Norfolk and Waveney STP - summary of key elements

Our Vision

1. We have agreed our vision:
   "To support more people to live independently at home, especially the frail elderly and those with long term conditions".

2. We have also agreed a set of **guiding principles** to help us work on challenging issues:

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

Our Overarching Priority - "Keeping me at home"

3. Our overarching priority is to keep people at home and help them to maintain their independence as long as possible. Providing locally delivered, integrated support, with care and treatment happening outside of acute hospitals wherever possible, and the whole system - including local communities - geared to getting people back home, and supported in community settings.

The change we want to see

4. The change we want to see – we have a commitment to deliver a shift from acute to primary and community care and harness our combined energies to manage demand. Changes in the following five key areas offer opportunities to improve health and financial gains:
   - People living with frailty and long term conditions
   - Acute admissions from care homes
   - End of life
   - Frequent users of emergency services
   - Prevention of unnecessary mental health admissions into acute care

The 3 national gaps

5. We have undertaken detailed analysis of the 3 national 'gaps' as they relate to Norfolk and Waveney and key headlines are as follows.

A. Health and Wellbeing Gap

- We have an older population which is increasing and we anticipate the **largest increase between now and 2025 to be in those aged 85 and over**. If nothing changes then, due to age alone, between now and 2025, we will see about 9,000 additional people with diabetes, more than 12,000 additional people with CHD, more than 5,000 additional people who have suffered a stroke and almost 7,000 additional people with dementia.

- Unaddressed, modifiable risk factors, together with increasing age, increases the likelihood of **multi-morbidity** (2 or more chronic conditions) with the costs of health and social care being driven far more by an individual's morbidity than by their age.

- Across the system, **emergency admissions are increasing at a greater rate** than that of our population as a whole, with the rate increasing fastest for people aged 85 and over, who account for nearly 5% of the total. The top five causes across all ages are for potentially preventable conditions, especially respiratory infection and cardio-vascular disease.

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

- There are **inequalities in health** with a high proportion of residents living in in the 20% most deprived areas. For example, if the most deprived areas experienced the same rates as the rest of Norfolk and Waveney, then each year more than 400 children would be of healthy weight, there would be 1,000 fewer emergency admissions for older people and there would be 60 fewer deaths due to preventable causes.

- **Urgent care activity and unwarranted variation -** in 2014/15 there were about 225,000 A&E attendances across Norfolk and Waveney, with about 83,600 (37%) attendances were for minor attendances. The rate of attendance and conveyance to hospital is increasing (faster for the older age bands) but the conversion rate from A&E attendance to admission has remained relatively flat. A proportion of the A&E attendances could be dealt with elsewhere or by the patient themselves. Across Norfolk and Waveney in 2014/15 there were about 11,600 ambulance arrivals at A&E for minor attendances and about 72,000 walk in attendances at A&E for minor attendances. There are some areas that have significantly higher attendances than expected. The walk in arrivals are generally determined by distance from A&E or the minor injury unit (in Cromer). If the areas where ambulance arrivals for minor attendances are significantly high were able to bring these down to the local average then about 3,200 A&E attendances could be avoided.

- **Variations in system activity -** across Norfolk and Waveney the RightCare "where to look" benchmarking packs suggest that if the CCGs had the same outcomes as the top five similar CCGs nationally then about 50,000 people would have better quality care or better health and wellbeing outcomes. This includes 7,000 people with better access to

psychological therapies, 6,000 people with better controlled blood pressure, 7,000 people with better controlled cholesterol and 2,000 additional people screened for cancer. Potential cost savings include £12 million in elective and day case, £19 million in non-elective and £16 million in prescribing. In 2014/15 there were 27 patients who between them were admitted 171 times for COPD and there were 13 patients who between them were admitted 115 times for alcohol related disorders. If these 40 patients were managed better then we could prevent almost 300 admissions per year

- **Norfolk's dementia prevalence is high** – being third highest in the region behind Suffolk and Southend. Notably 54.1% of people in council-funded long term residential and nursing care placements are aged 85+, compared to just 4.0% of the population overall. However, the recording of dementia prevalence is one of the lowest in England. During 2012/13 to 2014/15 there were about 400 admission per year where the primary diagnosis was dementia. There is also **variation in emergency admissions where the primary diagnosis is Dementia.** If the practices were able to address individual variation then potentially 25 admissions per year could be avoided.

- Although our rate of **admissions for injuries due to falls** is lower than average, they still account for over 4,100 admissions per year of which about 1/3 of admissions for injuries related to falls are for a broken hip (over 1,350 admissions per year for broken hip in older people). Across Norfolk and Waveney fractured neck of femur admissions in those aged 65 and over cost more than £9.5 million per year. There is variation by practice in admissions for injuries due to a fall - if practices were able to address individual variation then we could potentially avoid up to 190 admissions per year.

