team of HCAs visiting patients at home and a GP undertaking a virtual assessment in a static location. This pilot has worked well in rural Cumbria and it is believed that it can potentially help release GP time back into practice whilst also still delivering high quality patient care to patients that require a visit.

Delivery is not without its challenges however. With widely dispersed populations across a rural area, there are large blackspots and poor connectivity, both for local people and for health and care providers. We also have interoperability issues both between practices on different systems and between providers. These challenges will be factored into our plans and alternatives will need to be identified.

9.2 A description of the role primary care will play in delivering digitally enabled healthcare

General practice will exploit these technologies to increase the number of appointments available online while ensuring that systems are in place to ensure they are backed up by processes such as online consultations to ensure DNAs do not increase. We will ensure a seamless journey for the patient from NHS111 to out of hours and primary care, promote wellness and self-care and ensure that clinical time is focussed and available for patients who need it most by the deployment of efficient triage and signposting methods.

There is a current groundswell of digital interest in Norfolk and Waveney as several long talked about schemes come to fruition; positive digital disruption is causing practices to realise that it is time to innovate; patients are pushing this agenda as the use of technology in other areas of their lives increases. All of this is currently being achieved with a very small team.

We will increase the number of clinical digital innovators and digital change agents. Staff skills will be developed through digital training schemes and patient skills and the use of technology developed through having digital navigators available in GP practices. Digital Navigators are staff who have completed extra training in helping patients to use technology to track, manage and improve health outcomes and provide services. However, digital must not become something that is done to PCNs, but done by and embedded within. General practice has always been at the forefront of technological innovation in the NHS and must be given the time and resource to ensure this remains the case.

9.3 How the workforce will be configured to deliver digitally enabled healthcare

Staff skills will be developed through digital training schemes and patient skills and the use of technology developed through having digital navigators available in GP practices. Our Training Hub will support the PCNs to develop digitally with the provision of high quality training.

9.4 How services will be delivered and the timeframe for implementation

Our Digital transformation is a fundamental part of our plans for the future, with a vast range of priorities, including but not limited to, the following deliverables:

- To implement our STP Digital Strategy
- To develop and approve the outline business case for a new Electronic Patient Record across the three acute hospitals, and ensure the preferred solution enables integration to other provider systems, including general practice
- To establish business intelligence as a system-wide shared function across the STP
- To strengthen our cyber security arrangements and meet national standards

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- To establish a senior strategic STP team to progress our digital transformation across all sectors of the system
- To develop our learning networks to build a digitally ready workforce
- To review and strengthen the governance of the Digital workstream

Primary care digital deliverables

Table 3: Timescales for Primary Care Digital Deliverables

	19/20	20/21	21/22	22/23	23/24
Online Consultations					
NHS App promotion					
GP Connect					
GP IT Futures					
GovRoam					
Video consultations					
Interoperability across care settings					
Patient access to records					
Digital inclusion					
Staying well - wearable technology					
Digital innovations in care delivery (telehealth)					
Digital Region LHCRE					

9.5 Governance and operational arrangements

Our STP Digital workstream is led by our STP Chief Information Officer and is an enabling workstream for the STP. We have recently approved our STP Digital Strategy and there is a focus on developing a shared patient record and enabling information sharing across organisations.

This is overseen by the STP Workstream Delivery Group which reports into our STP Executive. The five CCGs have jointly appointed a Head of Primary Care Digital Strategy who works closely with the GPPOs and primary care leads in developing our digital approach in primary care. This role is a member of the STP Digital Workstream.

The Digital Workstream has an information governance sub group reporting to it to link matters of information governance to the digital transformation work.

9.6 Resourcing of the proposed arrangements, including set up and ongoing costs

Where possible, technology that is centrally funded will be used and promoted to patients. Through GPIT Futures, opportunities for integration with clinical systems will be developed. Other funding will be through identification of benefits and savings through investment, where the use of technology will bring quantifiable savings in reducing practice or hospital contacts or moving activity from acute to community care.

See appendix 4 for a case study on online consultations benefiting patients in Norfolk.

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10. Key element 5 - Local NHS organisations will increasingly focus on population health – moving to Integrated Care Systems everywhere

10.1 Summary of the current situation

Norfolk and Waveney STP have included GPPO representation within all key committees and groups, our PCNs will the foundation of our ICS and we view clinical leadership as crucial to the development of resilient quality services that are capable of improving outcomes for our population. Our 17 PCN clinical directors will be members of each of the five local delivery groups and will support the development of integrated care partnerships locally.

Norfolk and Waveney STP is progressing towards achieving ICS status. In the autumn of 2018 it was one of 6 systems nationally to be selected to take part in the "aspiring ICS" programme. This gave the system protected time for the first time to work together to develop plans to enable closer working. Since then the system has continued to develop and has been recognised in particular for its excellent work with PCN development as part of the programme and beyond. The system is well on track to achieve ICS status by March 2021, in line with the deadline set out in the Long Term Plan.

10.2 A description of the role primary care will play in the ICS and how we intend to ensure it supports key facets of patients' mental health

The STP published its Adult Mental Health Strategy in early 2019 following several months of engagement and co-production with service users, local people, Healthwatch and other representative organisations, the voluntary sector and our local providers. This can be seen at appendix 2. We have committed to configure Primary Care Mental Health Services (PCMHS) around PCNs with an extended workforce to support delivery. Team members will include a GP champion, supported by a mental health nurse working in the PCN, a named psychiatrist, peer support, social navigator, dementia practitioner, trauma therapist, wellbeing practitioner including long term conditions, carer champion and a social navigator. The lead GP will coordinate the team.

Referrals to secondary care will be made usually by the nurse/GP working in collaboration. MDTs supported by the psychiatrist will underpin care and facilitate step up and down, which will be seamless with access to service requests rather than refer and discharge model. Therapy provision will be provided in a more significant way by third sector providers with the expectation that the majority of mental health provision will take place in the primary care/community setting. There will be a much greater collaboration with social services, housing, debt and financial support through wellbeing hubs and via escalation and avoidance team services.
Mental health crisis will be supported by Crisis Hubs with support provided by third sector colleagues and peer support working alongside mental health workers. This will provide a safe space and de-escalation avoiding the need for CRHT involvement and A&E attendances. Crisis Hubs initially will be located in West Norfolk and Lowestoft (already operational) with Norwich and Great Yarmouth Hubs by December and October respectively. NHS111 clinicians will be supported to provide some of the crisis triage particularly out of hours.

The STP has also undertaken a full review of mental health and wellbeing support and services provided for our children and young people. A system wide transformation plan has been agreed in response to feedback and engagement with children and young people, their families and carers, professionals, clinicians and those in contact with children and young people.

The system will adopt the use of the THRIVE model including primary care settings. Instead of a tiered system that creates gaps and exacerbates waiting times, a THRIVE based system will focus on the needs of individual children, young people and young adults. All 0—25 year olds are considered to be ‘in’ the THRIVE framework. The majority will be ‘Thriving’. 1 in 8 are likely to need some kind of help, with the majority having needs met through ‘Getting Advice’.

Support will be personalised and will take place across a range of settings appropriate to the individual including community settings, schools and colleges, primary care and through digital platforms. Access to support will be through; a single phone number, direct through local teams, drop in services and digital and will be open to families, children and young people and partner agencies working with these groups. Primary care professionals will be able to access advice and guidance from mental health service providers without the need for a referral. Instead of moving a child or young person around the system, we will move the system around the child or young person.

The STP has established a strategic group to undertake a review into population health management and develop our strategic approach. Meanwhile each local system through Local Delivery Groups, has been supported to develop and test approaches to population segmentation to support immediate transformation of services.

