WEST NORFOLK CCG OPERATIONAL PLAN

2017/18 to 2018/19

INDEX

Our local vision

(and alignment with the Norfolk and Waveney Sustainability and Transformation Plan)

Our Vision is:-

"for the people of West Norfolk to have high quality care, delivered locally, within our available resources"

Our vision for how health and social care will be delivered in West Norfolk by 2021 is:-

"a thriving local hospital, a strong and united network of GPs, and a group of Out-of-Hospital providers of physical, mental health and social care services, all of whom behave as one integrated 'whole system' delivering high quality care by staff who are proud to work and live in West Norfolk"

This future Vision of one integrated whole system assumes that the organisations delivering health and social care in West Norfolk will be reduced in number to enable the model to be created. This does not mean less staff providing services, it means more flexibility about redeploying resources to the place they are needed by reducing duplicated tasks, functions and roles. This will increase the effectiveness and responsiveness of face-to-face patient and resident care and reduce bureaucracy and overlaps between the many organisations involved. This vision has been articulated and discussed over a number of years with the West Norfolk Health and Social Alliance and the current financial and political drivers make it an urgent, imperative action.

This vision aligns with and strongly supports the delivery of the Norfolk and Waveney Sustainability and Transformation Plan (STP). Our work-streams to implement the plan dovetail with the STP; some are joint schemes where there is a uniform approach across the county and some are local, where the characteristics of the locality determine the specific nature of the schemes. The transformation of services will be aligned with the Norfolk and Waveney system vision to ensure:

- Services treat people as a whole person and outcomes which are important to the person are what matter in their care.
- People will receive good care any time, any day, with the aim of safely keeping them at home where possible and appropriate.
- People and organisations who care for individuals talk to each other, with one individual responsible for a person's care who is easy to get hold of.
- The system recognises an individual's time is precious and visits are arranged recognising this.
- A trusting relationship is developed between an individual and the practitioners who care for them.

Our local vision

(and alignment with the Norfolk and Waveney Sustainability and Transformation Plan)

Five Guiding Principles of the Norfolk & Waveney System Transformation Plan

Preventing illness and promoting wellbeing	•The population of Norfolk and Waveney will be enabled to live healthy lives for as long as possible, through a spectrum of support: from targeting lifestyle risk factors (e.g. alcohol, obesity) to secondary prevention preventing unnecessary escalation to higher acuity care settings. Strong community services aligned with local authorities and the third sector support independence and increase resilience.
Care closer to home	•People are supported to live with maximum independence, with improved access to primary and secondary care, and supported by thriving links to the third sector. Enhanced community care delivers the right care at the right time in the right place, reducing demand on acute and residential services. End of Life care is structured to allow patients to die in their place of choice. A system-wide children's strategy will improve service provision for children and young people.
Integrated working across physical, social and mental health	•Integrated working across all system interfaces is co-ordinated to deliver holistic care with reduced duplication and gaps in care, and improved patient experience and outcomes. Services recognise the importance of social care and mental health parity of esteem.
Sustainable acute sector	•Acute services will be configured to be sustainable under future demand pressures through increased provider collaboration. Out of hospital services will reduce demand at the front door, and assist discharge processes to maintain capacity within the acute system
Cost-effective services	•Delivered within the finances available – providers and commissioners will work together to realise CIP and QIPP savings, release organisational efficiencies, and remove perverse incentive structures.

We will

- Implement agreed STP milestones, so that the Norfolk and Waveney STP is on track for full achievement by 2020/21.
- Achieve agreed trajectories against the STP core metrics set for 2017-19.
- Include clear and credible milestones

Our local vision

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Five Guiding Principles of the Norfolk & Waveney System Transformation Plan

Areas of key impact

Norfolk and Waveney STP work-streams have identified areas where they can best positively impact the health and care outcomes of our population and these align along the following system priorities:

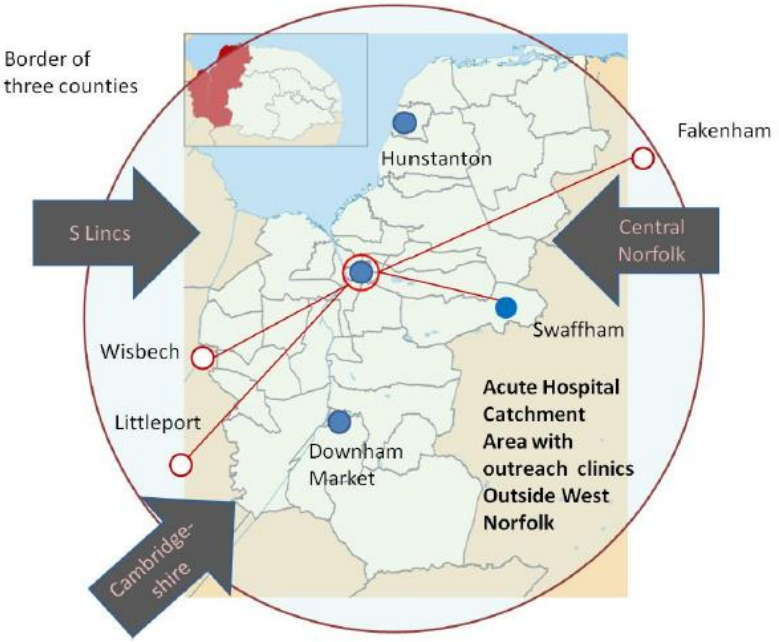
- Sustainable physical and mental health, social care and prevention services out of hospital
- Reducing acute activity, including A&E attendances, non-elective (NEL) admissions and inpatient length of stay (LoS) by establishing integrated locality or place based teams responsible for physical, mental and social care
- Improved management of planned care to meet national waiting time standards, and reduce variation and demand
- Adaptive and sustainable workforce

For West Norfolk, the transformation of community services means starting with one integrated community complex care hub in King's Lynn, incrementally adding formal and informal services that work together through arrangements such as honorary contracts and risk-sharing agreements. Out of necessity, this will initially be limited by the clinical space available currently but over the next 12 months, a capacity and fitness review will be conducted of all 'public estate' to determine the opportunities to accommodate the various developments planned that require premises and could potentially be delivered in the same space. For example, General Practice bids for new premises are being considered by NHS England at the same time as the West Norfolk Transformation Plan is working up proposals for community complex care hubs, acute mental health facilities and emergency primary and secondary care collaboration. These need to be considered in totality, with all agencies working to one local vision. Ultimately, the West Norfolk Transformation Plan will recommend a series of reform proposals for consideration by each organisation, to move from the current state to a future, reduced number of organisations, working as one integrated care delivery system. The financial impact this would have on individual organisations and on the future sustainability of local services will be a key focus for the programme.

