Norfolk and Waveney STP

October 2016 Submission

V1.4

in good health

Contents

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STP Footprint	Norfolk & Waveney
Footprint Number	22
Region	Midlands and East
STP Lead	Dr Wendy Thomson – Chief Executive, Norfolk County Council
Member Organisations	North Norfolk CCG (NN CCG); South Norfolk CCG (SN CCG); Great Yarmouth and Waveney CCG (GY&W CCG); West Norfolk CCG (WN CCG); Norwich CCG (N CCG); James Paget UHFT (JPH); Norfolk and Norwich UHFT (NNUH); Queen Elizabeth HFT (QEH); East Coast Community Healthcare CIC (ECCH); Norfolk Community Health & Care Trust (NCHC); Norfolk and Suffolk FT (NSFT); Norfolk County Council (NCC); Suffolk County Council (SCC); District, Borough and City Councils; East of England Ambulance Service Trust (EEAST); Norfolk Independent Care; IC24; Norfolk & Waveney Local Medical Committee; Healthwatch Norfolk

Executive Summary

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The Norfolk and Waveney (N&W) system has further developed its Sustainability and Transformation Plan (STP), taking account of NHSE feedback to strengthen plans and develop greater depth and specificity. As a consequence of this work, by 2021 the STP will drive high quality care through integrated delivery, making significant progress towards financial sustainability.

Transformation of services will be aligned with our system vision to ensure:

- Services look at 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 liaison for an individual'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 services who see them.

Progress since June

Since June we have strengthened our system's plans by creating additional dedicated workstreams for Mental Health (MH), Workforce, IT, and Estates Increasingly detailed financial modelling has revised the do nothing scenario to a 2021 deficit of £415.6m. The solutions contained within the STP reduce this deficit to £50.1m by 2021. Against this, the NHS system is in surplus of £0.9m with a residual social care and non-NHS deficit of £51.0m. In addition we have system-wide commitment to deliver savings in workforce, estates rationalisation and ICT, none of which are currently included in the financial bridge. Work to address the residual social care deficit will continue. We have strengthened our core STP team with a commitment from organisations to maintain and improve this further to drive effective delivery.

Areas of Key Impact

Our workstreams 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

Workstreams

Our programme architecture has been constructed to drive rapid and successful execution, with delivery workstreams across the health and care spectrum – Prevention and Wellbeing; Primary, Community and Social Care; Acute Care; and Mental Health. These are supported by enabling streams in Workforce, Estates and ICT. This is underpinned by support for Contracting, Communication and Engagement, and Finance and Business Intelligence (BI). Each workstream is developing detailed, impactful plans which combine consistently at system level to deliver a strong STP for our organisations to plan and align delivery of improved health and care in Norfolk and Waveney.

Financial Impact of Our Plans & Implications for capital

Whilst the recurrent impact of our plans are robust at year 5, further work is urgently required to understand the financial impact in each of the intervening years. Where high level assumptions are currently used, we need to move to a granular bottom up approach based upon the detailed plans from each workstream in the next 2 months. Further work is also required to enable the financial and activity implications of the STP to be described by organisation as well as at a system level.

There is a large, emergent 18 Week referral to treatment (RTT) issue at the NNUH which is currently being assessed. As a system the aim is to be complaint with RTT by Quarter 4 of 2017/18. This will involve hospital wide solutions and potential additional capacity to maintain performance. Whilst it is unlikely to have a recurrent financial effect, the size of the problem is likely to be financially and operationally significant in the intervening years. The system is working rapidly to size the problem and identify solutions and welcomes the support from NHSI Intensive Support Team. The non-recurrent cost (estimated at £11m) of addressing the issue is not currently incorporated in the 17/18 or 18/19 plans.

Due to the rapid development of solutions since the June submission, the implications for CAPEX are not yet clear in all cases. A robust assessment of capital across the system is required as well as granular plans for capital requirements as enablers to the solutions.

System Development

We recognise that, in order to deliver an effective plan which relies on integrated working, we need system-level leadership, culture and working. Discussions have taken place regarding integration and co-operation at both commissioner and provider levels to build the best platform for delivery. It is agreed that we need to work together to identify the best delivery model for Norfolk and Waveney and that around this model, system wide investment is required in IT, estates and workforce initiatives. The model will be built on STP-wide design principles and standards while maintaining flexibility of local delivery.

All partners in the STP recognise that adult social care is critical in supporting people in their own home and the impact that this has on reducing the need for intensive health care. This is reflected in additional investment in social care services, staffing and the voluntary and charitable sector (VCS). This investment alone will not be sufficient to deliver sustainable social care. Awareness by partners across the STP of community alternatives to care will also help to reduce both demand and cost.

The three acute trusts have agreed to establish the Norfolk Hospitals Group to accelerate the scale and pace of collaboration. This builds on existing strong relationships (NNUH currently supports both neighbouring hospitals in over 20 separate specialties and there is already a pathology partnership in place). Recently the Chairs and Chief Executives of the three hospitals agreed to create the Norfolk Hospitals Group to further develop collaborative working to help ensure the viability of hospital services across Norfolk. This group will bring together the clinical teams from specialties to explore clinical networks, common guidelines, balancing demand and capacity and shared recruitment. The work from KPMG in this area commissioned as part of the STP has been helpful in starting these important conversations and outlining possible models for future working. The Norfolk Hospitals Group presents a strong opportunity to further join up hospital services across Norfolk to help ensure patients receive consistent high quality care which is delivered locally wherever possible.

Executive Summary

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Monitoring Delivery

All workstreams have identified critical success measures and key performance indicators. These will be used to track progress of our STP delivery. System-level metrics have been identified which will cut across workstreams, giving a uniting influence and allowing workforce at all levels to buy into our transformation.

Communications and Engagement

We have pooled communications and engagement resource from across the partners to engage with the media and public on our STP plans – our “in good health” publication containing elements from the Case for Change and June STP submission has recently been published. Further engagement is planned to ensure citizen and patient involvement in developing our plans. A Clinical Care Reference Group has also been established to secure multi-professional clinical input in the planning process and to act as the first level of engagement with the clinical workforce. Communications through all STP member organisations, co-ordinated via assigned leads, engage the front-line in making the STP part of daily work and develop a shared culture.

Key STP Outcomes

By 2021 the Norfolk and Waveney system ambition is to:

- Have reduced the gap in health outcomes across the county through targeted intervention
- Have a sustainable, integrated primary care model which meets locally defined minimum standards and is easily accessible to all
- Reduce A&E attendances and NEL admissions by at least 20% vs do-nothing forecast
- Reduce NEL acute bed days by at least 35% vs do-nothing forecast
- Have a safe and sustainable acute service capable of meeting key access and quality standards, including RTT, the emergency care standard, and cancer 14, 31 and 62 day standards
- Provide physical, mental and social care through integrated place or locality based teams who work together to help the most vulnerable people manage their physical and mental health better and remain in their community
- Achieve parity of esteem between physical and mental health

Development of the Norfolk and Waveney STP

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Norfolk and Waveney STP – Plan on a Page

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Since the June STP submission, the Norfolk and Waveney Health and Care economy has progressed towards integrated solutions to address the gaps in population health, service quality and system finances. The system established its 5 guiding principles (below) within the June submission which are central to the design and delivery of the transformed services. To deliver this transformation the STP programme structure has been established around four delivery workstreams. This includes a newly formed Mental Health workstream to ensure improved quality of mental health services alongside the integration with physical health and social care. Each workstream has planned solutions to deliver the Five Year Forward View (5YFV) and improve patient and service user outcomes.

Norfolk & Waveney's STP: Five Guiding Principles

PREVENTING ILLNESS AND PROMOTING WELL-BEING

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 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 the system delivers holistic care with reduced duplication and gaps, 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 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 incentives.

STP Executive Board

STP Programme Board

STP PMO

STP Membership

- 5 CCGs (North Norfolk, South Norfolk, Great Yarmouth and Waveney, West Norfolk, Norwich)
- 3 Acute Providers (James Paget UHFT, Norfolk and Norwich UHFT, Queen Elizabeth HFT)
- 2 Community Providers (East Coast Community Healthcare CIC, Norfolk Community Health & Care Trust)
- 1 Mental Health Trust (Norfolk and Suffolk FT)
- Norfolk County Council
- Suffolk County Council
- District, Borough and City Councils
- East of England Ambulance Service Trust (EEAST)
- Norfolk Independent Care
- IC24
- Norfolk & Waveney Local Medical Committee
- Healthwatch Norfolk

Delivery Workstreams

Prevention & Wellbeing
- Targeting obesity and diabetes
- Secondary Prevention – Optimising Healthcare
- Social Prescribing

Primary, Community & Social Care
- Primary Care at Scale
- Improved access and capacity
- Integrated Out of Hospital Teams including social care and mental health
- Sustainable Social Care for all

Mental Health
- Integrated physical and mental health care
- Supporting more people in the community at an earlier point, reducing the demand on acute care and mental health acute beds

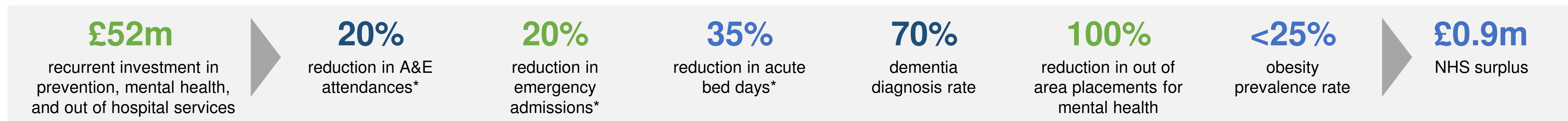
Acute Services
- Specialty sustainability
- Acute process improvement reducing avoidable bed days
- Reduction in NEL activity and reduced variation in practice will ensure RTT standards are met

Enabling Workstreams
- Workforce
- Estates
- ICT

Support Workstream
- Contracting
- Communications & Engagement
- Finance & BI

STP Outcomes by 2021

Each solution has measurable objectives, which when summed across the STP programme will deliver the key STP outcomes.



*vs 2021 do-nothing forecast

Progress Since June

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Following the June submission and feedback received in August, the health and care system has worked to develop more detailed plans and clearly articulate their impact on activity and finance. New developments to enhance the planning and delivery are outlined on this page.

Workstream priorities have been established which are described in further detail in the next section. These are underpinned by a suite of enabling strategies across workforce, ICT and estates.