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West Norfolk has established a process to adopt a population health management approach which is now being rolled into all CCG projects for QIPP and will be used to support the development of PCNs - to underpin all PCN Projects, and to support 100% of practice populations underpinned by the use of NHS Pathways. This process is set out in the diagram below:

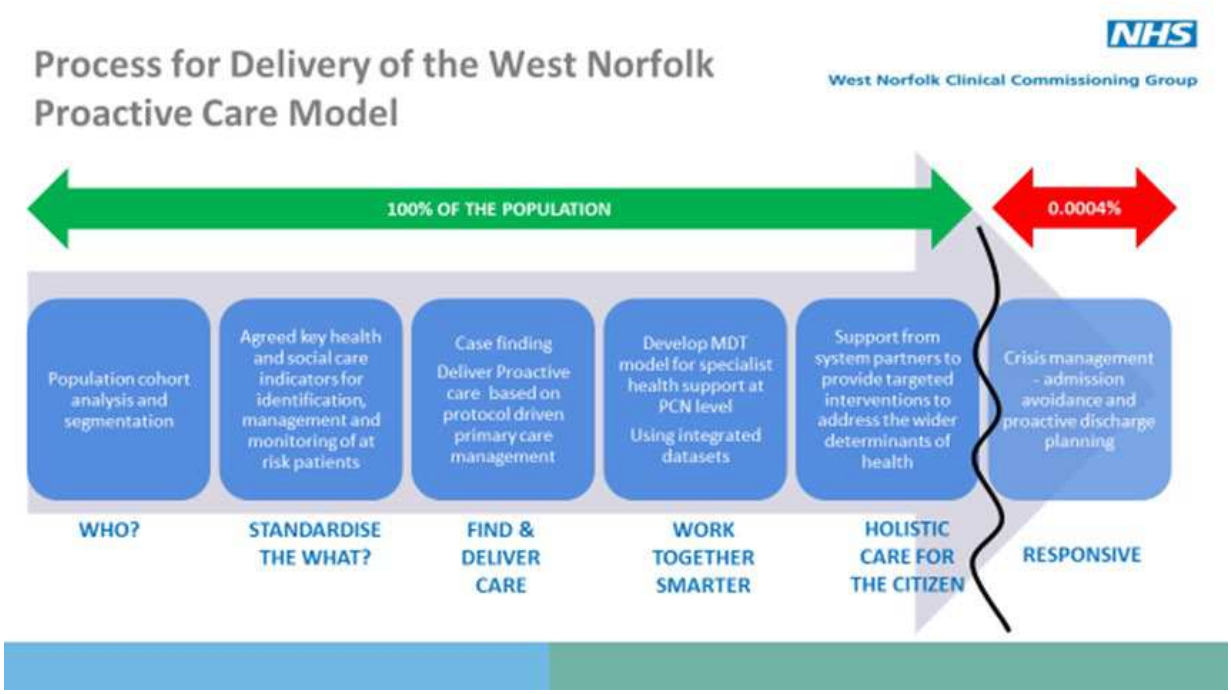

Figure 13: Process for Delivery of the West Norfolk Proactive Care Model

The approach has been tested in a variety of projects already running:

- Patient 500 – 7 care processes that impact NEL admissions
- Diabetes – HCA led model of delivery
- Community Epilepsy Team – reduction of sudden death from epilepsy (SUDEP)
- End of Life – EEAST use of NHS Pathways for ambulance crews

Great Yarmouth and Waveney is using data held within general practice and community providers to complement the population health work across the STP and have plans to actively review this collectively at practice, PCN and Place level to inform local priorities and deployment of resources.

Continuity of care is recognised widely across all PCNs and the local system as key to enabling patients and their carers/families in managing their wellbeing, long term conditions, and improving outcomes. Using a multi-morbidity search of practice data as a tool will be underpinned by a population health approach which promotes care based on the needs of the person with the condition(s), not the condition itself.

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In North Norfolk a PCN grouping of practices are amalgamating their historic appointment data to provide themselves with an overview of all patient activity since 2015 and to identify areas where they can work together and increase efficiency and patient outcomes. This is being supported by a Yale intern working closely with the GPPO who will consider this population data alongside the PCN workforce and report in the summer with recommendations which can be shared across the STP.

10.3 How the workforce will be configured to deliver services in an ICS

A review of PCN workforce will have a direct relationship with population health management and segmentation. This will enable our skilled workforce to be developed in stratification techniques to support the identified groups of patients at risk of ill health. It will also enable us to target and design our workforce to respond to population needs which we know differ across our geography.

The STP director of workforce is jointly leading the development of our strategic approach to population health management, ensuring a direct link into the development of our STP workforce strategy, which will be published in the autumn.

10.4 How services will be delivered and what role new technology might play and the timeframe for implementation

The proposed Primary Care Mental Health Service (PCMHS) will utilise an electronic referral system which is likely to be via SystmOne. This will allow data sharing and use of 'one trusted assessment' which will remain with the patients records. Data can be added to this for example if the patient re-presents. This avoids the need for multiple assessments by different mental health workers.

We are also exploring the use of an App with our UEA colleagues to provide a Directory of Services to provide ease of navigation. Online CBT and symptom trackers will also be developed. Mental health segmentation modelling and Right Care data will also be used to inform service configuration.

First wave PCNs will expect to go live with a version of the new model by October with other PCNs to follow by April 2020.

Crisis Hubs will be delivered in two localities by October 2019 with a crisis youth service to become operational in a similar time frame. E-referrals will also be made to this service in conjunction with professional conversations. On line consultation tools will be reviewed to assist with care navigation for mental health services and outcomes such as reduced secondary care referrals will be tracked using Snomed codes. GP TeamNet will also be utilised in general

practice to support clinicians to better understand the availability of more specialist mental health services.

10.5 Governance and operational arrangements

The STP Mental Health Workstream is leading the work on transforming our adult mental health services and the STP Children and Young People Workstream on child and adolescent mental health services. Both workstreams are working closely with the STP Primary and Community Workstream and are underpinned by the Digital and Workforce Workstreams. They are accountable to the STP Workstream Delivery Group and onwards to the STP Executive. Strategic commissioning decisions are made by the CCGs' Joint Strategic Commissioning Committee.

An STP group has been established to review and develop our strategic approach to population health management and it is supported by a PCN sub group to support practical delivery at Place and PCN level.

10.6 Resourcing the proposals including set up and ongoing costs

Data has been reviewed to help understand how local mental health services compare with others across the country and how things might change in the coming years. This showed an increasing public awareness of mental health issues which will likely mean an increase in demand for mental health services in Norfolk and Waveney. It also revealed a mixed quality picture with some services below national benchmarks or targets.

The system is operating in a constrained financial environment to meet current and future demand. This makes it critical to design services in the most effective way possible, to make best use of available resources to support the well-being of people of Norfolk and Waveney
In line with national direction and based on learning from local and international best practice it is proposed to address these issues through a new model of integrated care and support based in Primary Care Networks. This will enable services to be customised around the needs to local communities and for limited resources to be better used to meet the specific needs of the population in that given area.

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11. Measurement

11.1 Confirmed baseline to measure from and how the STP will measure change in the GP patient survey

In 2018, the STP commissioned a demand and capacity review of the whole system, the outcomes of which were published in early 2019 and can be seen at appendix 3. From this it was clear that, as well as the known workforce pressures in general practice, there was also already a significant capacity gap in the provision of appointments, on average around 9% across Norfolk and Waveney. Using the data we gathered, this was predicted to increase to 17% by March 2023 if nothing is done.

We will use our demand and capacity review as our baseline and will measure our interventions against this. We are currently working on a tool to measure the impact of our planned actions against our demand and capacity baseline and to determine what else needs to be done going forward. This will be supported by the further development of our STP dashboard which will be monitored monthly.

The GP Patient Survey is produced at both practice and CCG level. We will use these data at PCN, Place and System level to review progress of our plans and to determine where additional support is needed.

11.2 Monitoring the workforce plan through the general practice workforce publications from NHS Digital

Norfolk and Waveney STP will use existing established methods to monitor the delivery of local priorities through published reports and provide enablers for PCNs to deliver to their local populations.

This includes:

- 10 High Impact Actions including: active sign positing, new consultation types, reduction of did-not attend appointments, diversifying the workforce, matching capacity and demand, partnership working, social prescribing, personal productivity, self-care and QI expertise
- 100% return rate of the National Workforce Reporting System (NWRS) from our general practices
- Accuracy of data in NWRS with 0% variance across the STP
- Quarterly workforce trajectory monitoring with NHS England
- Monthly CCG Primary Care Commissioning Committee reporting within all public meetings
- Monthly STP Primary Care and Community Care Programme Board reporting

11.3 Monthly assessment when completing the GPFV monitoring survey

Currently the GPFV monitoring survey is completed monthly by individual CCGs. This survey aims to collect data on an ongoing basis in areas such as online consultations, staff training, primary care networks and access to general practice services.

Going forward this return will be completed quarterly, by CCG area and the data will be aggregated at STP level for STP reporting and monitoring processes. However, where the scheme is delivered at an STP level, responses will be provided at the CCG level by apportioning the volumes (e.g. total number of additional minutes commissioned) across CCGs based on their weighted population.

11.4 How the primary care annual assurance statements and technical definitions will hold the system to account

The requirements set out in the operational and planning guidance and the technical definitions have been incorporated into our plans. We have a programme of quarterly GPFV workforce checkpoint meetings with NHS England and we will develop our regular reporting to our Primary and Community Care Workstream meetings on progress against all requirements.

The CCGs are working with NHS England to combine the CCG assurance process now that the CCGs have developed a single executive and senior management team. We will ensure a consistent approach to reporting against these requirements through those meetings.

Whilst oversight and governance of the PCN contracts remains the responsibility of Primary Care Commissioning Committees, it is essential that in order to deliver the key priorities (as outlined elsewhere within this document) a collaborative approach is taken. The Norfolk and Waveney STP will be key to developing these relationships and will take a lead in ensuring community services are configured in line with PCN boundaries.