There are various structural models available nationally that can be employed to deliver our vision including Multi-specialty Community Providers (MCP), Primary & Acute Care Systems (PACS), Social Enterprise and Foundation Trust. We will pursue the model that best fits local circumstances and which ultimately leads to an Integrated Care Organisation delivering integrated whole system care

The Key Challenges : "Rurality"

West Norfolk is a primarily rural area with a large market town (King's Lynn) and with a population of approximately 170,000 people. The area has a well-defined health and care system geographically served by the largely coterminous West Norfolk CCG and Borough Council of King's Lynn and West Norfolk. At its centre is QEHKL, which serves a catchment population of approximately 330,000 people over 750 square miles in West Norfolk, the Wisbech area of Cambridgeshire, as well as some populations from neighbouring Lincolnshire and Central Norfolk.



There are 21 GP practices in West Norfolk and community and mental health services are provided primarily by county-wide NHS organisations with a West Norfolk locality focus.

The Key Challenges : Ageing Population

Health gap due to an aging population

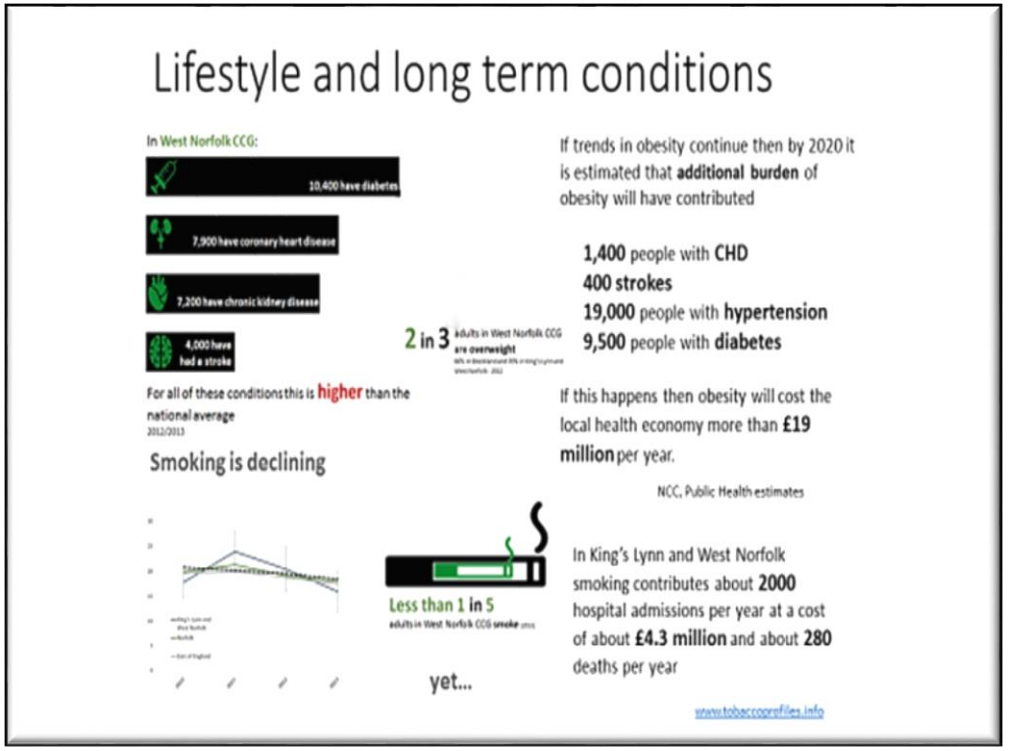
- 17% of the West Norfolk population are 70 years or older compared to 12% 70 years or older for England overall.
- The West Norfolk population is growing at around 0.6% a year overall, with the population aged 85 or older growing by 3.4%, while 15-25 year olds are declining by 1.6% per annum.

Evidence shows that an ageing population leads to higher dependency on out of hospital and in hospital care services and greater demand on healthcare services due to frailty and multiple conditions.

The impact of projected ageing on healthcare usage in West Norfolk, and therefore cost of providing healthcare, is 1.4% growth each year, which is just under £3 million increase in cost. This cost pressure will be compounded year on year, meaning a challenge of £15 million in 5 years.

The Key Challenges : Lifestyle and long-term conditions

Health gap due to lifestyle and long term conditions



2 in every 3 West Norfolk adults are overweight and if this trend continues then, over the next 5 years, this will contribute to significant increases in related long-term conditions including Coronary Heart Disease (CHD), strokes, hypertension and diabetes. Obesity will cost the West Norfolk system approximately £20 million per year.

In West Norfolk, smoking contributes about 2,000 hospital admissions per year at a cost of about £4.3 million and about 280 deaths per year. In contrast to other conditions where mortality is decreasing, alcohol related mortality is showing an upward trend.

The Key Challenges : Performance

The CCG faces a number of significant challenges in ensuring that the key national "constitutional" and other targets are achieved. Although progress was made in 2016/17 there remain a number of areas where performance is planned to improve in 2017/18.

These include:

- A&E 4 hour waits
- Ambulance Turnaround times
- Cancer 62 wait referral to treatment
- Improved Access to Psychological Therapies
- Dementia Diagnosis rates
- Health checks for people with a Learning Disability

In addition to these targets, there is a range of other clinically specific targets.

The Key Challenges : Quality

Care and Quality Gaps

Health performance – Primary Care

Variation in the quality of primary care can result in sub-optimal care for the frail elderly and people with long term conditions, and can result in people with relatively minor conditions attending the A&E department.

Although overall A&E attendances in West Norfolk are significantly lower than the England average (324 attendances per 1,000 patients, weighted for age/health status), there is variation of A&E attendances by GP practice –varying from 141 attendances per 1,000 patients (weighted for age and health status) per year to 313 per 1,000 (a variation of 122%).