Mental Health Workstream (see slides 13 & 19)

A dedicated Mental Health workstream was formed in August 2016 to maximise the contribution that transformation of mental health services can make to the system's goals. The system reviewed high level plans and priorities suggested by the workstream which include improvements in acute liaison, crisis resolution, physical health checks for people with mental health needs and plans to radically reduce out of area placements. This will be achieved through the introduction of new, integrated mental, physical and social care models designed to support those at greatest need at a locality level, facilitated by additional investment of £14.1m recurrently.

Enabler and Support Workstreams (see slides 15-17 & 20, & Appendices A & B)

Alongside the Local Digital Roadmap (LDR), we recognise that to deliver our plans effectively it is key to invest in and improve IT infrastructure across the system, therefore the LDR workstream has become more closely incorporated in the STP programme. Alongside this, workstreams for system-wide Estates and Workforce have been formed and have started to work through how they contribute to the STP. A high level estates strategy (Appendix A) will be further developed accounting for the transformation required by the delivery workstreams. The Workforce workstream will build on Health Education England (HEE) work and develop the Local Workforce Action Board to meet the recruitment, training and development of the new models of care. Our pooled finance and BI support has been utilised to model our solutions and we recognise this is an area of fundamental importance to guide the development of our plans.

We have pooled communications and engagement resource across the partners to engage with the media and public on our STP plans – our "in good health" publication containing elements from the Case for Change and June STP submission has recently been published. Further engagement is planned to ensure citizen and patient involvement in developing our plans. A Clinical Care Reference Group has been established to ensure multi-disciplinary clinical input in the planning process and to act as the first level of engagement with the clinical workforce. Communication through all STP member organisations, co-ordinated via assigned leads, will engage the front-line in making the STP part of daily work and develop a shared culture.

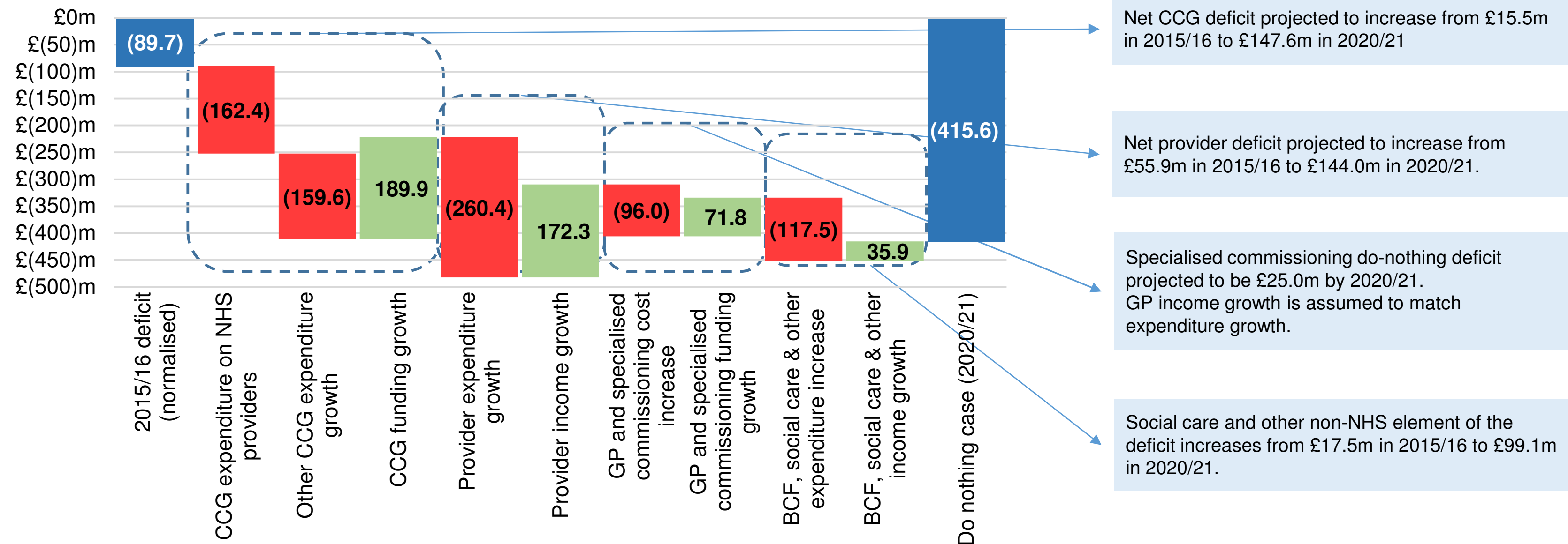
System Development and Leadership (see slide 32)

There is a good understanding of the key issues facing the footprint and a high level of consensus regarding the solutions required to address these however further work is required in the next three months to establish both the programme governance and capacity necessary to drive implementation. NHS commissioners in N&W have published a single set of commissioning intentions for 2017/18 and 18/19 and although there is no consensus currently regarding integrated commissioning of health and care there is a willingness to explore this further.

It is recognised across the footprint that a new integrated health and care model is essential to achieve the changes required in the next five years although the exact form is yet to be agreed. The system has appointed an Interim Programme Director who brings STP experience to the programme. This team requires dedicated resource to ensure delivery of the STP is effective.

Revised do-nothing financial position

The projected system do-nothing deficit is projected to be £415.6m, £316.6m relating to health system and £99.1m arising from social care and non-NHS. The do-nothing scenario shows the net CCG and provider positions deteriorating by £132.1m and £88.1m respectively. Increases in provider expenditure is principally activity-driven and this is reflected in tariff costs to the CCGs.



System Priorities

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Tackling the Gaps: Setting Our Priorities

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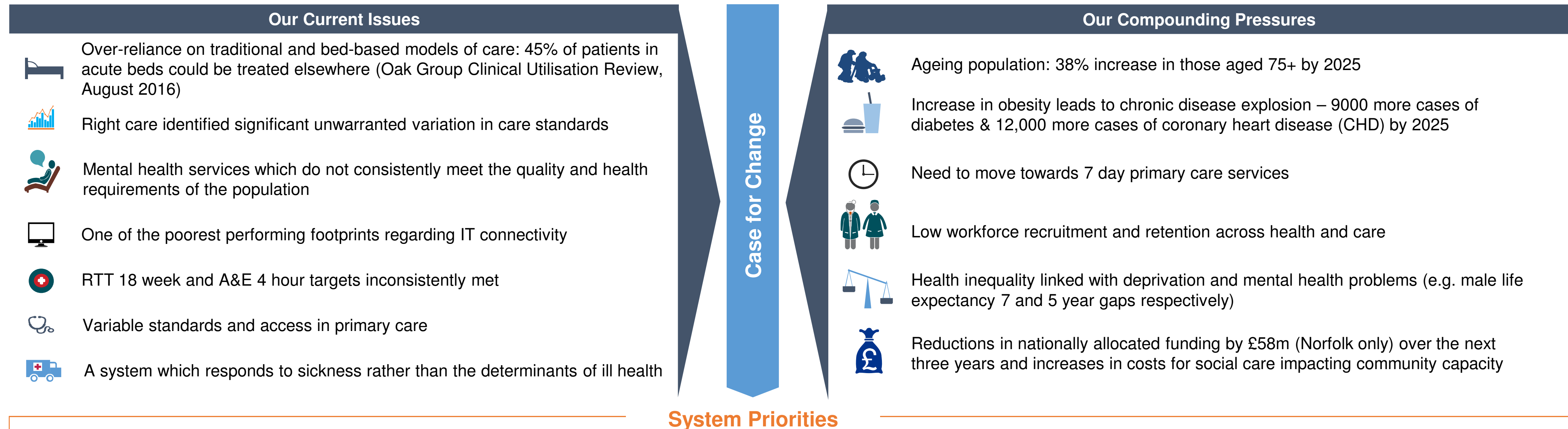
Our June submission outlined the reasons why we must change to become a sustainable health and social care system. In particular, it highlighted the current pressures on the system – variation in outcomes and an inability to consistently achieve key standards (e.g. A&E and RTT targets), coupled with impending demand pressures on the system such as an ageing population and increases in chronic disease. In response to this case for change, the system has identified five key priorities that form the priority areas for transformation which all programme workstreams are working towards.



System Priorities

Removing organisational boundaries to create integrated teams

Integration across physical health, mental health and social care will enable new ways of working and improve patient outcomes. Integrated teams will work across organisational boundaries, providing holistic care adapted to local requirements in Norfolk and Waveney. This will include better links between acute and out of hospital provision. System-wide work across ICT, workforce and estates will enable the delivery of new integrated models and reduce duplication. We will also focus on developing an integrated health and social care response to improve outcomes for children and young people.

Sustainable out of hospital and prevention services

Investment will increase in primary care, prevention, mental health, community services and social care. The sustainability of primary care services in particular is critical to shifting activity out of acute settings to home and community settings. Investment will help achieve the ambitions set out in the GP Forward View, including moving towards 7 day working, as well as address capacity, workforce and access issues. Working as one system and reducing demand in the long and short term will improve resident outcomes and reduce the cost of care, reducing the need for residential based care.

Reducing acute activity, in particular NEL and average LoS

Investment in primary, community and social care will enable treatment in the most appropriate care setting for patients who do not need an A&E attendance or an acute bed. This will be supported through improved ways of working with EEAST, and strong links with the district councils, voluntary and charitable sectors and robust prevention initiatives including effective risk stratification and case management for those patients with chronic conditions. This shift left will mitigate the projected increase in acute demand.

Improved management of planned care

Increasing demand for planned care is contributing to health provider unsustainability and there is currently an unequal distribution of unmet clinical activity across N&W. For example, one acute provider has a waiting list of 40,000 patients and the NHSI Elective Intensive Support Team estimate that this is 10,000 over a sustainable position. New approaches to managing outpatients, reducing the number of procedures with low clinical value, and managing system-wide RTT capacity will improve acute provider sustainability.

Adaptive and sustainable workforce

The workforce profile will need to change to match the future populations' needs. This will require rethinking of the traditional workforce models. N&W currently faces many of the workforce constraints seen across the country, with shortages in key specialties and difficulties in recruiting and retaining staff. N&W will work collaboratively with higher education providers, local academic organisations, and HEE to develop innovative solutions. The footprint is also operating within a challenging workforce environment for domiciliary and care home workers, and new approaches will be needed to support more people in the community and to meet the STP ambition.