The STP will further support the delivery of primary care data analytics for population segmentation and risk stratification based on national data, complemented with local flows, to allow PCNs and Local Delivery Groups to understand in depth their populations' health and care needs. Within the STP there will also be additional oversight and support of schemes at Place level to ensure these schemes are delivered as planned within the timescales and budget set out for each project so that the benefits of the investment are realised.

11.5 Describing how any learning from the GPFV MOU mid and end of year reviews will influence plans

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The CCGs have developed a single STP plan for delivery of our commitments against the MOU with NHS England. We will review how we have delivered against our MOU in conjunction with NHS England and adjust our approach as needed annually from April 2020. This is in addition to monitoring through the workforce assurance checkpoint meetings and GPFV returns.

11.6 How will the system be making sure that PPGs are engaged through the process so the patient voice is heard

Patient Participation Groups (PPGs) can help bring about real, positive change in their communities. They have an increasingly important role to play in helping to give patients a say in the way services are delivered to best meet their needs, and the needs of the local community.

Patients are at the focus of everything we do. We want to know what patients and our public think about the quality of their local health services, that they can influence how they are commissioned, and that people in Norfolk and Waveney have a good understanding of the challenges facing the NHS now and in the future.

Engagement with PPGs in developing PCNs will continue, their role in developing education messages for the public to support the transformation of services will also be key. It is vital that as we move forward with a commitment to a focus on health inequalities we support PPGs to ensure they are representative as possible of their communities. We are working with one of the PPG forums to develop options for PPG engagement in PCNs and the CCGs new single management team.

To help broaden engagement, Norfolk and Waveney STP has agreed to create a VCSE Health and Social Care Assembly, based on the model developed in Manchester. The Assembly will cover the whole of Norfolk and Waveney, operating primarily as a virtual body to maximise reach and engagement, but it will also meet in person too. The Assembly will include senior representatives from statutory health and social care organisations as well as the VCSE sector. We are working towards the Assembly being in place by July 2019.

11.7 A description of the role a primary care commissioning committee, or similar, plays or will play in the Integrated Care System and how you intend to ensure that it supports PCNs in their development

The NHS Long Term Plan sets out a clear direction that commissioning arrangements will change over the next few years. We will develop streamlined commissioning arrangements to enable a single set of commissioning decisions at system level and CCGs will become more strategic organisations supporting health and care partners to jointly focus on population health, service redesign and long term plan implementation. Our five CCGs have established a Joint

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Strategic Commissioning Committee which will include the strategic commissioning of primary care within its remit during 2019. Primary Care Commissioning Committees (PCCCs) are integral to this new way of working in terms of:

- Overseeing delegated budgets and delegated functions from NHS England
- Ensuring Primary Care at scale in line with the GP contract

The PCCCs function as a corporate decision making body for the management of delegated functions and the exercise of delegated powers.

Their main role and responsibilities are to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following:

- General Medical Services (GMS), Personal Medical Services (PMS) and Alternative Provider Medical Services (APMS) contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers; and
- Making decisions on 'discretionary' payment (e.g., returner/retainer schemes).

In performing their role, and in particular when exercising their commissioning responsibilities, the PCCCs take into account:

- The needs assessment and plan for primary medical care services at Place level
- Reviews of primary medical care services at Place level
- The STP Primary Care Strategy; including supporting integration with providers and local authority services and co-location of services
- The management of the primary medical care services budget

Our PCCC members have been fully briefed on the GP Five Year Contract and the formation and role of PCNs. Our PCCCs have approved the initial PCN applications and they will also be the governance and assurance route to approve the PCN Network Agreements and the PCN £1.50 per ahead funding along with having regular oversight on how the PCNs are investing these funds.

An overview of activity of the PCCCs to support the new system can be seen in appendix 6.

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11.8 STP/ICS plans to provide data for a PCNs local population to allow them to understand, in depth, their populations' health and care needs for symptomatic and prevention programmes such as screening and immunisation.

Work is underway to develop a STP strategic approach to population health management, addressing the information governance barriers to linking datasets and establishing one single linked data architecture. This is being led jointly by our STP Director of Workforce and Chief Information officer.

A sub group has been established to support every PCN to develop their evidence-based approach to population health management based on local priorities, with cross-organisation business information teams working together.

Progress already made:

- Public Health profiles have been provided based on each PCN geography, using nationally available data, which includes screening and immunisation data
- Segmentation data is available from two sources - NHS Pathways, Eclipse and the CSU
- Risk stratification tools are available for PCNs – NHS Pathways and Eclipse are being used in West Norfolk and CSU GEMima tool is being piloted in North and South Norfolk
- Support from Public Health and the CSU is available for PCN leaders to interpret data and facilitate population health management planning
- Further work is being planned across the STP to share the learning from the pilots and develop case studies of successful projects and to develop local outcome measures based on the priorities chosen
- PCNs are free to choose the tools they use, which will eventually access one centralised linked data architecture, either using existing tools for high level assessment, segmentation and individual risk assessment and management e.g. public health profiles, Eclipse/NHS Pathways, GEMima, or build own in-house using practice systems. Support will be available for PCNs to understand and use the tools and help make choices
- Using practice level data and understand service use patterns and risks
- Undertaking analysis to segment the practice list into levels of need and seeking to optimise health management for service users with 'rising' levels of need
- Focus on interventions that can prevent or delay loss of health targeting clusters of conditions where management and care can be optimised
    - e.g. frailty and associated risks - falls prevention/care planning
    - diabetes and associated risks – CHD
- Undertake sufficiently extensive reviews to look across the whole practice population and not shrink the analytical denominator e.g. just looking at diabetes will limit analysis to the 7% of the population with that diagnosis
- Establish systems (especially IT and administration based) to proactively identify services users with potential to benefit from optimisation of their care

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- Establish service models in house that support and deliver a proactive approach including reviewing service organisation and staff model and capacity. Including increasing skill mix in primary care to develop a multi-disciplinary team to support the GP
- Development of local outcome measures to monitor success

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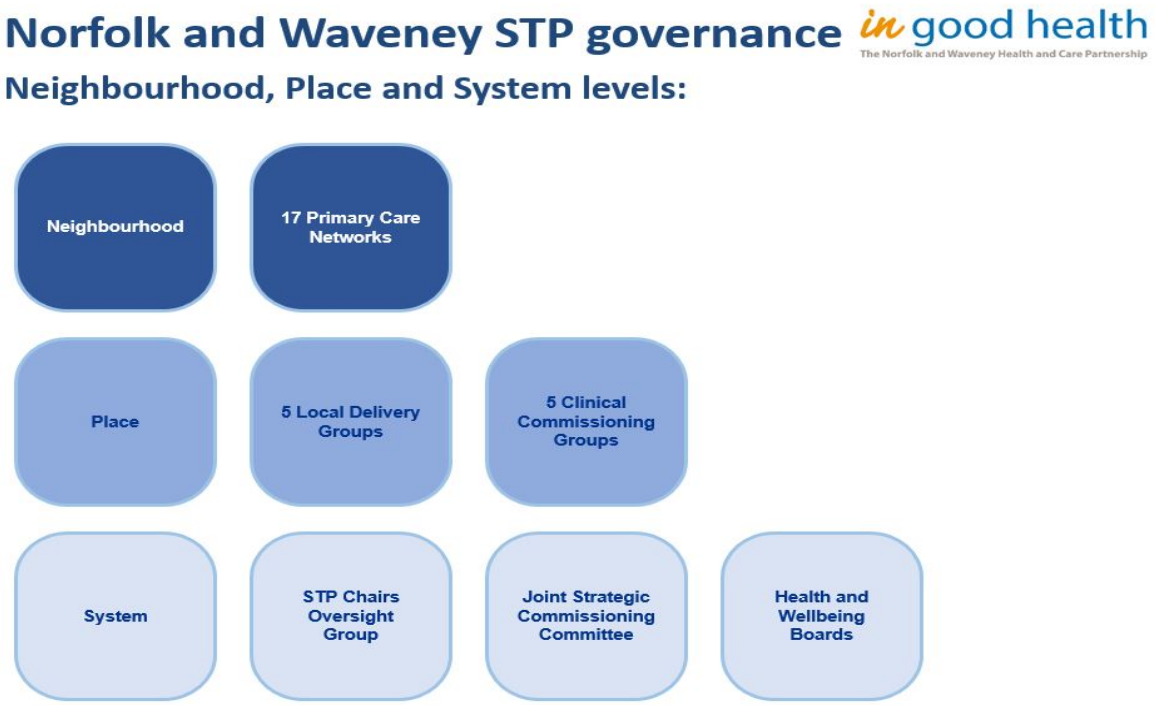
12. Appendices