- Across Norfolk and Waveney in 2014/15 there were over 2,300 **emergency admissions for Urinary Tract Infection (UTI) in people aged 65+.** There is variation across Norfolk and Waveney in the number of UTI emergency admissions. If practices were able to address individual variation then potentially up to 90 emergency admissions for UTI could be avoided per year.

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

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

B. Care and Quality gap

- We have challenges around **accessibility of services** across our three hospitals **in relation '18 weeks Referral to Treatment'** targets for elective care **and '4 hour wait'** targets in A&E settings, and there are opportunities to improve outcomes in community healthcare in key areas.

- We also know that our **mental health services** are facing a number of operational challenges which mean that we find it difficult to deliver high quality services in some areas

- **Ambulance response times** remain a challenge and it is possible that, at times, locality performance is masked by the performance of the area as a whole. Whilst we

recognise that rurality brings its own challenges, there has also been a shift in the acuity of those requiring an ambulance. Patients are more chronically and acutely unwell and often present with multiple conditions. This puts additional pressure on the ambulance service and the Emergency Departments of the Acutes.

- There are significant **workforce gaps** across community health and social care with vacancies in a variety of professions and care settings. We also have a projected loss over the medium term, with experienced staff reaching retirement age, which will impact on quality of care and capacity for developing innovative services.

- In terms of social care in Norfolk, when compared to statistically similar councils, we are the **highest users of residential care for people with learning disabilities** and for **people with mental health problems**, and are fourth out of fifteen councils for older people. Demographic factors also significantly drive demand for services for people with learning disabilities and physical disabilities and demand for these services, which involve complex care packages, is rising. A significant gap in the **availability and quality of care services** in Norfolk can be attributed to challenges within the social care market and there is a growing challenge in meeting the social care needs of the population with sustainable systems of care.

- The **Care Quality Commission's (CQC) assessments** of Norfolk's health and community trusts show:

Provider	CQC rating	Outcome
NNUH	Yellow	Requires improvement
QEH	Yellow	Requires improvement
JPUH	Yellow	Good
NCHC	Green	Good
NSFT	Red	Inadequate

C. Finance and Efficiency gap

- In terms of **size of the gap,** the position for the Norfolk and Waveney system for 2015/16 was a **£71m deficit**, with the split as follows: acute trusts £42m, other trusts £6m, Norfolk County Council £20m and CCGs £3m.

- Looking beyond 2015/16, forecast of the gap are a work in progress. At this point, estimates are that each year, the in-year system **deficit increases by somewhere between £9-43m** through annual system income increases driven predominantly by CCG allocations

- The **'Do nothing'** scenario **deficit in 2020/21** is therefore expected to be in the region of **£545m** based on the cumulative effect of 2015/16 position and annual deficits and before any potential savings through national or local efficiency schemes (eg QIPP, CIPS) or transformational savings.

Closing the gap

- Provider **Cost Improvement Programmes (CIPs) are assumed to continue** during the transformation period at a level in line with efficiency expectations and commissioners will also continue to drive savings in areas such as primary care prescribing and Continuing Health Care in line with past trends and in order to manage the growth anticipated in these areas.

- **Investment in primary care and community services** will enable the development of **local integrated community providers** with the key aim of delivering care closer to home and reducing emergency attendances and admissions. Investment in prevention services also supports the initiatives around improving lifestyles.

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

- The **RightCare approach** (national programme to maximise the value) suggests a savings opportunity of £48m across a number of disease groups and across elective and non-elective care and prescribing costs

- **Organisational landscape changes**, both within provider organisations and commissioner organisations, could potentially generate up to £14m in savings, or in excess of 10% of existing corporate costs

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

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

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

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

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

The workstreams – and our key proposals for change

6. Building on detailed analysis, and on the existing delivery plans already in place, the STP submission provides an outline of the focus, challenges, impact and proposed actions for our workstreams, summarised below.

A. Acute care

The challenges

- Each of the three acute trusts in our STP area are under directions from NHS Improvement to address their financial deficits.
  Coupled with this inconsistencies in the delivery of NHS standards, particularly A&E targets, ambulance handover and 18 week Referral to Treatment Times during 2015/16, not only affect patient care but carry financial consequences for the providers.

- A careful **assessment of the essential requirements** to support local delivery of acute care across the 3 hospitals is needed. This will determine the inter-relationship between core services, the required impact on staff, and the configuration of services as necessary.