Our System Priorities

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Workstreams have identified their top focus areas that address their respective key drivers of demand, cost and / or poor quality. Implementing these focus areas will also address the three STP gaps and develop a financially sustainable system delivering high quality care to improve patient outcomes. These impacts drive the workstream key performance indicators (KPIs).

WORKSTREAM	LINKS TO SYSTEM PRIORITIES	IMPACT ON STP GAPS		
		POPULATION HEALTH	CARE & QUALITY	FINANCE
PREVENTION & WELLBEING	• Stabilisation of obesity and diabetes levels • Reduction in unwarranted variation • Reduction in impact of social determinants of health	• Improve the prevention, detection and management of major chronic illnesses • Lifestyle behaviour changes addressed through population approach	• Development of a social prescribing model that enhances access to more appropriate community support mechanisms • Patient activation to improve self-care	• 25% or below – obesity levels in adults • 10% reduction in suicide • Reduction in core dependency on statutory services • £12.7m system saving in 2020/21
PRIMARY, COMMUNITY & SOCIAL CARE	• Improved primary care access and capacity • Integrated out of hospital services • Sustainable social care services, more integrated with health provision for children and adults • Reduced acute activity	• More proactive management of LTCs through individualised care planning • Improved GP same day access • Improved access to secondary care through better GP linkages	• Care closer to home through out of hospital services across footprint • Improved access to A&E through front-end streaming and Out of Hospital Service (OHS) coordination • Less duplication through integrated teams • Sustainable supply of care services	• 20% reduction in NEL admissions • 20% reduction in bed days • 20% reduction A&E attendances • £56.5m system saving in 2020/21
MENTAL HEALTH	• People supported in the community, reducing need for acute and residential beds • Reduced acute activity • More support for people with mental health co-morbidities	• Improved life-long mental wellbeing through early intervention services • Improved physical health of people with MH needs through more physical health checks • Improved detection and management of dementia	• Supported patient recovery through psychological therapies • Better trained community staff to understand MH pathways • Increased capacity to support people of all ages in crisis	• 100% reduction in acute out of area beds • 20% reduction in MH related A&E attendances • 10% reduction in frequent attendances by people with a reported mental health condition
ACUTE CARE	• More efficient internal processes to reduce lengths of stay • Rebalancing activity in order to consistently meet planned RTT and cancer targets • Developing options for sustainable hospital services across the three providers	• Making every contact count • Embedding prevention and wellbeing and mental health pathways within the acute care setting	• Reduced wait times for A&E and RTT • Increased day case rates • Improved diagnostic capacity • Faster discharge from hospital from criteria-led approach • Decreased Cancer wait times and increased one year survival rates	• 15% reduction in bed days delivered through improving hospital processes • RTT to national standards • 95% achievement of A&E target • £25.8m system saving in 2020/21
ICT	• Digital pathway mapping with clinical groups • Developed architecture e.g 3 Acute EPR and Connected Care Exchange • Integrated records with GP, Mental Health, Community, Social Care	• Empowering patients and the public so they can use information to support their health and social care • Reducing travel time through use of technology e.g., telehealth, telemedicine	• People only telling their story once, removing duplication • Improved quality of care due to better access to information across settings	• 65% e-referrals by 2016/17 • Higher proportion of prescriptions sent electronically • 20% increase in patient activation
ESTATES	• Integrated estates strategy • Reappraisal of planned land disposal to ensure it fits with objectives • Community Wellbeing and Health Care campuses	• An estates strategy that reflects the need of patients and staff for easy access and travel to identified locations	• Care closer to home through increased use of community and primary care estate	• Release value from void land • Centralise new infrastructure and key resources to reduce overheads • 10% reduction in estates costs
WORKFORCE	• System-wide programme of development for non-medical clinical and social care staff • Bring together the agency spend projects • Developing ways staff can work to the top of their license	• More staff trained to 'make every contact count' with prevention activities integrated across all settings • Reduced workforce shortages improves care provision across footprint	• Improved patient experience who receive care from well-trained, more resilient workforce • More highly trained staff providing more integrated services • Improved training and pipeline for domiciliary and care home staff	• Reductions in agency spend

Prevention & Wellbeing

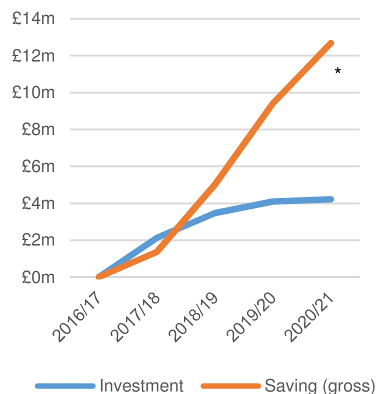
in good health

SRO:	Dr Louise Smith (NCC)
Lead:	Stephanie Butcher (NCC)

The aim is to develop a system wide programme to:

- Prevent ill health and achieve sustainable reductions in NHS and social care demand by embedding prevention across health and social care
- Reduce variations in access to health care where this contributes to the health and wellbeing gap
- Address the impact of wider socio-economic issues to prevent causing further demand on health and social care services
- Increase individual and community capacity for self-care, and increase patient activation

Financial Impact



* Includes all benefits of Rightcare

Key Workstream Objectives

- Improve the prevention, detection and management of major chronic illnesses that affect the N&W population, such as diabetes, CHD and hypertension.
- Reduce obesity and prevalence of diabetes and its impact on residents and the N&W care and health system.
- Reduce occurrence of smoking and alcohol-related harm.
- Development of a social prescribing model that enhances access to more appropriate community support, reducing dependency on core health and social care services for N&W's most deprived populations and improve patient outcomes – including to reduce suicide and self-harm.

Priority Projects

Targeted interventions – Obesity, diabetes, smoking and alcohol

- Train health, social care, local authority and the VCS to extend health promoting practice into normal consultations/visits to increase signposting to smoking cessation, alcohol reduction initiatives, physical activity and healthy eating for all ages
- Work with practices and NHS Health Check providers to maximise referral and uptake in the Healthier You Diabetes Prevention programme for those with non-diabetic hyperglycaemia (NDH)
- Scale up Tier 2 weight management programmes to provide more capacity to support people with BMIs > 30
- Improved self-care and ownership of health through peer support and patient activation
- Alcohol liaison service in acute trust to meet presenting demand

Social determinants of health – Social prescribing

- Building on existing community networks, implement a model for social prescribing that is transferable and flexible to local needs providing a broader and co-ordinated range of relevant options for health and care services to refer to, to support patients
- Community hubs for referral pathways to housing and welfare advice, mental health, healthy lifestyles, alcohol intake, falls prevention, financial and benefits advice, physical activity, befriending, to support outcomes for children and young people, working age adults and older people
- Co –location and training across health, social care, local authority and the VCS, building a directory of services; develop the capacity of the community, voluntary and third sector to deliver interventions

Optimising Health Care

Through a Right Care approach, increase opportunistic examination and management, identify localities to target improvements to disease-specific monitoring and management of atrial fibrillation (AF), hypertension, diabetes, dementia, asthma, and chronic obstructive pulmonary disease (COPD) by:

- Clinically led, systematic audit programme and management review of treatment through the Right Care Approach
- Training for non-GP staff
- "Catch up" NHS Health Checks and strengthen data sharing and referral

Key Assumptions

- The principles of prevention are embedded in both Health and Social Care, and there is significant system buy-in
- There will be sufficient funding available to support delivery of the proposed interventions
- There will be adequate resource and uptake of the proposed education and prevention programmes within the N&W footprint.
- Staff across secondary, primary and community care will be appropriately engaged to deliver the proposed solutions.
- The health, social care, local authorities, and voluntary sector will be adequately integrated to deliver and signpost the appropriate social interventions, including mental health

Resource and Enabling Requirements

- £4.2m recurrent investment
- Interdependencies with other Programmes critical in terms of delivery of interventions
- IT – licensing, hosting and maintenance of training packages
- Estates – Hubs; community facilities; impact of One Public Estate
- Workforce enablers – specialist recruitment; interdependency with other programmes; retraining and redefining roles
- BI: Evaluation of metrics to monitor progress and impact of priority projects

Critical Success Measures/KPIs

- Stabilisation in obesity levels & obesity attributable admissions: Obesity prevalence in adults 25% or below. Obesity attributable admissions 1,420 per 100,000 per year (directly standardised rate).
- Reduction in emergency admissions due to ambulatory care sensitive respiratory conditions; and due to primary diagnosis of dementia. Reduce emergency admissions with a primary diagnosis of dementia by 25% to 300 per year. Asthma emergency admissions reducing by 120 per year and COPD reducing by 400 per year.
- Reduction in the inequality of access to and outcomes from health and care services at all ages.
- 10% reduction in suicide (with MH work stream).
- Reduce alcohol-specific admissions from 300 to 250 per 100,000 per year.

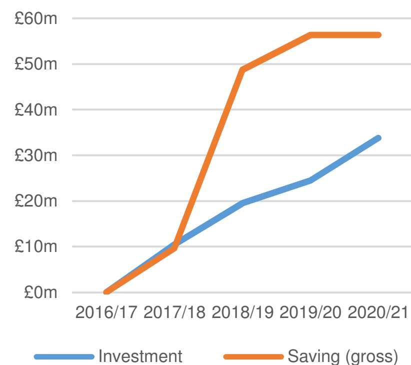
Primary, Community and Social Care: Demand Management

in good health

SRO:	Roisin Fallon-Williams (NCHC)
Lead:	Fran O'Driscoll (GY&W CCG)

- The STP is committed to delivering new models of care that enable people to access care closer to home, improving the quality of care delivered and reducing high-cost activity in acute settings.
- Co-ordinated care will allow patients to access the right care at the right time, with better care planning, reduced duplication and better patient outcomes. This initiative aims to reduce non-elective admissions, A&E attendances and enhance hospital discharge processes.
- The ultimate aim is to promote long-term sustainability of community and social care supported by workforce development and new ways of working.