12.1 Appendix 1: STP Governance

The diagrams below provide an overview of Norfolk and Waveney STP's governance arrangements:



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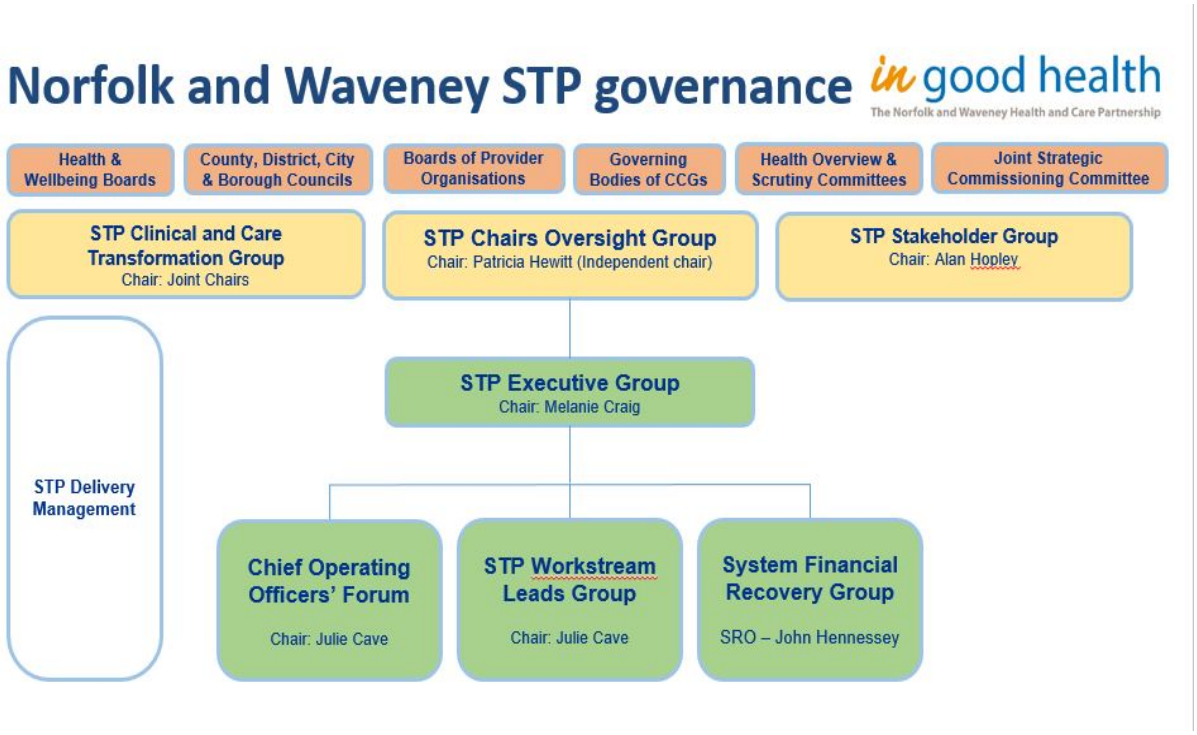

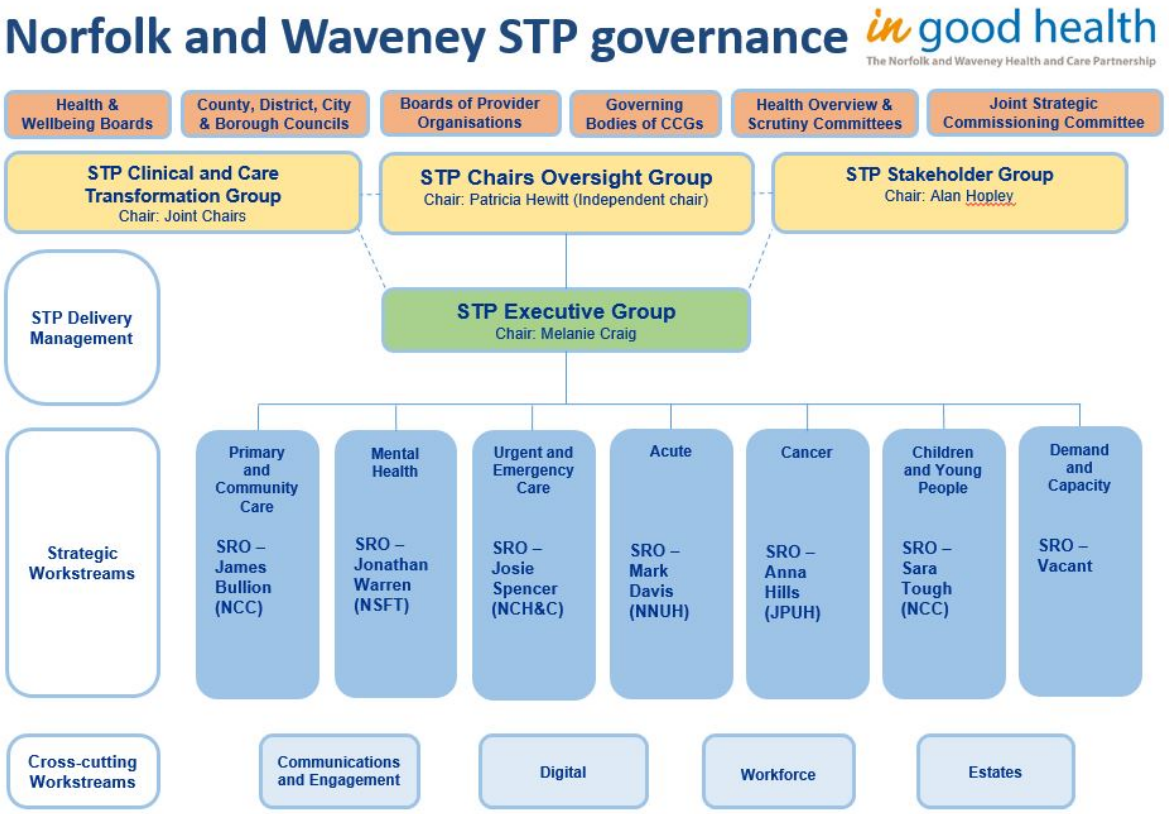

12.2 Appendix 2: Mental Health Strategy

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https://www.norfolkandwaveneypartnership.org.uk/news/news/norfolk-and-waveney-adult-mental-health-strategy.html

12.3 Appendix 3: Demand and Capacity Review

https://www.norfolkandwaveneypartnership.org.uk/our-work/system-transformation/demand-and-capacity-review.html

https://www.norwichccg.nhs.uk/about-us/joint-strategic-commissioning-committee-jscc/jscc-2019/february-2019/3390-jscc-agenda-and-papers-190219/file

12.4 Appendix 4: Online consultations benefits patients (Case Study)

A new IT system means local GP practices can now offer online patient consultations with 30 practices across Norfolk and Waveney expressing an interest. Online consultations involve patients contacting their GP surgery securely by using its website, or even an app.
Their message is read and passed to the right member of staff to deal with, such as a pharmacist, nurse, therapist or GP. In some cases the patient can be helped or advised by responding securely online - otherwise they might be asked to come in for a face-to-face appointment or to pick up medicines.

One practice already offering online consultations is The Hollies in Downham Market. Patient feedback since the launch shows a satisfaction rate of 93%, with patients agreeing that this new service has improved contact with the practice, and patients are very pleased that a system is in place that suits their needs.
Dr Mark Funnell said; “We used to struggle to offer routine appointments but now provide a same day service for the patient on whatever day is convenient to them whether their problem is urgent or routine. Additionally they have the option of accessing us through a web based solution and can do so overnight for an appointment the next day if they wish.
“Patients without internet access can still call in by telephone. Patients have been amazed at being asked to come in on the same day, and the vast majority are very happy with the change in the service. Follow up continuity has also been improved as patients can contact through this for a review on any day in the agreed week that I am available.

“Nothing is deferred to another day and I go home having dealt with everything and normally earlier than previously. It is to my mind a vast improvement in the service offered to the patient and a modern solution fitting in with the wants and needs of a modern population.”

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12.5 Appendix 5: GPFV workforce trajectories

Careers Start (First 5 years)

The scheme aims to address retention issues by working with the GP Provider Groups to offer a new flexible career approach or 'portfolio career' attractive to newly qualified GPs looking for an alternative to traditional partnership or practice roles. Through the pastoral support and the induction packs, we would aim to sell Norfolk and Waveney as a place to work and live promoting all that the area has to offer. We see this initiative as unique opportunity to provide dedicated professional development support and the opportunity for networking and peer support across a wider area through the GP Provider Group.

GP Careers Plus (Wise 5)

The scheme aims to open up opportunities for GPs wanting to work flexibly without the limiting factors such as indemnity arrangements, CPD, appraisal etc. This scheme is designed to retain GPs that would have ordinarily been lost to the system following retirement. It also enables GPs to have an individualised work plan based around their needs and provides much needed capacity to practices that have been unable to recruit.