Non-elective ambulatory care sensitive admissions (admissions to hospital that can be avoided) by GP practice are higher than the England average with, again, high levels of variation between GP practices. Rates vary from 11 admissions per 1,000 weighted patients per year to 27 (a variation of 150%), while the England average is 18.1 per 1,000 weighted registered patients (*Source: CPT Final Report M*

Avoidable Admission Conditions	Activity 2015/16	% of Total 2015/16	Costs £'000 2015/16
Influenza/Pneumonia	373	15%	£ 1,033
Pyelonephritis and kidney/urinary tract infections	367	14%	£ 943
COPD	343	13%	£ 613
Congestive Heart Failure	325	13%	£ 793
Atrial Fibrillation & Flutter	247	10%	£ 332
Angina	224	9%	£ 204
Dehydration and Gastroenteritis	179	7%	£ 557
Cellulitis	128	5%	£ 284
Iron Deficiency Anaemia	113	4%	£ 225
Diabetes	60	2%	£ 132
	2,360	93%	£ 5,115
Data is 10 months 2015/16, extrapolated to 12 months			

Table 1 highlights the activity and cost to the local health system in 2015/16 for the top 10 avoidable admission conditions (*Source: SUS data using Health & Social Care Information Centre Methodology*).

Health performance – Secondary Care

QEHKL has delivered sustained improvement in performance, including A&E 4 hour standard, access targets for referral to treatment, and meeting cancer access standards. The major challenge to the accessibility of services however remains the A&E 4 hour standard.

There are a number of contributing factors to this including increasing population demand, as well as challenges to the effective co-ordination of urgent care services across health and social care providers.

The Key Challenges : Quality

Health performance – Community and Mental Health Services

Community Services:- NCH&C were last reviewed by the Care Quality Commission (CQC) in December 2014 and rated good. Services are run well with only minor problems in relation to meeting the 18 weeks Referral to Treatment target for Adult patients of the Speech and Language therapy services.

Mental Health Services:- NSFT has been removed from special measures, following a recent CQC visit. The Trust still faces a number of challenges in relation to the Fermoy Unit (a 20 bedded standalone acute psychiatric ward commissioned by the CCG). The unit has been under a period of sustained pressure, with difficulties in recruitment, planned retirements and a heavy reliance on locum staff. The Trust has experienced difficulty in meeting national targets for IAPT (Improving Access to Psychological Therapies) and patients who complete treatment and move to recovery.

Health performance – Ambulance Service

The East of England Ambulance Service Trust (EEAST) response times remain a challenge across all national standards. The challenges of rurality and higher levels of acuity are contributing factors.

Social care

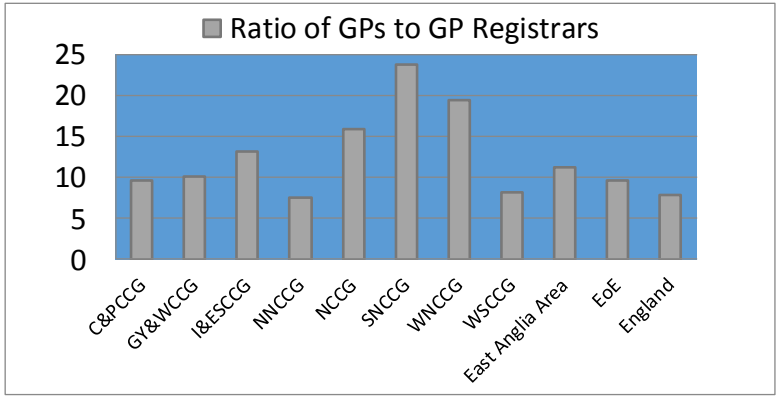
An analysis of Norfolk's position compared to its 'family group' of statistically similar councils shows the rate of people supported within residential care settings. It suggests Norfolk is the highest user of residential care for people with learning disabilities and for people with mental health problems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

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

A significant gap in the availability and quality of care services in Norfolk can be attributed to challenges within the social care market. Increases to the National Minimum Wage and National Living Wage, issues with significant ongoing staff turnover (particularly in home care), and an ageing care estate are driving increased costs, and a lack of some services in rural areas.

The Key Challenges : Workforce

The availability of suitably qualified and experienced staff is a significant challenge in West Norfolk and directly impacts on the quality of care. Sub-specialisation of acute services has created challenges for smaller hospitals, particularly in low volume specialties and within the context of delivering the 7 day services standards. Nursing recruitment and retention is also a national issue and has led to increased costs of delivery as the proportion of agency staff increases.



Community and social care services show significant numbers of vacancies in a variety of professions and care settings with some of this gap being covered by agency or bank staff. Recruiting to key posts, especially adult, mental health and learning disability nurses is especially challenging.

West Norfolk is likely to lose a significant number of GPs to retirement in the next 5 years as one third of the workforce is 50 or over. It is also likely that it will be difficult to replace this loss of workforce with equivalent numbers of GPs, as West Norfolk is attracting comparatively lower numbers of younger GPs and registrars (see Figure 3). West Norfolk has a high ratio (0.92) of full-time GPs, with male GPs making up 75% of those 50+ and female GPs having a younger age profile. The replacement of the current GP workforce is likely to require a higher GP headcount as new recruits follow the national trend towards a more flexible career e.g. part-time working (*Source: West Norfolk General Practice Workforce Analysis 2014*)

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

The Key Challenges : Funding and Efficiency

The West Norfolk health system forecast projects a system-wide "do-nothing" gap of £87 million by 2020/21, prior to consideration of commissioner and provider savings programmes. Although the system income increases each year, mainly due to increases in the CCG's financial allocation, this does not compensate for the additive effect of demand growth and inflation. Acute demand growth is approximately 2% per annum with other demand growth in the areas of primary care, mental health and prescribing of between 2-6% and inflation at 2-3%. Table 2 describes the financial position between 2016/17 and 2020/21 in the "do nothing" scenario.

WNSTP	Do Nothing				
£m	FY17	FY18	FY19	FY20	FY21
System Income					
WNCCG Allocation	240.4	246.4	252.3	258.7	269.9
Trust Income from Other Norfolk CCGs	6.3	6.4	6.5	6.5	6.7
Other Trust Income	65.1	66.0	66.6	67.4	68.5
Total Income	**311.8**	**318.8**	**325.5**	**332.7**	**345.1**
Cost of Provision					
Trust Expenditure	(192.5)	(198.3)	(203.4)	(208.8)	(215.9)
Commissioning of Other Services	(147.7)	(162.4)	(178.5)	(193.7)	(216.6)
Total Expenditure	**(340.2)**	**(360.7)**	**(381.9)**	**(402.5)**	**(432.5)**
"Do Nothing" System Deficit	(28.3)	(41.9)	(56.5)	(69.9)	(87.4)

The key drivers of historic financial deficit at the QEHKL are associated with:

- recruitment difficulties leading to additional premium cost inflationary pressures of agency staff;
- increased investment in clinical staffing to address emergency demand pressures and historic quality concern's; and
- under delivery of cash out efficiencies.