PCSC Financial Impact (inc. Primary Care work)



Key Workstream Objectives

Develop an integrated model of care that incorporates primary, community, secondary and social care to:

- Address the diverse needs of N&W, with a focus on the high cost/ high need population, urgent care and long term conditions.
- Facilitate alignment with new models of care, supporting a shift from the acute setting to care delivered closer to home.
- Reduce high-cost demand in acute (by reducing LoS and NEL admissions) and residential care.
- Enable local provision that is focussed on the community and responsive to individual and local needs with commonly agreed outcomes across the footprint.
- Provide an integrated service tailored to local needs that manages Long Term Conditions (LTCs) in the community.
- Improve integration of social care and mental health services into primary and community care to ensure holistic treatment.
- Support the independence of residents (including integrated rehabilitation and reablement), including better social and clinical outcomes for people with LTCs and end of life patients.
- Agree a strategy across the footprint for children, young people and maternity services

Priority Projects

1. ***Integrated Out of Hospital Services (OHS):*** Connecting health & social care professionals across primary, community and secondary care. OHS functions will include case management & care planning, improving palliative & end of life (EoL) care, signposting to community and VCS resources & linking with acute multidisciplinary teams (MDTs). This combined approach will deliver an integrated service tailored to local needs with input from social care & mental health, with a focus on promoting people's independence. It will also support reductions in acute activity from both the ''front end' and 'back end'.
2. ***Specialists in community:*** Development of integrated consultant roles e.g. Consultant Geriatricians working in community to support the OHS, attend MDT meetings and provide home visits. The specialist consultants will spend a set number of hours per week working across primary, community & secondary care, enabling better integration of patient care and enabling people to live at home.
3. ***Telemedicine and new ways of working for residential care:*** 24/7/365 telemedicine model of care using technology to remote-link care homes directly to healthcare professionals and local community-based services that can visit patients if necessary, increasing the confidence of care home staff and residents.
4. ***GP input into 111*:** Funding GPs to support multidisciplinary clinical assessment and enhanced triage in the 111 call centre. This integrated urgent care service will ensure people are directed to and treated by the most appropriate services including access to primary, social and mental health care via this single point of access and assessment.
5. ***Ambulance conveyance*:** The new operating model will support a reduction in conveyances by appropriate signposting to alternate pathways via the Emergency Clinical Advice and Triage centre within EEAST emergency operations centre (EOC) and utilising the mobile specialist paramedic staff as a mobile community health service, treating patients in their own home or community.
6. ***Front-end Streaming & Co-ordinated Care:*** Two-stage management of patients presenting at A&E consisting of a primary care front-end operating during weekends to triage and treat minor injuries and illnesses, and a front-end Care Coordinator redirecting patients to the OHSs where appropriate.
7. ***Individualised Care Planning:*** Employing specialist clinical staff to work with people to manage their LTC. This collaborative approach revolves around individualised goal setting, agreeing care management actions and mapping an escalation plan in case of condition deterioration/ exacerbation. This project also has the potential to build in advanced care planning for palliative and end of life patients.

Key Assumptions

- Targeted populations will have materially reduced 2020/2021 activity in the acute and residential settings.
- The OHS will have an appropriate skill-mix to ensure patients can be safely and effectively managed in the community.
- There will be adequate recruitment to the OHS & specialists in community roles.
- Patients suitable for out of hospital care will be sufficiently engaged with the alternative care delivery methods.
- Better awareness of and access to community provision will reduce both demand and cost in statutory health and social care.
- A viable social care provider market that secures access to good quality care at an affordable price.

Resource and Enabling Requirements

- Investment: £18.8m to support community health and social care services, including £16.4m in OHSs
- Workforce: Training, capacity and capability pipeline, including re-frame of current acute skills into the community & joint training on EoL competencies.
- Estates: Facilitation of joint location for health and care staff for OHSs.
- IT: Shared records, including capability for case finding cross-organisation. Procurement of the technology required to enable the priority projects.
- BI: Evaluation of measurement metrics to monitor the progress and impact of priority projects.

Critical Success Measures/KPIs

- Reduce non-elective (NEL) admissions by 20%
- Reduce bed days by 20%
- Reduce A&E attendances by 20%
- Improve A&E 4 hour targets
- Decrease in NEL/ A&E attendances from residential & nursing care homes
- Shift Ambulance conveyance rates from 60/40 conveyance to 50/50
- Long term conditions management metrics – e.g. number with care plan
- Reduced usage of long-term residential and nursing care
- Improvement in the % of EoL patients dying in their place of choice

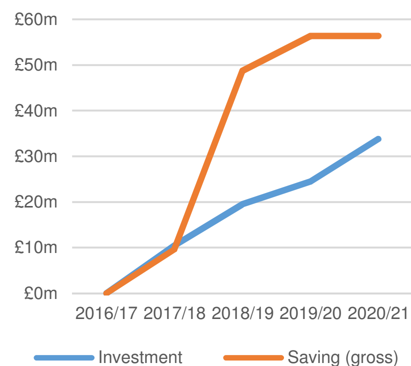
Primary, Community and Social Care: Supporting Primary Care

in good health

SRO:	Roisin Fallon-Williams (NCHC)
Lead:	Fran O'Driscoll (GY&W CCG)

- The Primary Care workstream requires investment to improve the quality of care delivered across the Norfolk & Waveney footprint.
- This investment aims to address the on-going issues around general practice capacity, recruitment and access to primary care.
- Investment in the proposed initiatives will further support implementation of the 5 Year Forward View priorities, enable better integration of care, and in doing so, improve demand management across the Norfolk & Waveney footprint.
- We also expect to move towards fully delegated primary care commissioning. We also expect that it will be a single co-ordinated approach across all 5 CCGs.

PCSC Financial Impact (inc. Demand Management)



Key Workstream Objectives

Develop and extend N&W primary care provision to:

- Enable N&W primary care to work at scale with flexible initiatives.
- Release existing capacity to meet increasing demand.
- Improve primary care staff retention, recruitment and skill-mix.
- Improve same day access to primary care.
- Improve the relationship between primary and secondary care.
- Enable Local provision that is responsive to individual and local needs with commonly agreed outcomes across the footprint.
- Facilitate alignment with new models of care, supporting a shift from the acute setting to care delivered closer to home.
- Develop a primary care strategy for the footprint.

Priority Projects

Enhancing the effectiveness of General Practice through:

1. ***Improving Primary Care Access & Capacity:***
   - *Phone Triage:* implementation of systematic phone triage to reduce demand for face-to-face appointments and increase accessibility to routine support.
   - *Sharing of Resources*: identifying opportunities for joining up back-office activities such as sharing of HR, finance & medical secretaries between practices and sharing of clinical resources.
   - *Pharmacy support:* employing pharmacists to work as part of the primary care team assisting with prescriptions, day-to-day medicine issues & consultations where appropriate.
   - *Paramedics in Primary Care:* use of paramedics in primary care, especially for initial assessment of urgent visits to relieve GP workload pressures. EEAST's proposed new operating model will support primary care by increasing the skill level of specialist practitioners to operate across the 999/primary care systems; this could include supporting GP assessments in the community.
   - *Improving Access to Senior Clinicians:* enabling primary care to contact senior clinicians for direct advice/consultation leading to better plans for patients, with fewer referrals and better decision making.
2. ***Improving Staff Retention & Recruitment within Primary Care***
   - Providing additional training and alternative opportunities for primary care clinicians.
   - *Improving skill mix and additional training for wider practice teams:* implementing alternative roles to release GP capacity & reduce workload pressures e.g. Advanced nurse practitioners to remove clinical burden and training reception/ clerical staff to read, code and action incoming clinical correspondence.
   - *Practice nurse development:* improving training capacity in general practice, increasing the number of pre-registration nurse placements & supporting return to work schemes for practice nurses.
   - *Practice manager resilience:* additional support for practice managers and increased training opportunities.
   - *Expansion of GP Fellowships.*

Key Assumptions

- Workforce Skill-mix: there will be an appetite for additional training and alternative roles.
- Recruitment: there will be sufficient recruitment of staff to fill the alternative roles in primary care.
- Service user engagement: service users will be appropriately engaged with alternative care delivery pathways.
- ICT capability will be sufficient to enable the priority projects and primary care collaboration within N&W.

Resource and Enabling Requirements

- Investment: £15m to support primary care health services, including implementation of the demand management initiatives that have a primary care element e.g., OHSs.
- Workforce: Training, capacity and capability pipeline, including a re-frame of current acute skills into the community and a "shift left" for provision.
- IT: Shared records and system interoperability between organisations including capability for case-finding across organisations.
- BI: Evaluation of measurement metrics to monitor the progress and impact of priority projects.

Critical Success Measures/KPIs

- 90% of patients have same day access.
- 100% of patients have routine appointment within 2 weeks.
- 90% patient satisfaction with primary care services.
- Less than 5% GP attrition rate.
- 75% success with GP recruitment.
- Improved back-office efficiencies.

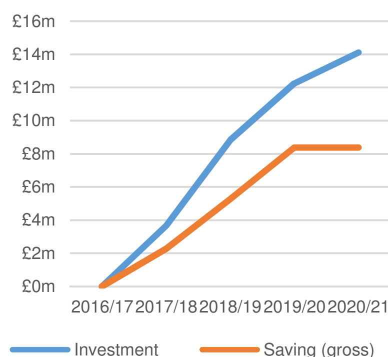
Mental Health

in good health

SRO:	Michael Scott (NSFT)
Lead:	Jocelyn Pike (SN CCG)

- The ambition of Norfolk and Waveney STP is to embed delivery of mental health within the health and care system, supporting people in the community wherever possible. Acute mental health beds will be only for people who need them, and the emphasis will be on people's recovery.
- The STP will support the improvement of the quality of care for people with mental health needs, and meeting the national 5YFV expectation
- Health, care and community teams will support the resilience of individuals including those with physical health conditions.
- Children and young people are a priority of the workstream. An additional £1.9m in investment is allocated through the Local Transformation Plan to CAMHS.

Financial Impact



Key Workstream Objectives

- Offset and reduce the growth in out of area bed days
- Reduce suicide and self-harm
- Increase recording of dementia, improve access to support and reduce use of residential and acute care
- Support community and primary care to provide mental health support at an early stage, including those with physical health conditions
- Increase community based treatment for children and young people, aligned to the STP and delivered through the Local Transformation (LTP)
- Reduce acute hospital and residential care use for people of all ages with reported MH problem, including children and young people and dementia

Priority Projects

Target conditions – Dementia

- Simplified pathways across N&W that make better links with community provision and physical care health needs, starting from an increased diagnosis rate
- Specialist dementia / carers workers aligned with the social prescribing model (Prevention and Wellbeing), dementia friendly communities and VCS support. Training for community staff to recognise dementia.
- Joined up mental and physical health care for people diagnosed with dementia, supported by wider out of hospital services and specialist mental health provision where needed, including reablement for people with dementia.