GP Fellowships: (First 5 years and Mid-career)

The aim of this scheme is offering GPs the opportunity to develop skills outside of GP practice with support to pursue higher education in a chosen specialised area which could be clinical or non-clinical such as leadership.

GPN Careers Plus

Programme to adopt similar approach for GP Careers Plus however tailored to meet the requirements of the nursing workforce.

Pilot to be launched to support the wider nursing workforce across Norfolk and Waveney. This will be initially targeted to the GPN demographic for the “retirement” age group.

N&W LMC Pastoral Support Service

This confidential pastoral support offer will support struggling GP and practice managers as part of the wellbeing programme. The objective of the service is to support GPs and Practice Managers to find positive solutions where they are encountering challenges in their work or personal lives.

GP Wellbeing Programme (Schwartz Rounds)

The Schwartz Rounds programme is to provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. It will support over 100 practices for a two-year programme. After this period all practices involved in the programme, will have funded membership for an additional two years to obtain resources and support when required.

Norfolk and Waveney – Confidential Coaching and Mentoring Support Service

AKESO is providing a confidential individual structured coaching/mentoring service across Norfolk and Waveney STP.

This service is available to our GPs who feel they might benefit from some time to reflect on issues that they face. These issues may impact their work and personal life – ranging from skills and performance to developmental areas.

Coaching/Mentoring Interventions

Confidential sessions will be facilitated by a trained colleague within the AKESO network. These sessions will support doctors by exploring issues and setting goals. In addition, methods of assessing progress are carried out in a non-judgemental way. This service will also offer onward referral to other agencies as appropriate e.g. GP health service.

A graphical overview of all our GPFV retention schemes offered within Norfolk and Waveney STP and the planned trajectory for delivery of our workforce for 2019/20 is below.

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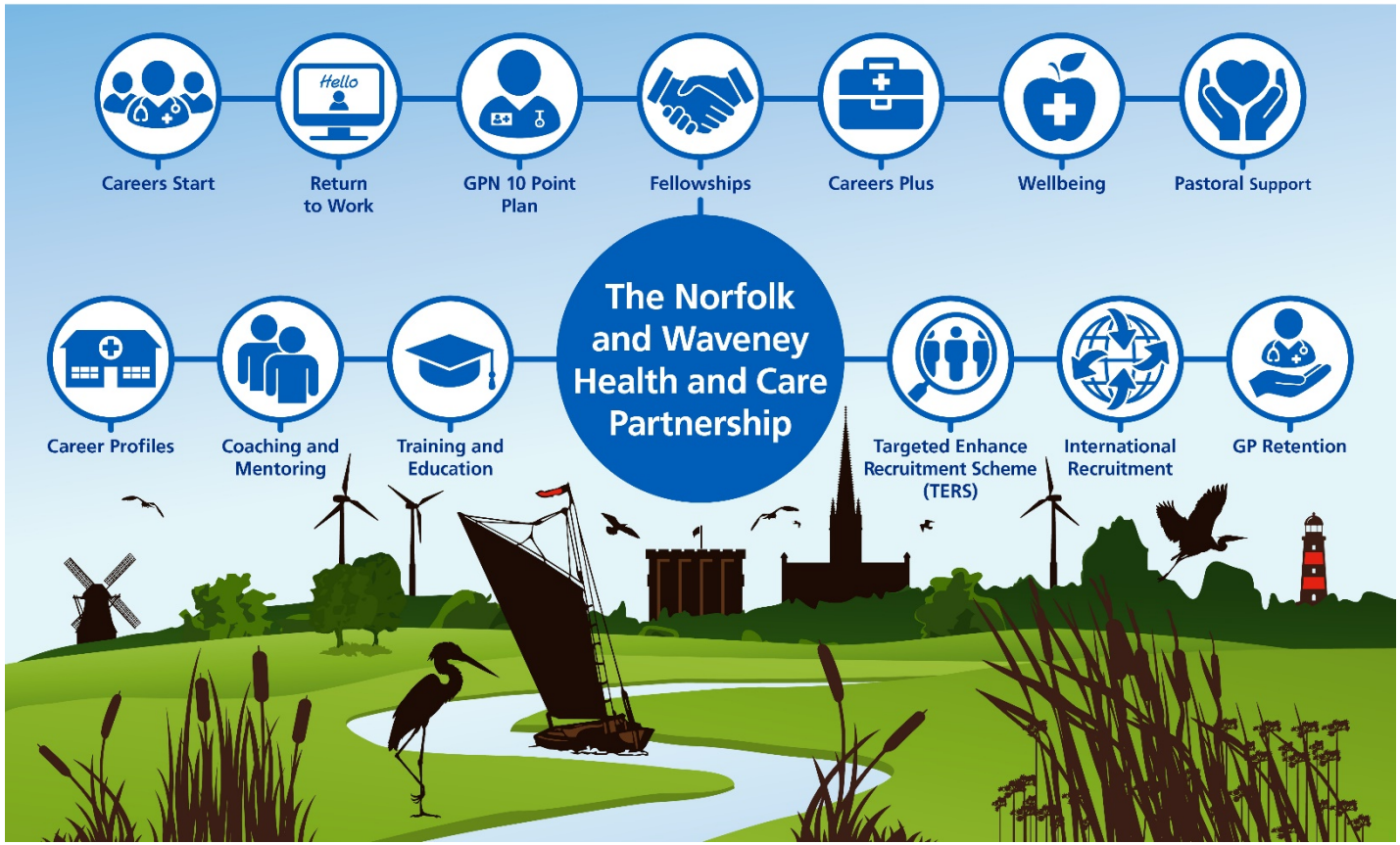
Single Point of Access Website (General Practice Support Hub)

Norfolk and Waveney's General Practice Support Portal provides confidential information, together with advice and support on career and personal development. Click on the icons to find out more about the different opportunities on offer and how you can access them.



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GPFV Trajectories approved by NHS England

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	Calculated Field
	Prepopulated Cell
	Enter Data in Cell

		Headcount							FTE					
		2018/19 Inflows Oct-Mar	2019/20 Inflow				2019/20 Planned inflow	Participation rate	2018/19 Inflows	2019/20 Inflow				2019/20 Planned inflow
			Q1	Q2	Q3	Q4				Q1	Q2	Q3	Q4	
GP	New Fully Qualified GPs	2	5	20	6	5	36	0.75	1.50	3.75	15.00	4.50	3.75	27.00
	Induction & Refresher scheme	0	0	0	0	3	3	0.6	0.00	0.00	0.00	0.00	1.80	1.80
	International recruitment	0	0	0	2	2	4	0.8	0.00	0.00	0.00	1.60	1.60	3.20
	GP Retention Scheme	0	0	3	1	3	7	0.4	0.00	0.00	1.20	0.40	1.20	2.80
	Other GP retention initiative	6	6	8	8	6	28	0.4	2.40	2.40	3.20	3.20	2.40	11.20
	Other	0	0	0	0	0	0	0.75	0.00	0.00	0.00	0.00	0.00	0.00
Clinical	Nurses	4	6	14	11	10	41	0.82	3.28	4.92	11.48	9.02	8.20	33.62
	Direct Patient Care staff (excluding physician associates and pharmacists	0	12	11	12	11	46	0.7	0.00	8.40	7.70	8.40	7.70	32.20
	Physician Associates	0	2	2	2	2	8	0.85	0.00	1.70	1.70	1.70	1.70	6.80
Clinical	Pharmacists	0	5	5	5	5	20	0.86	0.00	4.30	4.30	4.30	4.30	17.20
Non Clinical	Admin Staff	0	31	31	31	31	124	0.66	0.00	20.46	20.46	20.46	20.46	81.84

		Headcount							FTE					
		2018/19 Outflow Oct-Mar	2019/20 Outflow				2019/20 Planned outflow	Participation rate	2018/19 Outflow	2019/20 Outflow				2019/20 Planned inflow
			Q1	Q2	Q3	Q4				Q1	Q2	Q3	Q4	
GP	Retirement	8	8	8	8	8	32	0.88	7.04	7.04	7.04	7.04	7.04	28.16
	Other	5	5	5	5	5	20	0.8	4.00	4.00	4.00	4.00	4.00	16.00
Clinical	Nurses	2	9	9	9	5	32	0.82	1.64	7.38	7.38	7.38	4.10	26.24
	Direct Patient Care staff (excluding physician associates and pharmacists	0	9	9	10	10	38	0.7	0.00	6.30	6.30	7.00	7.00	26.60
	Physician Associates	0	0	1	0	1	2	0.85	0.00	0.00	0.85	0.00	0.85	1.70
Clinical	Pharmacists	0	0	0	0	1	1	0.86	0.00	0.00	0.00	0.00	0.86	0.86
Non Clinical	Admin Staff	0	24	24	24	24	96	0.66	0.00	15.84	15.84	15.84	15.84	63.36