Working with others: Our local system approach

There is on-going dialogue with local people, local organisations, patients and carers about potential changes to the way services are provided in West Norfolk. This is because we believe that effective engagement and communication is essential at every stage of the service change process, from planning changes to monitoring outcomes. We ensure that we talk to those patients and carers who will be most affected by changes to services. We have published an 'Evidence for Change' document and held extensive stakeholder events to gain the views of local people and patients. We also hold Annual Stakeholder Events over a five week period, from the end of August to mid-September, with the aim of focussing on sustainability, local system priorities and our work plan for the following two years. We use a variety of exhibition boards, presentations and focus groups to share evidence with local people in order to prompt an informed discussion as part of our long-term sustainability engagement work.

A copy of the summary report from the events can be found on the WNCCG website at:
http://www.westnorfolkccg.nhs.uk/sites/default/files/pdf/2015%20Stakeholder%20Events%20-%20Summary%20Report.pdf

We have well established and effective systems to engage and communicate with stakeholders and we undertake routine activities in a number of ways and forums:

- Annual General Meeting (AGM)
- Annual Stakeholder Events
- Maternity Services Liaison Committee
- Patient Participation Groups (PPGs)
- West Norfolk Patient Partnership
- Annual Report
- Patient Stories, Concerns and Feedback
- HealthWatch Norfolk
- Health Overview & Scrutiny Committee (HOSC)
- Patient Representatives on CCG Committees and Groups
- Website and Social media
- Media releases

The West Norfolk Alliance, a partnership between county and district councils, the West Norfolk CCG, NHS providers and the third and voluntary sector, has driven the integration and transformation agenda at a local level. West Norfolk system sustainability is owned by all the local partners and solutions are being driven by cross-organisational clinical leadership with on-going and iterative engagement with wider clinical colleagues and wider staff. Our Sustainability Communication and Engagement Plan binds together the strands of clinical and staff engagement.

Working with others : Our STP approach

Whilst we are properly focused on the needs of our West Norfolk population and how we can address these, we are increasingly working with other partners within Norfolk and Waveney. We have drawn up an Sustainable Transformation Plan for Norfolk and Waveney and are just finalising the Delivery Plan.

The intention is to work closely together so that where it makes sense to do things on a larger scale we do so, and where we do things locally we do this within an agreed overall Norfolk and Waveney framework.

There are clearly instances where work needs to be done by each CCG locally, however there are circumstances where this could lead to duplication and inefficiency and we wont shy away from working together where it is efficient and clinically sound to do so.

Finances

Clinical Commissioning Groups (CCGs) have a fundamental financial duty to ensure that their expenditure does not exceed the amount allocated by NHS England. Part of the process for delivering this duty is for a CCG to produce a balanced financial plan each year. Furthermore, CCGs are expected to meet key financial planning requirements set down by NHS England (the “business rules”).

The financial plan for West Norfolk CCG Plan for 2017/18 – 2018/19 builds on work done to inform the West Norfolk element of the Norfolk and Waveney Sustainability and Transformation Plan (STP).

The CCG’s control totals (i.e. expected in-year surplus) notified by NHS England for 2017/18 and 2018/19 is an in-year surplus of £0.5m and £0.6m respectively. These control totals reflect the requirement for the CCG to have a cumulative surplus of 1% by 31st March 2019.

The resulting Best Value savings targets for the CCG are £10.3m in 2017/18 (4.3% of spend) then £9.0m in 2018/19 (3.6% of spend), which represent a significant challenge. Work continues to develop a robust QIPP plan for 2018-19 as part of the CCG’s operational planning process.

Finances (Continued)

Income - Each year the CCG receives an allocation of funding based upon the size of the population served amended for a number of changes to reflect increases in tariff's and cost bases and assumed levels of savings.

Expenditure - The CCG's largest area of expenditure by far is acute services commissioning which consumes 55% of the CCG's resource.

For the 2017/18 budget, the CCG has assumed;

- Price growth of 0.1% (comprising a cost uplift of 2.1% and a national efficiency requirement of 2%),
- A reduction in prices of £2.2m in relation to the impact of HRG4+activity,
- Increased activity growth of 4% (which is a composite of various growth rates including 5% growth on Non-Elective activity and 3.2% growth on Elective) and
- A transfer of activity to Specialist commissioners of £1.4m

Running Costs – The CCG's running costs are assumed to remain at previous years levels with no increases.

Income		
£ 000	2017/18	2018/19
Recurrent	244,103	249,961
Non-Recurrent	(3,973)	(4,041)
Total In-Year allocation	240,130	245,920
Expenditure		
Acute	132,323	135,427
Mental Health	17,543	17,493
Community	22,677	22,986
Continuing Care	12,050	11,240
Primary Care	37,764	38,596
Other Programme	12,367	14,677
Total Programme Costs	234,723	240,420
Running Costs	3,698	3,658
Contingency	1,209	1,241
Total Costs	239,630	245,320
Surplus	500	600

These figures exclude the transfer of delegated commissioning for primary care which took place on 1st April 2017.

Our Whole Programme Approach:

Explanation

To allow the WNCCG to be focused and clear on what our priorities are moving forward while maximising the resource that is available we have established a portfolio of programmes.

These programmes will be the 'vehicles' for all our developments and through the programmes we will:-

- Establish change;
- Improve patient experience;
- Meet our statutory and organisational commitments;
- Drive Best value and efficiency.

(The programmes within the portfolio are detailed in fig1)

In the course of developing an approach for managing programs successfully, there are some universal principles and benefits that apply to programs.

- Remaining aligned with the local, regional and national strategy;
- Leading change;
- Envisioning and communicating a better future;
- Focusing on benefits and "threats" to their achievement;
- Designing and delivering a coherent capability;
- Learning from experience;
- Adding value.