Rehabilitation and Reablement (Complex Needs)

Support more people in the community, reducing need for residential and acute beds

- Early Intervention Services – supporting people with first and early presentation of psychosis to improve life-long mental wellbeing and reduce self harm / suicide
- Increase physical health checks for people with mental health needs, embed an outcome framework to monitor and improve health
- Single point of access as part of the wider out of hospital system

Implement a consistent MH liaison service across N&W

- Acute MH liaison service across N&W, combined with expanded Crisis Resolution Home Treatment capacity to support more people of all ages in crisis; reviewing existing provision and developing new services based on need.
- Frequent attender service to target the 70 people with mental health needs that disproportionally use emergency provision, providing a fully joined up service with VCS, out of hospital services and community provision.

Supporting people with MH Co-morbidities

- Psychological Therapists in out of hospital services to support patient recovery and normalise talking therapies in the delivery of care for people with physical health needs targeted at conditions with high co-morbidity
- Community staff will be supported to better understand pathways, refer for appropriate local services, identify non-statutory solutions and link with communities
- Additional primary care support targeted at local practices with the highest levels of need, including mental health practice nurse roles, and GP champions.

Key Assumptions

- Additional support in primary and community care will increase awareness of MH and early interventions, reducing need for secondary health involvement.
- Improving the mental health of N&W residents with physical health needs will reduce the need for both secondary mental health services and acute care
- Investment in ambulatory care models with mental health support will improve outcomes for patients, and reduce the need for admissions for people of all ages
- Improving awareness of mental health services and interventions in primary and community care will reduce demand and free up capacity
- Changes to the complex needs pathway will support more people in the community, and improve outcomes, including physical health, employment, self harm and suicide.

Resource and Enabling Requirements

- Investment – £14.1m to meet local and 5YFV priorities in the delivery of care across all settings. Comprising: £5.9m for acute liaison, £6m for reablement and recovery, £0.8m for dementia and £1.4m for integrating physical and mental health care
- Workforce – training across the health, care and community sectors on MH. Recruitment and pipeline for community psychiatric nurses, psychological therapists and peer support roles.
- IT –Alignment of systems in acute hospital and community settings. Access to SystmOne and other systems for MH staff.
- Estates – New/refurbished hubs in three main urban areas. Pop-up hubs in market towns. Space required to deliver interventions in acute hospitals and primary care.
- BI: Evaluation of measurement metrics to monitor the progress and impact of priority projects.

Critical Success Measures/KPIs

- Stop out of area bed placements
- 20% reduction in referrals to secondary care mental health
- 10% reduction in secondary care mental health active caseload
- 10% reduction in frequent attendances at A&E by people with a reported MH problem
- 10% reduction in use of acute hospital by people with a reported MH problem
- 10% reduction in suicide (with Prevention and Wellbeing)
- Increase dementia recording to 70%, and reducing the number of people supported in residential care

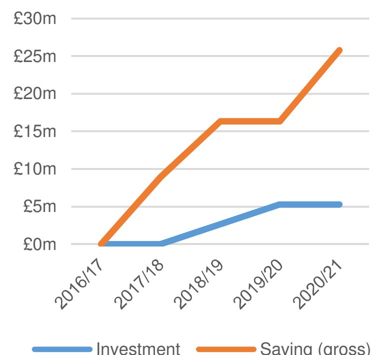
Acute Care

in good health

SRO:	Christine Allen (JPH)
Lead:	Andrew Palmer (JPH)

- The Acute Care work stream leads the development and delivery of more integrated acute care services across the Norfolk & Waveney provider base, to ensure consistent delivery of improved patient outcomes, experience, and RTT and cancer targets.
- This comprises the James Paget University Hospitals NHS Foundation Trust, Norfolk and Norwich University Hospitals NHS Foundation Trust, and the Queen Elizabeth Hospital Kings Lynn NHS Trust.
- This includes review of 7 specialties: maternity, cancer, radiology, cardiology, stroke, dermatology, and paediatrics

Financial Impact



Key Workstream Objectives

1. Rebalancing acute activity between providers in order to consistently meet planned RTT and cancer targets:
   - Improved demand management (supporting the PCSC, MH, and P&W work streams to deliver admission avoidance schemes)
   - Reduced length of stay by improving the process of care across the acute system
2. Ensuring acute clinical service sustainability at an STP footprint level across the key nominated specialty areas and their interdependencies
3. Delivery of elective care to meet current and future demand, and address the current backlog in planned care waiting lists across the system

Priority Projects

Acute provider service sustainability

- Clinical, operational and financial sustainability assessment of 7 nominated acute specialties (maternity, cancer, radiology, cardiology, stroke, dermatology, and paediatrics) for the three acute trusts. This incorporates analysis of workforce and clinical activity, performance against service guidelines, and assessment of local and regional patient flow.
- Facilitated tripartite meetings convening clinical leads and service managers for each nominated specialty at each trust, with CCG and primary care representatives, to review the sustainability assessments and develop and assess the impact of future care model options for reduction of the planned care backlog and consistent delivery of RTT and cancer targets, including a robust appraisal of opportunities for further service collaboration and/or transformation.
- Development of demand and capacity model to help quantify gap between current and future demand and supply across acute providers, which will inform development of future care models and help address backlogs. Providers will work together with the intensive support team (IST) to develop a system wide solution to meeting RTT across the STP by March 2018. Specifically the project will clear the RTT backlog during 17/18 (additional 5,000 patients), and then deliver a sustainable position by end of 18/19 (a further 5,000 patients). The non-recurrent cost (estimated at £11m) of addressing the issue is not currently incorporated in the 17/18 or 18/19 plans.

Improved internal acute processes

Four priority areas have been agreed across the three acute trusts to develop and implement comprehensive programmes to address issues identified:

1. Enhancing ambulatory care e.g. Early assessment through ambulatory models facilitated by increased consultant in-reach with improved ambulatory access and care pathways. This will contribute to meeting the 4-hour access target which is an on-going priority.
2. Facilitating discharge e.g. Enabling 'discharge to assess' through new/improved virtual ward capacity and supporting systems; criteria led discharge, with goal to eliminate 'red days' (where no value added activity takes place); plan for every patient e.g. embed into rounds, discharge ownership, bed management and reporting, partner engagement.
3. Reducing LoS via: 1) enhanced ambulatory care, 2) enabling acute elements of discharge to assess, 3) early comprehensive frailty assessment and discharge planning.
4. Diagnostic capacity, in particular to enhance delivery of cancer targets e.g. Rapid diagnostics offering enhanced 'Point of Care' testing to accelerate pathway and process.

Other key areas to ensure consistent delivery of improved patient outcomes, RTT and cancer targets, and improved system efficiency will include:

- Benchmarking to reduce clinical variation, including through Right Care and Better Care, with a focus on day case rates and collaborative working to address issues identified
- Acute elements of the five 'must dos" for the new A&E Delivery Boards, working closely with partners, particularly 111, mental health and the ambulance service
- Review options for further back office consolidation at a system wide level across the three acute trusts

Key Assumptions

- Forecast population growth of 4% increase 2015-2021
- Disproportionate growth of older population, with ~1500 more people aged 85+/year
- Forecast increase in A&E attendances of 40,719 by 2020/21
- Forecast increase in emergency admissions of 12,490 by 2020/21
- Unsustainable elective waiting list at the tertiary centre, exceeding current capacity by approximately 10,000 patients

Resource and Enabling Requirements

- Health and social care services available in community to enable "left shift" from acute services e.g. Integrated Out of Hospital Services (new job roles and approaches to workforce to be supported by the Workforce enabling workstream)
- Transition funding to support changes in care models and "cut over" plans is essential
- Fully functional integrated electronic patient records, care plans and care coordination systems available to relevant professionals across all providers in the health system (to be delivered by ICT enabling workstream)
- Collaboration and partnership from existing acute and non-acute providers including on new models e.g. Mental Health Liaison Services
- STP process to develop complementary skill sets to support the work stream and programme delivery
- Development of an appropriate payment/contract model to support 'load sharing' across the STP footprint
- Unified approach to commissioning to deliver a single set of STP focussed commissioning intentions across the footprint
- Providers and Commissioners to develop options to replace the 'many to many' approach of multiple contracts with a 'one to one' approach to simplify financial planning, contracting and funding flows to support system wide service transformation

(the precise details and measurable impact of each project in this work stream will be quantified as part of developing the individual PIDs for each project, due later in the year)

Critical Success Measures/KPIs

- 20% reduction in A&E attendances and non-elective admissions (primarily delivered by avoidance schemes in primary care and out of hospital work streams)
- 20% reduction of acute bed days (post 2 days initial assessment) delivered by growth of out of hospital capacity (not just additional community beds)
- 15% reduction of acute bed days (post 2 days initial assessment), delivered by improving hospital processes
- Achievement of national cancer waiting time and RTT standards

ICT

SRO:	Dorothy Hosein (QEH)
Lead:	Geraldine Wingfield-Hill (NCHC)

- The Local Digital Roadmap is structured around three ambitions:
- Digitally Enabled Individuals – build capability and support cultural change to enable patient connectivity and workforce sustainability.
- Connected Quality Care – aligning the digital journey with the care pathway so that the information goes hand in hand with the patient.
- Innovation Through Technology – transformational digital technology allowing health and care to deliver innovative services.

Key Workstream Objectives

- **Digital patient** – Patients and where appropriate their families or carers have access to their care record. They are partners in their own care and able to self manage where appropriate.
- **Digital GP** – GP have timely access to electronic data regarding any health and social care interventions which take place outside the immediate primary care setting. The digital GP is fully enabled with clinical decision support tools.
- **Digital clinician** – The clinician and healthcare professional is working in an e-hospital where paper and data flows have been optimised, and the patient record is part of a wider shared record between acute hospitals and the wider health economy.
- **Community working** – The community healthcare professional, social care professional and mental health therapist have access to real time or near real time data at and near the point of care. A different type of care is enabled through digital collaboration.
- **Capability and change** – Create a sustainable workforce which is attracting and retaining digital natives who will build health and social care for the future.
- **Intelligence led healthcare** – There is whole systems intelligence to support population health management and effective commissioning, clinical surveillance and research. Real time analytics at the point of care support decision, and innovative research.
- **Unified communications** – There is a standards based approach to infrastructure, including networks, email and digital innovation applications to enable the workforce to log in and connect anywhere, and hold digital interactions using communication technology online.