APPENDIX 1

Norfolk and Waveney Sustainability & Transformation Partnership

2019/20-2023/24 Primary Care Strategy

			Historic Trend - FTE						Forecast Plan - FTE							
			17-18 Q1	17-18 Q2	17-18 Q3	17-18 Q4	18-19 Q1	18-19 Q2	2018/19 Net Flow	2018/19 Forecast	Q1	Q2	Q3	Q4	2019/20 Plan	Growth
Rolling Total	GP	Excluding Registrars	0.00	541.90	541.28	534.88	532.41	528.77	-7.14	521.63	516.74	525.10	523.76	523.47	523.47	0.4%
	Clinical	Nurses	0.00	368.54	373.16	370.42	377.14	379.99	1.64	381.63	379.17	383.27	384.91	389.01	389.01	1.9%
		Direct Patient Care staff (excluding physician associates and pharmacists	0.00	372.43	372.25	374.09	374.49	381.67	0.00	381.67	383.77	385.17	386.57	387.27	387.27	1.5%
		Physician Associates	0.00	0.80	0.80	3.47	3.47	3.47	0.00	3.47	5.17	6.02	7.72	8.57	8.57	147.1%
		Pharmacists	0.00	4.20	4.79	5.93	7.92	10.43	0.00	10.43	14.73	19.03	23.33	26.77	26.77	156.7%
	Non Clinical	Admin Staff	0.00	2021.51	2034.60	2042.15	2009.60	2043.84	0.00	2,043.84	2,048.46	2,053.08	2,057.70	2,062.32	2,062.32	0.9%

APPENDIX 1

Norfolk and Waveney Sustainability & Transformation Partnership

2019/20-2023/24 Primary Care Strategy

12.6 Appendix 6: Primary Care Commissioning Committees activity

Primary Care Commissioning Committees -			
Activity	Date	Progress	Role of PCCC
Briefing on GP Contract and PCNs	Feb 2019	Completed	Noting
PCN applications	16 May 2019	Completed	Approved
Primary Care Strategy	June 2019	In Draft	Approval
Primary Care Delivery Plans	1 July 2019 - onwards	drafts	Approval and oversight/assurance
PCN network agreements	July 2019	On track for completion 1 July 2019	Members to note progress
PCN annual network agreement changes	April 2020 -onwards	On going	To approve
Enhanced Hours DES at PCN delivery level to ensure 100% population coverage	July 2019	To be presented after 1 July 2019	To note and approve
PCN Maturity Matrix Progress	March 2019	On going	Regular assurance reports to Committee
PCN Implementation of the 7 national DES service specifications	July 2019 – March 2023	On going	Regular assurance reports to Committee
GP 5 year Contract updates and areas for implementation	April 2019 – March 2023	On going	Approval and noting

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2019/20-2023/24 Primary Care Strategy

PCN Dashboard	April 2020	Awaiting details	Assurance and approval for actions
PCN Funding	April 2019 - onwards	Completed	Approval and assurance
PCNs patient and public engagement in local plans	July 2019 - onwards	On going	Assurance of engagement
Locally commissioned services via PCNs	To be developed during 2019	On going	Approval and assurance of delivery/performance to meet population health needs.
PCN workforce recruitment to new roles	April 2019	On going	Noting and assurance
PCN Improved Access and Extended hours DES	April 2021 - onwards	Awaiting national directive	Approval and assurance of 100% population coverage
Risk and Issues	On going	On going	To receive oversight and advise and approve PCCC risk and issues registers
Regular reports from PCNs on their activity and progress	On going	On going	To have oversight and assurance.
PCN Clinical Directors attend PCCC	TBC post 1 July 2019	TBC	To develop relationships with PCCCs.
Reports from community providers within the PCNs	July 2019 - onwards	On going	To have assurance and oversight and support any barriers etc.

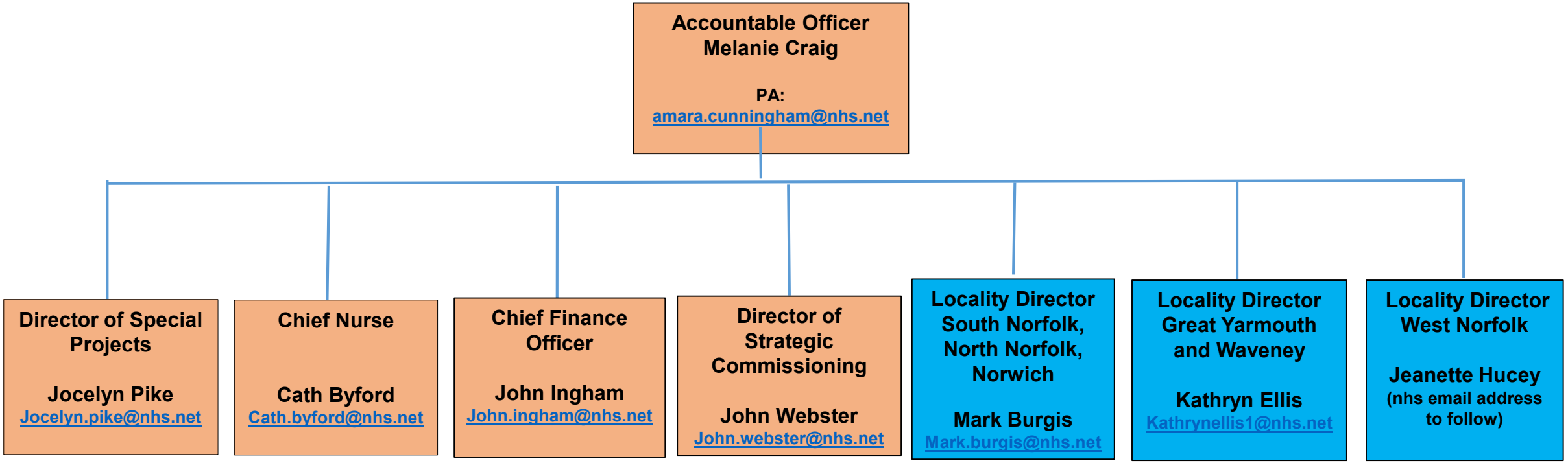
APPENDIX 1

Norfolk and Waveney Sustainability & Transformation Partnership

2019/20-2023/24 Primary Care Strategy

Great Yarmouth and Waveney
North Norfolk, South Norfolk
Norwich, West Norfolk
Clinical Commissioning Groups

Executive Team



Great Yarmouth and Waveney
North Norfolk, South Norfolk
Norwich, West Norfolk
Clinical Commissioning Groups

Moving Forward Together

A proposal to merge the five Clinical Commissioning Groups in Norfolk and Waveney by April 2020

The five NHS Clinical Commissioning Groups in Norfolk and Waveney have begun an engagement process with a view to formally merge by April 2020.

We believe merging makes good sense. We think one strong health commissioning organisation across Norfolk and Waveney will help to address pressing issues and offer greater clarity to patients and professionals. The NHS Long Term Plan also states that there should "typically" be one strategic commissioner (CCG) in any emerging Integrated Care System (ICS).

This means there are important questions about how this happens and how we can safeguard the strengths of CCGs, such as local focus and clinical leadership.

As the Chairs of the five organisations, we want your views and feedback.

We understand that you want to know practically how this proposal would work, how it meets the needs of future challenges within health and social care, and how it would affect you as someone living and working in Norfolk and Waveney. This document outlines the proposal, and provides you with the opportunity to give feedback on your thoughts. We encourage you to make your voice heard – the views of local people and partners will be taken into account when the five CCG Governing Bodies meet in September 2019.

Signed,

The Chairs

About this document

We are asking for your views on changing the way NHS commissioning is arranged in Norfolk and Waveney.
NHS commissioning is the process of planning, agreeing, buying and monitoring health services.

Currently, Norfolk and Waveney is covered by five commissioning organisations:

- NHS Great Yarmouth and Waveney Clinical Commissioning Group
- NHS Norwich Clinical Commissioning Group
- NHS North Norfolk Clinical Commissioning Group
- NHS South Norfolk Clinical Commissioning Group
- NHS West Norfolk Clinical Commissioning Group

NHS Clinical Commissioning Groups (CCGs) took over responsibility for planning, paying for and monitoring local health services in April 2013.

They are organisations combining the expertise of local family doctors (GPs) and NHS managers; putting local doctors and nurses at the very heart of deciding what health services to provide, where and how.

How long do I have to give feedback?

You can respond to this proposal over the period 6th August to 6th September 2019.