Key proposals for addressing the challenges

7. The Norfolk Provider Partnership, involving the three acute trusts in Norfolk and Waveney alongside other key organisations, recognises that an ambitious agenda should be pursued to ensure clinical services are placed on a sustainable footing, national standards are consistently delivered across Norfolk and Waveney, and opportunities for improving efficiency realised at pace. Within the STP process, the NPP **Partners have agreed the following key proposals**:

- **An acute services review** – will be undertaken, in the context of the whole Norfolk and Waveney health and social care landscape, to analyse demand and capacity and review the clinical interdependencies between the three hospitals. The work will concentrate on the clinical transformation required to ensure a viable clinical infrastructure.

- **Reducing the time spent in hospitals** - by patients through the development of out of hospital services. There is a need for a single plan covering Norfolk and Waveney which sets ambitious targets for reducing the length of stay, and it will be important to build on evidence of what works locally

- **Organisational reform** - the scale of change required across Norfolk and Waveney is unlikely be delivered without reform, changes to delivery models and current payment mechanisms.

B. Primary, community and social care

Our assessment

8. The evidence tells us that **well-designed schemes to move healthcare closer to home** can deliver benefits in the long term and that the costs of delivering care in the community may be lower than those of delivering care in acute hospitals.

9. We know that to shift care out of hospitals, and re-provide these services effectively in the community, **a whole-system approach is needed**. Any proposed review of the 3 hospitals cannot happen in isolation but must go hand-in-hand with strategies around community provision and a clear understanding of the impact or unintended consequences of both...

Our key proposals for change

10. Our proposal is for a **new kind of community care** - building primary care capacity and a culture of independence through multi-disciplinary working and the co-ordination of voluntary and third sector health and wellbeing initiatives. (For the purposes of this document, 'Community Services' is an umbrella term to include general practice, community physical and mental health care, social care, voluntary and non-statutory care services).

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

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

13. Building on learning from local initiatives, the Norfolk and Waveney STP will **focus on providing the right services in the right place**, **supporting independence and ensuring**:

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

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

15. Much debate continues to happen both at locality and county level around the type, size and number of integrated community care centres across the footprint area. Whilst these conversations continue all are in agreement however that integrated multidisciplinary working is critical to delivering the change we seek.

16. **Actions**

    - **Prioritising areas by shifting resource** – as services move into a community setting there will need to be a like for like reduction in investment in acute/specialist settings. Opportunities will exist to repatriate current provision provided out of Norfolk into any capacity released into acute settings as a result

    - We will **seek opportunities** to access the System Transformation Fund to allow for double-running and/or pump priming of initiatives and we will **make best use the learning** both from the contractual models of the National Vanguards and from local models

    - **Cultural and behaviour change will be key** in underpinning the successful creation of our new models of care and we will need to align incentives and responsibilities; to identify "what is in it" not only for community and patients, but also for clinical groups, community and primary care, mental health, and social care.

- **Stabilising the system through the period of change** will be critical to our success – ensuring that there are robust shared local and operational plans that allow the system to change at pace without adversely disrupting services to patients and to the community in the process.

C. Prevention and Wellbeing

Our assessment

17. The evidence tells us that:

- A good proportion of NHS time is spent on non-health problems such as housing and welfare
- A good proportion of ill health can be prevented by lifestyle changes and long term conditions can be prevented from getting worse by good self-management
- Significant unexplained variations in activity between areas which can be reduced by improving system processes and quality

Our key proposals for change

18. We want to change what we do in health and social care to:

- **Increase community capacity** to directly address individual's socio-economic problems rather than medicalise them and help people be better connected with each other
- **Change the nature of the health and social care offer** to help people manage their own health especially long term conditions

19. We will need **interventions at scale** aimed at **delivering prevention** and **reducing variation**. For example, rolling out the **diabetes prevention** programme and addressing obesity at scale, moving 10,000 adults from being obese to normal weight each year. Improving the management of diabetes in working age adults through patient activation and education and better management in primary care.

20. Through our **adult social care strategy** (Promoting Independence) we will move to a whole-system approach that positions 'formal' care services as the best option for only those people with the highest care needs, and a **wider range of informal and community-based care options** for people whose needs mean that their independence is restricted, but who can be supported to remain at home whilst staying well or regaining wellbeing.

The impact

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

- More people living free of formal care, and fewer people will need funded care
- More people will live at home, or living at home for longer
- More people, and in particular more people of working age, will not need to live in residential care
- More people with mental health needs or learning disabilities will have opportunities for paid or voluntary work

- More people that do require formal care will take their personal budget as a direct payment
- There will be fewer urgent admissions to hospital or residential care by people with social care needs.

Our Key Questions

22. We conclude that our system faces the following key decisions:

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