Key Assumptions

- The digital readiness across organisations will be increased in line with projected trajectories, starting from an average position far below the national average
- Services will embrace the adoption of digital solutions, agree to data sharing and resource appropriately

Resource and Enabling Requirements

- Investment: Revenue expenditure of £12.7m per year. Possible funding sources include STP, Driving Digital Maturity fund, Estates and Technology Transformation fund, Better Broadband for Norfolk
- Workforce: Culture and training of staff will be in place to attract and retain digital natives, and to upskill existing staff in digital approaches

Priority Projects

<u>2016/17</u>

System analysis – Working with clinical groups to map digital pathways. This includes establishing integration with Primary Care, Mental Health, Community, and Social Care; and the architecture of the Connected Care Exchange. Anticipated ready to start procurement by March 2017.

Electronic Patient Record (EPR) Procurement – Build on the NNUH Outline Business Case for a new EPR to ensure the 3 acute providers travel together toward one EPR. Pump prime funding now needed to revisit the work, adding in QE and JPH. Build an HM Treasury Five Case Model compliant Strategic Outline Case by December 2016 followed by Outline Business Case by March / April 2017.

Build the digital capacity 16/17 Footprint has no Clinical CIO and Wachter review was published September 2016. Clinical time is needed to work on the Local Digital Roadmap with the CIO lead and delivery team. Footprint to use secondments to build a virtual team based on talent management, digital standards, working with National Information Board and Health Education England. For a short time and at the beginning, a backfill cushion is needed in year one to build capacity.

<u>Beyond 2016/17</u>

- **E-hospital** – To support a healthy and robust acute service, the e-hospital will transform the way care is delivered from the acute hospitals. There will be a three acute EPR, running on up to date infrastructure, and operating cohesively with other shared and individual clinical systems. Medical imaging will be consolidated where possible and the highest levels of specialist support will be enabled through technology.
- **Connected care exchange** – To support an increase in out of hospital care a connected care exchange will link up multiple care organisations using an interoperable platform supporting access to multiple care records. Out of hospital hubs will support health and wellbeing where care can be delivered closer to the home. Access to records is available to health and care individuals from multiple care settings.
- **Intelligence-led healthcare** – There will be a focus on digital which can support Prevention and Wellbeing, underpinned by business analytics to inform integrated commissioning. A shared business intelligence service can be accessed by multiple organisations. Access is through an appropriate view of the provider, commissioner, social care, academic researcher or patient level data across the footprint.
- Solutions are supported by underpinning infrastructure through unified digital communications. This includes assessing the opportunity to deploy telehealth and telemonitoring into key specialties to manage capacity gaps. Priority areas include dermatology and residential care consultations.

Critical Success Measures/KPIs

- E-referrals: 65% by 16/17 and 80% by 2017/18
- 20% increase in patient activation by 2017/18
- All GP practices enable online repeat prescription ordering by 2017/18

Estates

in good health

SRO:	Mark Taylor (NN CCG)
Lead:	Alistair Nelson (QEH)

- The ambition of the estates workstream is to fully understand the current assets in the system and to optimise their use.
- This will result in a reduction in duplication and release value
- We will also develop financial 3rd party funding, with support from finance
- We recognise that each individual provider has its own estates strategy, however the combined STP estates strategy will build on these individual plans.

Key Workstream Objectives

- Review the impact of increased use of community and primary care estate to support prioritising care at home or closer to home
- Ensure the estates strategy reflects the need of patients and staff for easy access and travel to identified locations.
- Realign capital projects to meet STP clinical plans to drive down acute activity and focus on preventive care.
- Optimise estates to reduce real estate stock.

Priority Projects

1. Developing and implementing an integrated estates strategy
   - Finalise the register of assets to understand current estates
   - Creation of N&W One Public Estate (OPE) that will support each workstreams' key objectives.
   - Identification of key estate stock for 'quick wins' in terms of land disposal to fund key projects. Develop 3rd party funding to replace Centre capital.
   - Centralised key estate resources to reduce overheads and duplication.
   - Integration of procurement to ensure estates are meeting Lord Carter recommendations and ERIC returns to achieve best value.
   - Create a new STP team to drive space utilisation and focus on the overall real estate.
   - Establish localised geographical teams to drive changes in estate requirements and achieve local aims and requirements.
   - Review whether there is a need to redesign A&E to relieve pressure on the three acute providers and examine potential Ambulatory Care and Diagnostics (ACAD) centre based in Greater Norwich area.
2. Releasing and generating value
   - Reappraisal of planned land disposal to ensure it fits with STP objectives and that there is no potential for revenue generation
   - Create a generic finance model for 3rd party funding with the key aims of delivering value for money and providing sustainability.
   - Develop funding model/s with councils and the Charity Bank (funding for social projects)
3. Community Wellbeing and Health Care campuses
   - Establish Wellbeing Hubs in Great Yarmouth, King's Lynn and Central Norwich, to act as an access point to all primary care and mental health services.
   - Realign existing services around the hubs to offer all-age, open access, light touch support, improve physical health outcomes, and a point to navigate into community assets.
   - Develop diagnostic / therapeutic hubs in the community for LTCs to support the Mental Health and PCSC workstreams
   - Prevention of new builds from 3rd parties and use of existing stock for value release.

Key Assumptions

- All current/committed projects in progress receive capital funding up to 2017/19 as supplier to regulator.
- The strategy is driven by the Clinical Care Reference Group.
- The estates strategy reflects the STP plan for the first three years, which will see reduced acute activity and a move towards care being provided closer to home.
- Governance processes required to make these changes continue to be aligned to the STP Executive.

Resource and Enabling Requirements

- Realignment of decision-making structures with clearly defined transformation parameters
- Resource is required for planning phase to drive changes and projects
- Financial resource for development of 3rd Party /OPE funding for key projects

Critical Success Measures/KPIs

- Realignment of capital projects related to Acute activity
- Drive new finance models for 3rd party and/or OPE investment
- Develop new model for releasing and generating value from void land
- New infrastructure and key resources centralised to reduce overheads
- Combined estates footprint rationalised by 10% by 2020

Workforce

in good health

SRO:	Roisin Fallon-Williams (NCHC)
Lead:	Ross Collett (HEE)

- The aim of the Workforce workstream is to protect our workforce supply by ensuring we train and employ the student population we have invested in as well as develop our existing workforce to meet the requirements of the new models of care.
- We also recognise that moving to new models of care will require a more adaptive and up-skilled workforce. The workstream will focus on training and up-skilling staff to support them during these changes.
- As the models of care become clearer, this workstream will work across the footprint to provide:
  - BI support to include baseline, supply and demand data to model future requirements;
  - support the development of and deliver a workforce strategy;
  - support the development of a transformation and investment plan

Key Workstream Objectives

- Develop the new workforce requirements based on the new models of service delivery.
- Protect our future workforce supply and improve workforce recruitment and retention.
- Improve workforce productivity
- Reduce premium staffing costs (reduction in Agency spend)
- Further develop leadership and organisational development at a system level
- Deliver on the workforce elements of national commitments e.g., GP Forward view, Five Year Forward View for Mental Health etc.

Priority Projects

1. **Address recruitment and retention issues across health and social care**

- Coordinate the workforce demand modelling / skills profiling project(s) along identified care pathways using recognised national tool e.g. WRaPT / SWIPE
- Develop a system-wide approach to recruitment and retention of newly-qualified staff
- Develop and implement a new business model with Higher Education Institutes (HEIs) as we move to self funding in 2017
- Delivery of "resilience" training to improve retention and reduce sickness absence of existing workforce
- Joint project with Local Enterprise Partnerships and social care to improve recruitment and retention in the care home sector.

2. **Improve workforce productivity**

- Deliver a suite of development resources to up-skill existing health and social care workforce and support associated culture change
- Deliver "Talent for Care" consistently across the system in health and social care
- Scope future sustainable funding opportunities to support future staff development initiatives
- Continued rollout of "coaching principles" to deliver high quality learning for students across the system
- Development of different roles in the primary care and social care workforce, including domiciliary care. For example development of generic workers and assistant grades across disciplines.

3. **Reduce premium staffing costs**

- Bring together the agency spend projects that are currently taking place at organisational level into one programme across the STP
- Work strategically with the relevant organisations to reduce agency spend and monitor implementation

4. **Develop leadership and organisational development**

- Scope and coordinate existing local, regional and national leadership provision across the footprint
- Deliver talent management and leadership systematically across the footprint, using HEE resources as appropriate.

5. **Deliver on the workforce elements of the national commitments**

- To coordinate and monitor the delivery of the workforce elements of the national commitments e.g., GP Forward View, Five Year Forward View for Mental Health etc. For example, looking at ways to build resilience amongst practice managers, diversifying the skill-mix within primary care staff, and training for staff to deliver integrated physical and mental health care.

Key Assumptions

- The same numbers of non-medical degree students are being trained by HEE and that any changes to the fee-model will not impact the number of students in the pipeline.
- Any changes to the apprenticeship levy from HEE do not impact or alter the number of students completing the Talent for Care apprenticeship.
- There are opportunities to reduce the premium costs associated with bank and agency spend that will support financial balance over time.

Resource and Enabling Requirements

- Support is required to undertake the demand modelling work, in particular to invest in a tool e.g., WRaPT / SWIPE
- Joined up working with the four work programme leads to ensure workforce implications of the new care models are understood and planned for
- Funded human resource to run the workforce workstream on a day-to-day basis

Critical Success Measures/KPIs

- Increasing numbers of postgrad students choosing to take up employment in STP footprint – baseline measure to be agreed.
- Workforce profile will change to match STP models of care with increased productivity to manage demand – baseline measure to be scoped.
- Target reductions in agency spend will be met and premium cost of care delivery will reduce – organisation targets brought together at STP level.

Workstream Milestones

in good health

Each workstream has set milestones to guide and track project delivery. Across all workstreams the immediate priority is to develop detailed Project Initiation Documents (PIDs) to provide a detailed framework for both the enabling workstreams and individual organisations to incorporate in their plans.