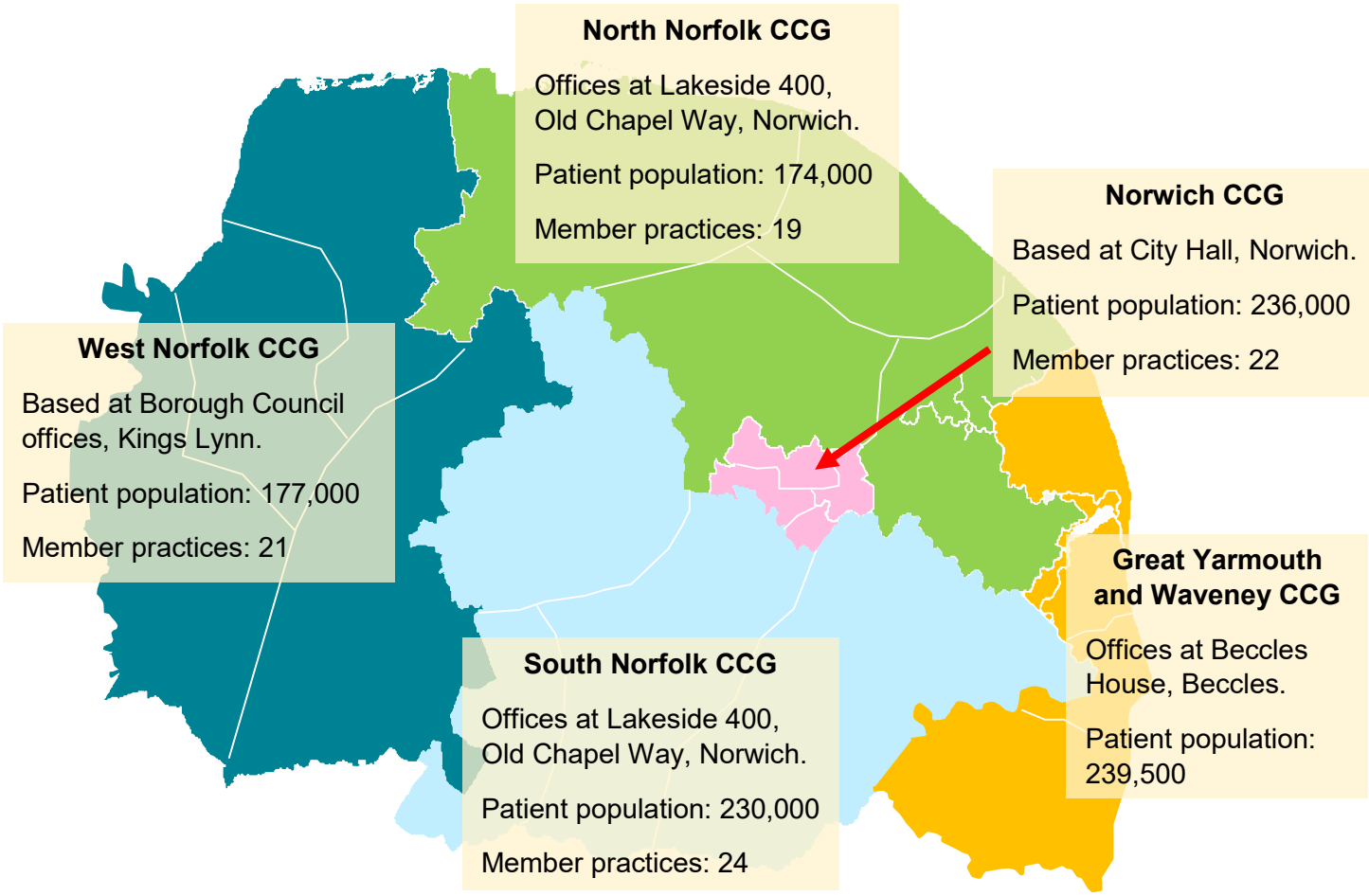
What is not included in this proposal?

This proposal is specifically about the future of NHS commissioning arrangements in Norfolk and Waveney.

It is not focus on any other NHS organisation, or NHS funded health services, and does not affect hospital or primary care (GP) services.

What are the current arrangements?

There are currently five separate Clinical Commissioning Groups in Norfolk and Waveney. Each one is a separate legal entity with its own Governing Body structures. The information below is as reported in each CCG's Annual Report 2018-19.



Each CCG has its own membership of local GP practices, Council of Members, and Governing Body with elected members from GP practices, lay members and senior management. Each has its own Governing Body Chair and committee structure including for Primary Care Commissioning, Quality and Remuneration.

In 2018 the CCGs created a shared Joint Strategic Commissioning Committee (JSCC), to co-ordinate the work of the five CCGs.

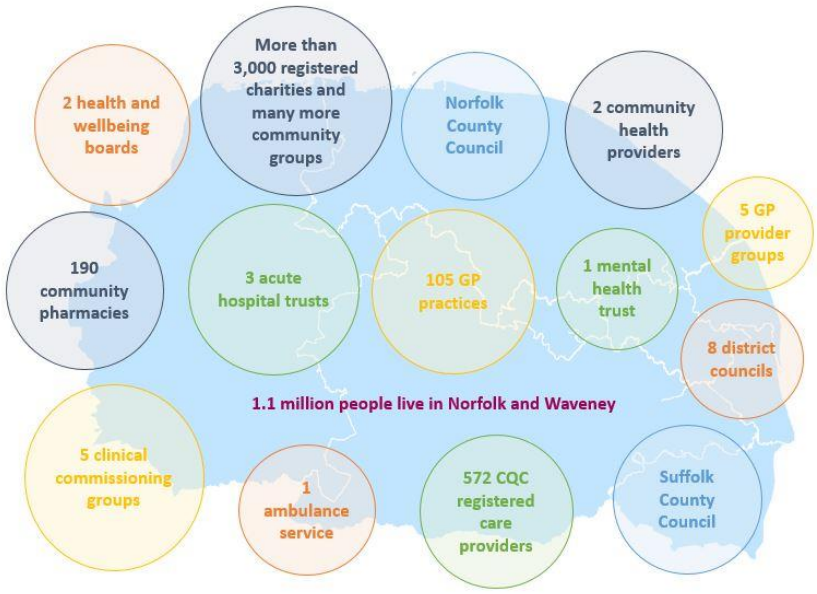
In April 2019, the CCGs began creating one joint team of staff and management to carry out the work of all five CCGs. Ultimately this will offer clear executive leadership, capacity and economies of scale. Melanie Craig was appointed joint Chief Officer, and an Executive Management Team and senior team is currently being finalised. During late August a process will begin to develop one full staff team structure.

A transition group, made up of key members of staff from across the five CCGs, has been arranged to work on the development of the single management structure, to ensure that business as usual activity at the CCGs can continue.

The CCGs' Chief Officer is also Executive Lead for the Norfolk and Waveney Sustainability and Transformation Partnership. This is a partnership of local health and care organisations working together to build healthier communities in Norfolk and Waveney. The partnership includes local GP practices, hospitals, community care, social services and mental health teams that together provide services to more than a million people.

About Norfolk and Waveney

Norfolk and Waveney is a large rural area, with large urban settlements and many smaller market towns and villages.



Our population in Norfolk and Waveney is generally older and it is projected to increase at a greater rate than the rest of England, which creates a challenge for the health and care system. Almost all of the population increase over the last five years has been in the over 65 age groups and we anticipate the largest increase between 2014 and 2025 to be in those aged 65 and over.

These changes will increase the need for health and social care support as multi-morbidity, frailty and risk of emergency admissions increase with age, which will impact on primary and community care provision. This means that due to age alone between 2014 and 2025, we will see about 9,000 additional people with diabetes, more than 12,000 additional people with CHD, more than 5000 additional people who have suffered a stroke and almost 7000 additional people with dementia (ref: local modelling, Public Health Information Team).

The changes we propose

The five CCGs propose to merge into one CCG for all of Norfolk and Waveney, with one Governing Body. A joint staff team is already being created to work across the existing five CCGs.

During early discussions among Governing Body members from all five CCGs, there were two areas which they wanted to be addressed:

- Ensuring our work is locally focussed as well as focused on the whole on Norfolk and Waveney
- Ensuring our work continues to be clinically-led. This means local doctors and nurses being involved in our work, our decision making and providing advice.

We believe these concerns can be addressed by:

Clinical leadership

- Ensuring there are clinicians drawn from our local areas elected to the new Governing Body and providing advice and leadership in the CCG's work
- Each existing CCG has a 'Local Delivery Group' where health, council, voluntary sector and other partners meet to plan services in that local area. This is where strong, locally-focused decisions can continue to be made.
- There are new "Primary Care Networks" (PCNs) being developed across Norfolk and Waveney to bring GP services, community, mental health and social care teams closer together. Each PCN will be able to ensure local services are tailored to local need.