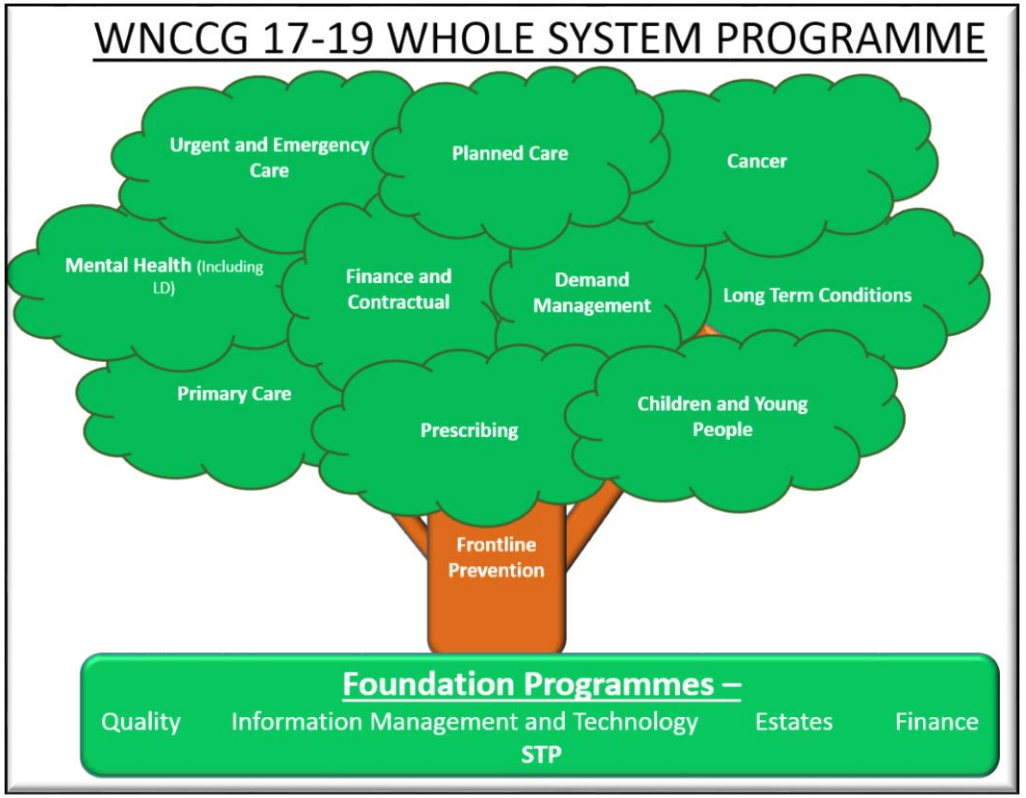


Fig1.

Why is this important?

The Cancer Programme is fully in support of and aims to deliver the recommendations of '*Achieving World-Class Cancer Outcomes: Taking the Strategy Forward*' which states: 'Earlier diagnosis makes it more likely that patients will receive treatments which can cure cancer. It saves lives. Creating the transformational shift to faster and earlier diagnosis is dependent on people being aware of and understanding the early signs and symptoms of cancer, approaching healthcare services if they have concerns, and on healthcare services acting swiftly to diagnose them.'

What are we trying to achieve?

The aim is to increase the proportion of patients identified through screening and managed pathways whilst reducing the numbers of patients diagnosed through emergency routes as well as focusing on population groups and geographic areas with poor cancer outcomes.

We will use RightCare date to identify areas of variation in care and outcomes and will focus on these.

- We will work with Public Health England, local authorities and primary care to improve uptake of screening programmes, specifically for breast, colorectal and gynaecological cancers.
- Ensure the 2015 NICE Guideline NG12 is fully embedded in all GP practices. This guideline reduces the threshold of risk to trigger an urgent cancer referral.
- Review specific tumour site pathways to improve.
- Support recovery and survivorship programmes.

National Targets / NHS Must Do's

- Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.
- Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.
- Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.
- Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.

Ensure all elements of the Recovery Package are commissioned, including ensuring that:-

- all patients have a holistic needs assessment and care plan at the point of diagnosis;
- a treatment summary is sent to the patient's GP at the end of treatment; and
- A cancer care review is completed by the GP within six months of a cancer diagnosis.

Programme – 01 Cancer

Finances

Cancer	
Total Best Value Target	12,094,000
Programme Target	0
% Best Value Target	0.0%

Programme Key Objectives

- Review of pathway (both elective and non-elective) for Upper GI and Lung. For lung pathway review to include specific focus on prevention schemes such as smoking cessation and weight management.
- Optimise screening uptake, with particular focus on hard to reach population.
- Deep dive to understand what is driving the variation in elective activity for skin cancer although will be linked to variation seen for excision of skin lesions.
- Prescribing of hormone therapies and immunosuppressant's
- Increasing diagnostic capacity which will include review of the radiology workforce to support sustainability
- Promotion of shared decision making regarding diagnostic process and also the treatment options available

Why is this important?

Demand for mental health services across all ages continues to rise. In order for the system to better support this whole system change is needed ensuring that future provision sees mental health care embedded within future delivery models. A key challenge in achieving this is in continuing to ensure that mental health services are able to provide the best care possible during a period of and system change.

The CCG is committed to ensuring delivery against the objectives and standards reflected within the Norfolk and Waveney STP and the system wide commissioning intentions for 2017-2019.

This will ensure that the future community mental health service will be embedded within an integrated service approach that is focused on delivery within and/or aligned to Primary Care and enables a preventative approach across all ages that supports a reduction in need for urgent and crisis care interventions.

What are we trying to achieve?

Our aim is to, working with partners, commission an excellent model of service provision for children and young people (0-18 years, but 0-25 years where this includes SEND) that takes into account universal services for all children, services for children with additional/special needs and for children and young people needing Child and Adolescent Mental Health Services (CAMHS). Throughout, consideration of safeguarding will be central and the "signs of safety" approach used in commissioning and planning discussions where required.

We aim to commission and support maternity services which are high quality and sustainable, work well to meet the needs of families, ensuring a satisfying personalised experience for women and families and which are evidence based, safe and up to date.

National Targets / NHS Must Do's

- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of CYP IAPT by 2018;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine case; and one week for urgent cases.
- CCGs and providers should come together in local maternity systems to design and deliver maternity services improvements in line with the recommendations in the national maternity review, Better Births.
- CCGs should set out improvement plans to halve the number of children waiting 18 weeks by Q4 2017/18 and eliminate 18 week waits for wheelchairs by the end of 2018/19.
- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
- Implement the national maternity services review, Better Births, through local maternity systems.
- Undertake system wide work to reduce unplanned paediatric admissions to hospital as highlighted by *Right Care*
- Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.

Programme – 02 Maternity, Children and Young People

Finances

Maternity, Children & Young People	
Total Best Value Target	12,094,000
Programme Target	40,000
% Best Value Target	0.3%

Programme Key Objectives

- Timely and reliable access to CAMHS
- Services for children and young people with ASD, post diagnosis (including children with ASD and no LD)
- No "gap" in service for children with a neurodevelopmental need
- Sustainable children's community nursing which provides support wherever the child with complex health care needs is – including appropriate training support to parents/providers of respite care/care at school
- More children treated at home where possible, fewer hospital admissions
- A reduction in children and young people receiving treatment far from home
- Effective, "joined up" services for children and young people with SEND – with health providing clear input when needed – so our partner organisations know when to ask, who to ask and what to ask
- Sustainable choice for women in terms of place of birth – hospital, MLBU and home

Why is this important?