PCSC: Demand Management

2016/17

Q3
- Agreed further specification and form for each OHS
- Mapped current OHS workforce resources including primary care, identified gaps, and developed job specifications and joint recruitment plans

Q4
- Agreed sequence of rolling out OHSs, including agreement of commissioning and contracting mechanisms
- Establish extensivist GP pilot in West Norfolk, including current suggested models
- Developed and agreed a plan in conjunction with the cancer alliance to improve EOL and palliative care in line with national guidance for implementation
- Identified, recruited and trained GPs wanting to work alongside 111 service.
- Ambulance conveyance: Trained, developed and appointment of core MDT & initiation of Integrated Clinical Hub implementation. Identification and development of appropriate 24/7 alternate community pathways to be completed. Gap analysis to be undertaken.
- Strategy for children developed
- Develop joint workforce strategy across STP for short-term initiatives (including OHS)

2017/18

Q1
- Agreed a pilot geriatrician in the community in Norwich
- Identified ways to recruit geriatricians
- Develop a specification for telemedicine (or other) for residential care with key stakeholders
- Agreed arrangements with the 111 provider (IC24) for GP involvement.
- EEAST to pilot alternative intervention-type resources across the STP footprint to reduce potential ED conveyances i.e. Falls Intervention Vehicle
- Piloted coordinated care role in GY&W A&E
- First OHS team recruited and rolled-out to meet local variation and footprint needs.
- Develop joint workforce strategy across STP for longer-term initiatives (including acute workstream initiatives)

Q2
- Released specification for telemedicine for residential care and IT requirements
- Agreed the payment mechanisms and outcomes framework for providing individualised medical care planning service in practices that want to participate
- Second OHS team recruited and rolled-out to meet local variation and footprint needs.
- Implementation of GP / 111 input for key time periods where there is likely to be greatest impact.
- Agreed joint workforce strategy across STP

Q3
- Learn from initial evaluation of South Norfolk care home vanguard
- Released EOI to residential care homes for telemedicine trial
- Developed staff training requirements for implementation of individualised medical care plans
- Third and fourth OHS teams recruited and rolled-out to meet local variation and footprint needs.
- Ambulance conveyance: Post implementation review. Increase in the scope of types of calls to be triaged. Creation of placements across the Clinical Hub service. EEAST's proposed new operating model will support a reduction in conveyances to ED by appropriate signposting to alternate pathways via the clinical hub and paramedic staff.
- Evaluated pilot coordinated care role in GY&W A&E and began roll-out at JPH, where there is already an established ambulatory care model
- Implemented coordinated care role ahead of winter 2017 in QE and NNU.
- Released an EOI for primary care practices wanting to adopt individualised medical care plans.

Q4
- Reviewed use of community bed provision to assess whether OHS are impacting the need.
- Undertaken appropriate procurement for IT companies to deliver telemedicine services.
- Trained residential care home staff to employ telemedicine
- Trained primary care staff for the first two care groups for the individualised medical care plans (diabetes and respiratory)

2018/19

Q1
- Final three OHS teams recruited and rolled-out to meet local variation and footprint needs.
- Evaluated outcomes of the geriatrician in the community pilot & developed and implemented the wider roll-out plan for further geriatricians in the community.
- Ambulance conveyance: Continue workforce recruitment and development.

Q2
- Conducted and evaluated pilot with selected residential care homes for telemedicine trial.

Q3
- Rolled-out telemedicine across the footprint, beyond the pilot.

Q4
- Individualised medical care plans: agreed the next set of care groups and continued training for primary care staff.
- Completed the evaluation and assessed the impact of OHSs

2019/20

- Continued roll-out of staff training for use of telemedicine in residential care homes
- Expanded input of GP into 111 to other time periods where needed.
- Implemented training for new care groups for the individualised medical care plans.

Workstream Milestones

in good health

Each workstream has set milestones to guide and track project delivery. Across all workstreams the immediate priority is to develop detailed Project Initiation Documents (PIDs) to provide a detailed framework for both the enabling workstreams and individual organisations to incorporate in their plans.

PCSC: Supporting Primary Care

2016/17

Q3
- Identified priority practices requiring support to remain sustainable
- Prioritised primary care workforce issues on which OHS are dependent
- Agree workforce strategy for primary care for the new models of care

Q4
- Received EOI for each model of care
- Additional student nursing placements planned
- Developed links with external education bodies

2017/18

Q1
- Expanded existing initiatives across patch e.g., telephone triage
- Identified 'buddy' relationships amongst practices who are early adopters of initiatives

Q2
- GP Fellowship post opportunities established, advertised and filled
- Practice manager training and development programme established

Q3
- Improved back office efficiencies: identified practices suitable to share back office support

Q4
- Commenced and completed training for identified posts in priority areas with interested parties.

2018/19

Q1
- Evaluated and rolled out initiatives where appropriate

2019/20

- Full Alignment with the GP Forward View:
  - Active signposting
  - New consultation types
  - Reduced DNAs
  - Team Development
  - Productive Workflows
  - Personal Productivity
  - Partnership Working
  - Social Prescribing
  - Supporting Self Care
  - Developing QI Expertise

Acute Care

2016/17

Q3
- Establish specific working group to scope and evaluate options for improved diagnostic capacity as a priority within the acute workstream programme
- Develop and commence implementing system level initiatives to enhance ambulatory care
- Develop initiatives to facilitating patient discharge

Q4
- Reduction in bed days target to deliver 5% point reduction in year 1
- Evaluate outcomes from the acute specialty review
- implement system level initiatives to enhance ambulatory care
- Begin implementing initiatives to facilitating patient discharge
- Develop and commence implementing initiatives to reduce inpatient LoS
- Evaluate options for further back office consolidation
- SOC and OBC for improved diagnostic access

2017/18

Q1
- Reduction in bed days to deliver 10% point reduction (Flat phased beginning Q1),
- Design new care models for acute service review specialties
- Complete FBC improved diagnostic access across the STP
- Phased implementation and consolidation of selected system level initiatives to enhance ambulatory care across the acute providers
- Phased implementation and consolidation of selected initiatives to facilitating patient discharge across the acute providers

Q2
- Commission new care models flowing from acute service review

Q3
- Procurement of additional diagnostics
- Phased implementation and consolidation of selected initiatives to reduce inpatient LoS across the acute providers consistent with Community Team ramping up

Q3 &4
- Implementation and delivery of new models including capacity load bearing

2018/19

Q1
- Reduction in bed days target to deliver 21% point reduction
- Begin evaluation of new care models across the three acute trusts based on the outputs from the sustainability review
- Full delivery of Ambulatory and admission avoidance schemes

Q2
- Implementation assessment and evaluation of additional diagnostics including potential for contract management

Q4
- Completed implementation and consolidation of selected initiatives to reduce inpatient LoS across the acute providers

2019/20 – 2020/21

- Reduction in bed days target to deliver 28% point reduction in year 4, 35% in year 5
- Further consolidate and evaluate new care models and other selected initiatives with recommendations for further improvements

Workstream Milestones

in good health

Each workstream has set milestones to guide and track project delivery. Across all workstreams the immediate priority is to develop detailed Project Initiation Documents (PIDs) to provide a detailed framework for both the enabling workstreams and individual organisations to incorporate in their plans.

	2016/17	2017/18	2018/19	2019/20-2020/21
Prevention and Wellbeing	**Q3** • Completed PIDs and planning for implementation • Interdependencies and links agreed with other workstreams • Phasing sequences agreed **Q4** • Target localities agreed for RightCare initiatives, and reflected into plans • Estates and co-location opportunities identified, including wellbeing hubs • Training plan developed • Weight loss programmes commence (phase 1)	**Q1** • Pilot phase (pre STP) diabetes programme impacts (Q1) • RightCare audits commence and action plans (Q1) **Q1 &2** • Training plan and first wave training delivered (Q1&2) **Q2** • First social prescribing goes live (Q2) • Existing alcohol liaison service refreshed in line with need (Q2) **Q2 &4** • Targeted Intervention Services commissioned and commenced (Q2&4)	**Q1** • Social prescribing schemes 2 and 3 go live (Q1) **Q2** • Weight loss programmes commence (phase 2) (Q2) • Next wave training delivered (Q2) **Q4** • Progress reviewed and approach refreshed for subsequent years (Q4)	• Remaining social prescribing models go live • Evaluation completed and work programme redefined • Impact of KPIs and key deliverables

	2016/17	2017/18	2018/19	2019/20-2020/21
Mental Health	**Q4** • Children & Young People LTP implemented, incl. mental health and eating disorders • Perinatal MH services developed • Additional community resources aligned with OHS development, including training plan	**Q1** • Crisis response and acute liaison in priority areas • Complex needs pathway developed and aligned with social care • Early Intervention for Psychosis (EIP) model developed in N&W **Q2** • Implement pilot of further integrated adult/older peoples teams (NCC,NSFT and NCHC) in West Norfolk **Q3** • Expanded psychological therapies in place. • Integrated therapeutic interventions in physical health collaborative care in place in remaining areas **Q4** • Review impact of crisis services across age group	**Q1** • Health and social care complex needs pathway in place. **Q3** • Provider negotiations regarding further changes to system completed	• Models are consolidated. • Evaluate models and recommendations for further changes. • Strategic plan is updated and further changes based on impact of STP projects

Workstream Milestones – Enablers

in good health

The Enabling Workstreams have set milestones in line with the requirements from the delivery workstreams as set out below.