Local accountability

- Ensuring an appropriate geographic spread of lay members from each area of Norfolk and Waveney
- Retaining local 'Councils of Members' - meetings of member GP Practices to discuss CCG business - if the practices wish to
- Our new management structure includes three Executive Director posts responsible for strengthening locality working (West Norfolk, Central Norfolk and Great Yarmouth and Waveney)

Local visibility

- Our working bases would still be in King's Lynn, Norwich and Beccles.
- We would hold Governing Body meetings in public in different parts of Norfolk and Waveney so members of the public can attend as and where they wish.

Why do we want to make changes?

The NHS Long Term Plan was issued in January 2019 and sets out a vision for the NHS over the next 10 years and beyond. It states that by April 2021 every area will have an Integrated Care System (ICS) which includes a single CCG.

"Every ICS will need streamlined commissioning arrangements to enable a single set of commissioning decisions at system level. This will typically involve a single CCG for each ICS area. CCGs will become leaner, more strategic organisations that support providers to partner with local government and other community organisations on population health, service redesign and Long Term Plan implementation."

NHS Long Term plan, section 1.51.

Benefits for patients:

We have listened hard to clinicians and patients over the years and we believe the biggest issues are wider 'system' issues that can only be addressed by having one strong, unified commissioning voice. For example we want - and must get - better mental health services with reduced waits and fewer out of area placements, quicker help for children and young people, especially in terms of mental health referrals and we must find ways to address rising demand in planned and unplanned acute care; We think having one CCG, one Board and one commissioning voice will help achieve this.

Benefits for staff:

- Greater resilience as part of a larger organisation
- Working together as one organisation will generate economies of scale and reduce duplication
- Create opportunities for involvement in new areas of work to support career progression
- Create opportunities to work in a new way, making the best use of new technology and improve staff work-life balance
- Provide more consistent leadership and direction for staff working across the Norfolk and Waveney Health and Care Partnership

Benefits for partners:

- Breaking down the barriers to shared working and paving the way for the Integrated Care System (ICS)
- Providing a single point of contact for partners and a single vision for commissioning services
- Support for existing partnerships and working relationships at place and neighbourhood levels

Financial benefits:

NHS England and NHS Improvement requires the cost of running CCGs to be reduced so that more money can be ploughed into patient care,

This is how our 'running costs' will reduce in Norfolk and Waveney.

We are saving money by creating one single team of staff. However we think we can save more public money by having one CCG and one Governing Body, instead of five of each.

The total cost of running five Governing Bodies is £1.4 million per year. There are also hidden costs, for example staff time in servicing the five Governing Bodies. At this stage we have not carried out sufficient engagement to determine the number of lay and clinical members we would need on a new single Governing Body, but we would certainly expect to make a financial saving. Whilst we cannot say precisely how much money could be saved, at this moment, we would wish to speak with our practices and partners to inform the details of any future model.

We must also bear in mind the vital importance of continuing to have local expertise and clinical expertise. Many of our Governing Body members are doctors or nurses and it is vital to retain strong 'clinical engagement'. Our lay members also bring a wealth of experience which we need - and are required to have - to run public services properly.

Why not keep five CCGs?

The landscape is changing and we do not think this is an option.

We have achieved much as five, smaller CCGs since 2013 however decision-making across the 'wider system' is slower and more expensive with five Governing Bodies. Keeping five CCGs would not help us meet new demands and priorities, such as the need to improve performance, quality and our financial challenge across the whole of Norfolk and Waveney. We think our partners that provide services across larger areas, such as some NHS Trusts, would find it better to work with one bigger CCG.

NHS England and NHS Improvement criteria

There are national criteria which must be addressed, for merging CCGs. These are summarised below. The CCGs in Norfolk and Waveney believe that these criteria are currently addressed, or will be addressed following engagement with member practices and partners.

- **Alignment with (or within) the local STP/ICS** - please see page 6
- **Co-terminosity with local authorities**: Great Yarmouth and Waveney CCG, and its predecessor Primary Care Trust, has served its populations in Norfolk and the Waveney area of Suffolk. This is not least because of the strategic importance of the James Paget University Hospital to this distinct area.
- **Strategic, integrated commissioning capacity and capability**: - please see page 6
- **Clinical leadership**: Safeguarding and strengthening our clinical leadership, as well as our local focus, would be paramount. This is described on page 5
- **Financial management -** a new CCG is required to have robust financial governance including independent audit. An experienced finance team is already in place and details of future arrangements would be developed before any application.
- **Joint working**: A merger should build on collaborative working between the existing CCGs and represent a logical next step from current arrangements. This is described on page 3
- **Ability to engage with local communities**: Safeguarding local focus and engagement is paramount. This is touched upon on page 5. As part of the process to apply to merge, the CCGs would be required to set out its engagement strategy. Each CCG has Local Delivery Groups which bring together a wide range of partners and these would be safeguarded and built upon.
- **Cost savings** - please see page 7
- **CCG Governing Body approval**: the merger application must show evidence of approval by each existing CCG Governing Body. The 5 CCGs have so far agreed to explore a possible merger and a final decision would be expected in September.
- **GP members and local Healthwatch consultation -** this is underway or in development

What have we learned so far?

We know from speaking to local stakeholders such as our community and stakeholder engagement panels, our Patient Participation Groups (PPGs) based around GP surgeries, our Member Practices and staff that there are issues of great importance to them:

- It is important to keep local differences and 'grass roots' relationships within the larger area
- The issues of both rural and more urban areas need to be equally reflected
- It is important not to lose the voice of patients and public in local areas
- It is important not to lose existing examples of good practice
- Larger organisations can feel more remote and less accountable locally

How can I have my say?

We want to hear from anyone who wishes to share their views on the proposal set out in this document.

To give us your views please complete our online survey at:
https://www.smartsurvey.co.uk/s/NorfolkandWaveneyCCGProposal/

Alternatively, to request a hard copy of the survey please email:

snccg.communications@nhs.net

Or write to:

Freepost RTJE-GXBZ-CSJR
NHS Norwich CCG
Room 202
City Hall
St Peters Street
Norwich
NR2 1NH

What happens next?

The deadline to give feedback on this proposal is 6th September 2019. We will then write a report, including all of the feedback that we have received.

This feedback will then be considered by the CCGs and NHS England and Improvement in order to help NHS England and Improvement make a final decision regarding the future of the Norfolk and Waveney CCGs later this year.

The final decision will be made public as soon as possible.

Appendix 4

Integration - Key Risks

Risk	Likelihood	Severity	Mitigation
Loss of democratic accountability	Low	High	• Ensure that governance through democratic structures remains clear • Section 75 in place to govern and monitor structural relationships with NHS partners • Ongoing review of Section 75 will provide further scrutiny the effectiveness of this. • Member involvement with STP/ICS development and of the Health & Wellbeing Board
Failure to deliver NCC statutory requirements	Medium	High	• Clarity around NCC priorities and responsibilities • Establish clear performance indicators and ensure robust monitoring • Clear guidance and support provided to NCC officers involved in developing integrated ways of working locally
Potential funding shortfall for Adult Social Care due to integration of capital and revenue budgets between the Council and NHS. NB on ASC risk register.	3	5	• Section 75 agreements in place to manage forward planning and joint arrangements • Partnership Boards in place • Introduction of Improved Better Care Fund • Regular monitoring and liaison with health partners on outstanding debt
Dominance of NHS culture and medicalised models of delivery	High	Medium	• Senior leadership creates greater visibility of local authority culture and approaches • Challenge at senior level • Organisational development to support culture change

Appendix 4

Risk	Likelihood	Severity	Mitigation
Reputational damage arising from NHS problems with a number of Trusts in special measures and financial insecurity.	Low	Low	• Being alert to upcoming issues • Joint communication and press activity through the STP
Potential for integration to impact on reputation through pressure on integrated staff/ joint teams regarding capacity and focus on departmental priorities impacting on reputation / ability to deliver. NB on ASC risk register.	Low	Medium	• Pressure closely monitored by ADs and escalated to Director Integrated Services. • SMT monitor and consider the implications and costs across both organisations. • Issues can be escalated to S75 Monitoring Board for resolution. • Budget and performance metrics and holding to account sessions are kept separate and focussed.
Loss of efficiencies by moving towards a localised approach to delivery at Primary Care Network level, rather than delivery on a countywide basis	Medium	Medium	• Evidence-led business approach to determining localised solutions and understanding implications of moving away from countywide delivery mechanisms.
Delayed Transfers of Care (DTOC): A significant increase in DTOC might jeopardise additional integrated funding (iBCF) and have adverse consequences as well as for the quality of care This would further increase financial pressures on the health and social care system. NB on ASC risk register.	High	High	• DTOC Improvement Plan in place • Improved Better Care Fund is targetted, in part, on reducing DTOC • Winter plan in place to support co-ordination between health and social care and improved management of surges in demand