The future Vision of one integrated whole system assumes that the organisations delivering health and social care in West Norfolk will be reduced in number to enable the model to be created. This does not mean less staff providing services, it means more flexibility about redeploying resources to the place they are needed by reducing duplicated tasks, functions and roles. This will increase the effectiveness and responsiveness of face-to-face patient and resident care and reduce bureaucracy and overlaps between the many organisations involved. This vision has been articulated and discussed over a number of years with the West Norfolk Health, with the current financial and political drivers make it an urgent, imperative action.

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What are we trying to achieve?

The Long Term Conditions programme aims to undertake a review of the services currently offered to the population of West Norfolk who are at risk of, or have been diagnosed with, a long term physical health condition, and implement new models of care to drive improvements in quality and sustainability, whilst ensuring the patient experience/journey meets their needs and desired outcomes.
Through the use of the RightCare programme, particular areas of focus have been identified.

National Targets / NHS Must Do's

- Develop and implement plans to tackle obesity and diabetes, including referring 500 people per 100,000 population annually to the National Diabetes Prevention Programme and improving GP participation in the National Diabetes Audit.

Programme – 03
Long Term Conditions

Finances

Long Term Conditions	
Total Best Value Target	12,094,000
Programme Target	641,000
% Best Value Target	5.3%

Programme Key Objectives

- Appropriate referrals made to relevant respiratory teams across the service/pathway
- Improved usage of available services, leading to improvement in patients care journey
- Joint care plans being developed for respiratory patients and being shared across providers
- Improved access times for patients to diabetic foot care
- Improved access to structured education for diabetes patients
- Use of Eclipse Live to appropriately risk assess patients and support practices with most variance
- Reduction in admissions and re-admissions of respiratory patients to acute trust

Why is this important?

Demand for mental health services across all ages continues to rise. In order for the system to better support this whole system change is needed ensuring that future provision sees mental health care embedded within future delivery models. A key challenge in achieving this is in continuing to ensure that mental health services are able to provide the best care possible during a period of and system change.

The CCG is committed to ensuring delivery against the objectives and standards reflected within the Norfolk and Waveney STP and the system wide commissioning intentions for 2017-2019.

This will ensure that the future community mental health service will be embedded within an integrated service approach that is focused on delivery within and/or aligned to Primary Care and enables a preventative approach across all ages that supports a reduction in need for urgent and crisis care interventions.

The CCG will continue to work in partnership in 2017-2019 to deliver the ambitions of the LD Transforming Care Programme and ensure people with learning disabilities' needs are met.

What are we trying to achieve?

Our aim is to, working with partners – including people who use services – and in line with the Five Year Forward View for Mental Health, to continue to offer and ensure parity of esteem for mental health in our commissioning and take forward a system wide transformational approach to securing future mental health service provision. This programme focusses on mental health and learning disability services for adults. Mental health and learning disability service commissioning for children and young people, and as part of the maternity pathway, is covered in the Maternity, Children and Young People Programme.

National Targets / NHS Must Do's

- Deliver in full the implementation plan for the mental health Five Year Forward View for all ages, including Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;
- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline.
- Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21.
- Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.
- Reduce inpatient bed capacity by March 2019 to 10-15 CCG-commissioned beds per million population, and 20-25 NHS England-commissioned beds per million population.
- Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.
- Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability or autism.

Programme – 04 Mental Health

Finances

Mental Health	
Total Best Value Target	12,094,000
Programme Target	100,000
% Best Value Target	0.8%

Programme Key Objectives

- An integrated approach to commissioning, promoting holistic care.
- Increased access to services - right time, right place, right care.
- Focus on recovery and outcomes for people receiving treatment.
- A reduction in the need for urgent and crisis care interventions.
- Sustainable mental health care embedded within future delivery models ensuring parity of esteem.

Why is this important?

It is important that the CCG makes sure that the best value is achieved for every £1 spent. Therefore it is vital that wherever possible we review the financial and contractual dealing so that we have so that efficiency is found.

What are we trying to achieve?

The purpose of this programme is to focus in the financial and contractual levers and opportunities that we have which can contribute towards our savings. Additionally there are three CHC schemes which are designed to review all the high cost packages for individual patient placements for patients with complex mental conditions and for patients with physical disabilities (PD). This includes review of individual patient placements (IPP) to ensure a robust and timely review is undertaken. The project will also include review of the patients who are eligible for CHC and whose current care package is in excess of £1,500 per week (i.e. those deemed to be high-cost) to ensure that the care package has been reviewed and meets clinical need.

National Targets / NHS Must Do's

Continuing Healthcare

Improving processes to provide speedier assessments for patients and to implement emerging best practice; and mainstream delivery model for NHS Continuing Care and continuing care for children.

Programme – 05 Financial and Contractual

Finances

Financial and Contractual	
Total Best Value Target	12,094,000
Programme Target	4,643,000
% Best Value Target	38.4%

Programme Key Objectives

Why is this important?

The Planned Care Programme covers a wide range of specialities / services which are scheduled in advance. Scheduled or planned care includes booking outpatient consultations and treatments as well as diagnostic tests. Therefore the Planned Care relates to those services and treatments which are not carried out in an emergency, often those which patients are referred to by their GP. The specialities identified for work within this programme are those where variation has been identified by using RightCare data, through local intelligence or where specific issues have been noted or arisen.
We want our planned care services to deliver high quality, personalised care, which enables patients to see the right person, in the right place, at the right time.

What are we trying to achieve?

We want high quality, efficient and integrated care that meet the needs of local people, represent value for money and provide a better experience for patients as they will receive care in the best setting and fastest possible time. We will work with clinicians from primary, community and secondary care to develop services where we know there is scope for better patient care. As well as ensuring that we are able to manage growth in demand due to demographic changes and population growth and need.
The programme will take a rigorous and systematic approach by speciality reviewing pathways and service models using evidence of best practice to inform service development options.
We will ensure that services that are provide are patient-centred, effective but affordable services, and focused on delivering in a range of settings / communities rather than just in hospitals.

Throughout all work we will ensure that services will improve patient outcomes by:

- Strengthening primary care and community services and supporting patients to participate in decisions about their own care empowering them to self-manage where appropriate.
- Supporting our hospitals and surgical teams to deliver the best outcomes for those who do need their services
- Reducing waiting times by streamlining services and removing delays at every stage of the patients journey to ensure everyone is seen before 18 weeks
- Supporting patient choice by actively sharing information on options for their care and the outcomes they can expect.

National Targets / NHS Must Do's

RTT
Deliver the NHS Constitution standard that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment.
RTT
Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.
FINANCE
Demand reduction measures include: implementing Right Care; elective care redesign; urgent and emergency care reform; supporting self-care and prevention; progressing population-health new care models.

Programme – 06 Planned Care

Finances

Planned Care	
Total Best Value Target	12,094,000
Programme Target	1,587,000
% Best Value Target	13.1%

Programme Key Objectives

All "Must do's" align to our local priorities however on a on going basis we will continue to monitor the situation and review so local priorities may be considered in year depending on priorities and impact.

Why is this important?

The aim of the Prescribing QIPP programme is to deliver significant savings by medicine optimisation through continuous development of positive relationships with West Norfolk Practices to engage in cost effective drug switches, incorporating clinical audits and medication reviews, including the proposal of embedding pharmacists within GP practices. This will also potentially avoid hospital admissions. The Prescribing Medicines Management Team (PMMT) plays an important and financially significant role within the CCG. Over the past two years the savings achieved from medicine optimisation facilitated by the team has increased and there is the potential to continue to achieve savings moving forward. There is a desire to evolve further projects to deliver savings such as use of Bio-similar, Prescribing Further and Faster, High Cost drugs and delivery of a Self-Care project. It is paramount that quality, safety and sustainability of the team is continued to be developed.

What are we trying to achieve?

- The intention is for significant savings to be made from switching drugs from branded to generic and vice versa, savings are also made through medicine optimisation, patient medication reviews - including care home residents and prescribing audits, encouraging prescribing according to local formulary. This is ongoing work within the PMMT.
- Further projects are to be introduced to capture other ideas and ways to streamline their implementation.
- Currently the PMMT Team works by supporting and guiding GP practices with drug switches and by agreeing particular focusses for individual practices, also working alongside other Health Care Professionals across West Norfolk.
- Having a project focussed way of working will introduce news ways of thinking and development inviting team members to express their ideas and to be involved with implementing new projects. This will change the way that individuals approach their work and what areas they focus on.
- The proposal includes embedding pharmacists (and possibly technicians) into GP Practices, this will be done through an initial pilot of an NHSE Pharmacist in a GP Practice.

National Targets / NHS Must Do's

None

Programme – 07 Prescribing

Finances

Prescribing	
Total Best Value Target	12,094,000
Programme Target	1,819,000
% Best Value Target	15.0%

Programme Key Objectives

Integrated working across physical, social and mental health

Integrated working across all system interfaces is co-ordinated to deliver holistic care with reduced duplication and gaps in care, and improved patient experience and outcomes. Services recognise the importance of social care and mental health parity of esteem.

Sustainable acute sector

Acute services will be configured to be sustainable under future demand pressures through increased provider collaboration. Out of hospital services will reduce demand at the front door, and assist discharge processes to maintain capacity within the acute system.

Cost-effective services

Delivered within the finances available – providers and commissioners will work together to realise CIP and QIPP savings, release organisational efficiencies, and remove perverse incentive structures.

- Implement agreed STP milestones, so that the Norfolk and Waveney STP is on track for full achievement by 2020/21.
- Achieve agreed trajectories against the STP core metrics set for 2017-19.
- Include clear and credible milestones

Why is this important?

The Primary Care programme will maintain a clear focus upon the delivery of the GP Forward View. The Forward View will transform the way in which general practice works and will address some of the pressures currently faced with regard to workload, workforce and the infrastructure required for successful transformation to occur.

What are we trying to achieve?

There are no QIPP savings attached to this programme, although there is an expectation that the actions undertaken will facilitate success in some of the other programmes, for instance through reducing attendance at A&E through increased GP appointment capacity or improvements in access.

National Targets / NHS Must Do's

- Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support, and the ten high impact changes.
- Ensure local investment meets or exceeds minimum required levels.
- Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors working in general practice by 5,000 in 2020, co-funding an extra 1,500 pharmacists to work in general practice by 2020, the expansion of IAPT in general practice with 3,000 more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.
- By no later than March 2019, extend and improve access in line with requirements for new national funding.
- Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes.

Programme – 08 Primary Care

Finances

Primary Care	
Total Best Value Target	12,094,000
Programme Target	0
% Best Value Target	0.0%

Programme Key Objectives

The GP Forward View makes a number of funding commitments to enable the successful delivery of the programme. It also introduces 10 High Impact actions to be undertaken in supporting the delivery of the GP Forward View .

10 high impact actions to release time for care

1.Active signposting: Provides patients with a first point of contact which directs them to the most appropriate source of help. Web and app-based portals can provide self-help and self-management resources as well as signposting to the most appropriate professional.

2.New consultation types: Introduce new communication methods for some consultations, such as phone and email, improving continuity and convenience for the patient, and reducing clinical contact time

3.Reduce Did Not Attend (DNAs): Maximise the use of appointment slots and improve continuity by reducing DNAs. Changes may include redesigning the appointment system, encouraging patients to write appointment cards themselves, issuing appointment reminders by text message, and making it quick for patients to cancel or rearrange an appointment.

4.Develop the team: Broaden the workforce in order to reduce demand for GP time and connect the patient directly with the most appropriate professional.

5.Productive work flows: Introduce new ways of working which enable staff to work smarter, not harder.

6.Personal productivity: Support staff to develop their personal resilience and learn specific skills that enable them to work in the most efficient way possible.

7.Partnership working: Create partnerships and collaborations with other practices and providers in the local health and social care system.

8.Social prescribing: Use referral and signposting to non-medical services in the community that increase wellbeing and independence.

9.Support self care: Take every opportunity to support people to play a greater role in their own health and care with methods of signposting patients to sources of information, advice and support in the community.

10.Develop QI expertise: Develop a specialist team of facilitators to support service redesign and continuous quality improvement.

Why is this important?

Urgent and Emergency Care is delivered by a range of providers and high quality services across West Norfolk however, the current system is disjointed and can be confusing for both health professionals and the public in knowing which service to access. This, combined with a rising number of complex patients is putting tremendous strain on existing health and Social Care resource and budgets and the current model is not sustainable.

There are a number of admission avoidance and intermediate care services provided by various organisations however, patients can experience delays in receiving appropriate care due to a number of reasons such as gaps in services, lack of capacity, poor communication or delays in agreeing funding. The current model also lacks clear pathways for specific conditions and sufficient resources to ensure patients are proactively identified and managed in the community to prevent them going into crisis and requiring unnecessary escalation to secondary care.

During 2016/17, a number of new initiatives and processes were introduced to encourage closer working between services and to support improved patient flow through the health and social care system.

- Re-locating Norfolk First Response and the Duty Crisis Team into St James with NCHC.
- Integration of the Hospital at Homes Service and Community IV Team.
- Commissioning 20 Intermediate care beds at Amberley Hall.
- Increasing capacity within the Hospital Care at Home Service.
- Extending operating hours for the Rapid Assessment Team (RAT).
- Placing a GP in ED at weekends and over bank holidays to support minor flow.
- Re-launching the Care Home Forum and introducing quarterly meetings. Due to their success and at the request of attendees, these meetings are now held bi-monthly.
- Running an Acute ICC pilot at the QEHKL.
- Commencing twice weekly community MDT meetings to focus on delays within community beds.
- Introducing a daily triage process in the community for intermediate care referrals.
- Moving to a single referral form for community bed capacity.
- Introducing an improved daily bed capacity reporting template.
- Implementing a Discharge to Assess process for Continuing Health Care.
- Implementing an Integrated Palliative Care Service.

These changes have had a positive impact on patient flow across the system, however these initiatives and the processes around them still represent an element of silo working and do not address the issues we currently have in delivering seamless, integrated urgent and intermediate care pathways and consistent achievement of the ED 4 hr standard.

What are we trying to achieve?

Building on the work undertaken during 2016/17 our aim is to commission sustainable and affordable services and enhance education and support within the community to ensure patients receive timely invention from the right care professional offering the right care in the most appropriate setting. This should support a significant reduction in non-elective activity and pressure at the Acute Trust and allow patients to move through the care system in a timely and seamless manner.

The new model aims to truly integrate health and social care services and improve pathways and ways of working with third sector organisations to ensure there are no barriers or delays in the care pathway for patients. It is anticipated that the public will see “one health and social care system” and not experience any difficulties or delays when urgent or intermediate care is required from multiple services or providers.

The projects within the Urgent and Emergency Care Programme will focus on:

Proactive attendance and admission avoidance and care planning, Intermediate Care and Rapid Response – by supporting the proactive identification and ongoing management of frequent attenders and complex patients to prevent unnecessary escalation to secondary care.

Discharge planning will focus on embedding a robust and consistent system-wide approach to managing discharges for patients who require support on discharge from the Acute Trust.

National Targets / NHS Must Do’s

- Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.
- By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.
- Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.
- Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.
- Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis.
- Via the Better Care Fund (BCF) planning guidance, all CCGs to work with local authority partners at a Health and Wellbeing Board level to pool budgets and develop and agree an integrated spending plan for using their BCF allocation.

Programme – 09 Urgent and Emergency Care

Finances

Urgent and Emergency Care	
Total Best Value Target	12,094,000
Programme Target	1,480,000
% Best Value Target	12.2%

Programme Key Objectives

Why is this important?

Demand management with regard to referrals is a key area for the CCG to develop. Considerable variation is seen across West Norfolk practices. This variation in the rate of referrals initiated in Primary Care that needs to be understood and addressed. This programme seeks to ensure that referrals lead to a patient being seen in the right place, at the right time, first time for their first outpatient appointment.

National Targets / NHS Must Do's

RTT

Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.

Programme – 10 Demand Management

Finances

Demand Management	
Total Best Value Target	12,094,000
Programme Target	1,784,000
% Best Value Target	14.8%

What are we trying to achieve?

The programme will address and understand the variation in GP referral rates, ensuring that wherever possible and appropriate that referrals into secondary care are reduced. In doing so, the programme will acknowledge that:

- Any intervention to manage referrals cannot look at the referral in isolation but needs to understand the context in which the referral is being made.
- Changing referral behaviour is a major change management task that will require strong clinical leadership from both primary and secondary care.
- There are inherent risks at a point of referral, as clinical responsibility is passed from one clinician to another and any referral management strategy needs to have robust means to manage those risks.
- There may be just as much under-referral as over-referral by local GPs. A strategy to reduce over-referral could, and indeed should, expose under-referral. This will limit the potential reductions in demand.
- We will not introduce financial incentives to drive blanket reductions in referral numbers.
- Reductions in referrals from one source can be negated by rises in referrals from other sources. Any demand management strategy needs to consider all referral routes and not just target one.
- A whole systems strategy will be required to manage demand, with active collaboration between primary, secondary and community care services.

Programme Key Objectives

1.The use of Advice and Guidance – The usage of Advice and Guidance is recorded and the referral conversion rate is also presented. This will continue to be monitored to identify if practice uptake of the service increases over time. Through collaborative working with our main acute provider, we will identify Frequently Asked Questions (FAQ's) and use these in feedback to practices.

2.Peer Review in practices – Practices have been encouraged to undertake peer review of their referrals, particularly in speciality areas where they have a higher than typical rate of referral. Those practices who have received a CCG visit have been positive about undertaking this task and have agreed to feedback any significant findings. These findings, where appropriate will be shared across primary care to enable the sharing of best practice.

3.Shared Decision Making promoted to GPs and patients – Practices have been asked to promote this within their organisations, empowering patients and acting as a reminder of best practice for referring clinicians.

4.Adherence to clinical thresholds via the prior approvals process. Introducing this new way of working allows referring clinicians to ensure that the patient meets the criteria for referral, avoiding unnecessary referrals for patients who do not meet the criteria.

5.Choice – The CCG needs to develop a system that ensures that choice aligns to system capacity as best as possible.

6.Alternatives to Outpatient appointments – Alternative pathways are being developed, allowing patients to be seen outside of secondary care.

7.Consultant to Consultant referral protocols – We will ensure that through collaborative working with our acute providers, that requests for referrals are not made to General Practice by hospital employed consultants to refer if the consultant should have done so.

8.Direct Access to diagnostics – We will introduce, through joint working arrangements, appropriate direct access to diagnostic tests . This will reduce the need for referral to a first outpatient appointment simply to access tests.

9.Straight to test for cancer – We will introduce, through joint working arrangements, systems to allow referral straight to test for cancer.

10.Referral Management Service – We will work with West Norfolk Health to build upon the functions already performed. The data collected through West Norfolk Health can be used to provide more detailed analysis of referral information and will provide more timely data.