ICT

	2016/17	2017/18	2018/19	2019/20-2020/21
ICT	• Seed funding already requested from NHS England to kick start priority projects October to March 2017	• Leveraging the use of existing systems via ten universal capabilities between now and March 2018 • Achieving a more joined up local health and care economy through better use of the digital services which are already available.	• Paper free and paper light through: • Records, assessments and plans, Transfers of care, orders and results management, medicines management and optimisation, decision support, remote care, asset and resource optimisation	• Achieve the strategic vision of digital technology working for patients and the public so they can feel and be empowered by the information supporting their health and social care.
	Q3 &4 • Strategy agreed for footprint NHS email	Q1 • EPR procurement Q2 • GP mobile working 50% of footprint Q3 • Social care system included Q4 • 25% patients access their own GP record • Telemedicine procurement linking care homes	Q1 • GP mobile working 100% of footprint Q2 • Mental health electronic prescribing Q3 • EPR ready phase one Q4 • Telemedicine live in footprint	

Workforce

	2016/17	2017/18	2018/19	2019/20-2020/21
Workforce	Q3 • All STP partners across health and social care sign-up to developing a joint STP workforce strategy. • Bring together all NHS Provider agency spend projects into one coordinated plan to monitor delivery going forward.	Phasing the delivery of implementation plans for each work programme to deliver the STP workforce strategy working with the LWAB and CEPNs. These plans will meet the workforce requirements of the national commitments.		
	Q4 • Develop and gain STP sign-off of an agreed workforce strategy • Setup appropriate workforce education and infrastructure to support the delivery of the joint workforce strategy: • Local Workforce Action Board (LWAB) to be set up and functional • Community Education Provider Networks (CEPN), or equivalent, to be in place across the STP footprint • Implemented self funding business model for students in non-medical HEE programmes • Rolled-out coaching principles across STP Providers • Developed and tested recruitment and retention approaches to check effectiveness • Developed and delivered resilience training • Developed a plan for the Local Enterprise Partnerships project in three areas: apprenticeships, registered nurses and care home managers • Developed resources and begun roll-out of staff development training • Scoped the use of modelling tools (e.g. WRaPT / SWIPE) to support the STP. Tested early pathways with the tool. • Coordinated plans to reduce agency spend • Scoped and coordinated leadership and organisational development training and projects	• Rolled-out recruitment and retention approaches that have been proven to be effective. • Implemented a plan for the Local Enterprise Partnerships project in three areas: apprenticeships, registered nurses and care home managers • Completed roll-out of staff development training • Developed a workforce demand model using a modelling tool (e.g. WRaPT / SWIPE) and implemented on key pathways. • Begun implementation of plans to reduce agency spend, with benefits starting to be realised. • Deployed leadership and organisational development training and projects	• Continued rollout of sustainable resources • Continued implementation of demand modelling and application of outputs • Delivered full agency spend reduction plan • Implemented leadership and talent programme and plan	• Completed rollout of coaching model • Continued rollout of sustainable resources

Workstream Milestones – Enablers

in good health

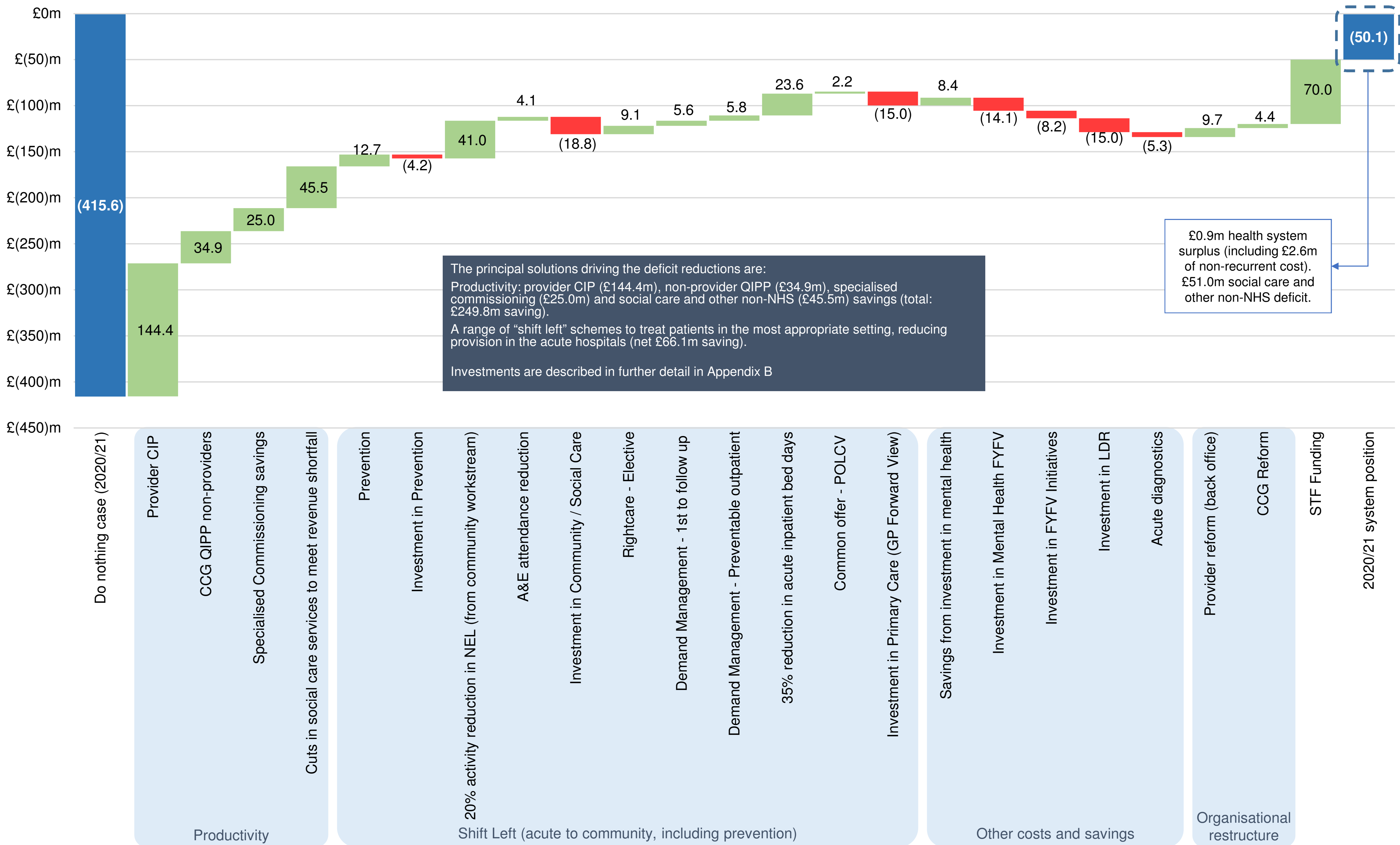
The Enabling Workstreams have set milestones in line with the requirements from the delivery workstreams as set out below.

	2016/17		2017/18		2018/19
Estates	Q4	• Obtain funding for estate implementation team to enable next stage • Create a new STP team to drive space utilisation from Q2 to Q4 2017 to bring sustainability and focus on the overall real estate. • Consolidation of Health & OPE estates for infrastructure planning to meet STP needs • Develop relationships with OPE Community Programme team to drive the consolidation of the estate • Establish governance for working across the estates	Q1	• Start space utilisation/rationalisation for disposals and income generation • Specification of creating centralised resources for estates • Share quick win locations to support workstreams for Primary, Mental and Preventative • Start 3rd party financial models for submission in Q3 • Prevention of new builds from 3rd parties and use of existing stock for value release • Prelims on Healthcare campuses	Q1: • Transformation plan for centralising service providers • Estates Team established
			Q2	• Identification of key estate stock for quick wins in terms of land disposal for funding key projects, Develop 3rd party funding to replace Centre capital • Establish localised geographical teams established to drive changes in estate requirements and mutual support of achieving localise aims • Reappraisal of planned land disposal to ensure it fits with STP objectives and no potential for revenue generation • Consolidation of acute providers capital budgets	Q2 &3: • Review of rationalisation of the disposal of void locations • Develop outpatient estate requirements in the community • Identification of new capital programmes for supporting initiatives from workstreams
			Q3	• Create a generic finance model for 3rd party funding with a key aims of value for money, sustainability without excessive charges , • Develop funding model with councils and Charity Bank (funding for social projects) • Review of all service contracts for efficiency savings – potential centralised tendering	Q4: • Consolidation of savings and efficiencies • Review of estate strategy • Disposals of additional estate stock
			Q4	• Submission of new overall estates strategy in direct support of STP clinical strategy • Workforce Enablers Centres of excellence for Training in support of community carers – will generate revenue • Tender specification for all service contracts • Drive efficiencies and bring whole STP leverage for procuring services • Prepare capital projects where 3rd party funding is available. • Project management of healthcare campuses – four locations	

Financial Impact

Solutions and Impact

in good health



in good health

Solutions and Impact

The assumptions underlying each element of the financial bridge are set out below. In most cases (e.g. QIPP and RightCare) the solution has been specified in such a way that avoids double counting. We have set out the key risks associated with each assumption.

	Assumptions and target	Workstream	Net impact of scheme	Impact on activity
Provider CIP	• Minimum 2% recurrent savings for all providers • EEAST CIP is assumed to cover the projected increase in the baseline deficit of £14.4m. ***Risk: underachievement of recurrent savings.***		£144.4m	-
CCG QIPP non-provider	• Savings derived from prescribing and Continuing Healthcare (CHC). ***Risk: impact on demand for social care services arising from savings in CHC.***		£34.9m	-
Specialised Commissioning savings	• QIPP from specialised commissioning is assumed to cover the “do nothing” deficit. ***Risk: insufficient savings made to cover deficit***		£25.0m	-
Prevention	• A range of prevention schemes including diabetes, CHD, undiagnosed hypertension and social prescribing which are assumed to reduce activity in acute and ambulance providers. ***Risk: the benefit of some prevention schemes may not be realised until after the 2020/21.***	Prevention and Wellbeing	£12.7m	OP: (2,849) Elective: (689) NEL: (4,085) A&E: (6,391)
Investment in prevention	• Investment required in social care to deliver the prevention programme. This has been assessed by NCC for each scheme, based on Public Health England evidence. ***Risk: any delay in funding these schemes may delay benefits until outside the five year STP planning timeline.***	Prevention and Wellbeing	£(4.2)m	-
20% activity reduction in NEL (from community workstream)	• The schemes are: residential and nursing care homes, 111 with GP input, ambulance conveyance rates, out of hospital teams and outpatients. • The schemes are assumed to be funded by investment in primary, community and social care as detailed below. ***Risk: there remains a risk that the capacity of new service models is absorbed by existing unmet demand for services.***	Primary, Community and Social Care	£41.0m	NEL: (28,738)
A&E attendance reduction	• The cost of A&E attendances which did not require referral or follow-up was £13.4m (cost to the CCG) and 37.8% of A&E attendances received guidance only. A 30% reduction was assumed.	Primary, Community and Social Care	£4.1m	A&E: (57,785)
Investment in Primary Care	• This investment is part of the requirement to support the 20% reduction in NEL admissions and 20% reduction in bed days. It is calculated at the level required to support the national funding commitments of the GP Five Year Forward View.	Primary, Community and Social Care	£(15.0)m	-

Solutions and Impact (continued)

in good health

	Assumptions and target	Workstream	Net impact of scheme	Impact on activity
Investment in Community / Social Care	• This is part of the requirement to support the 20% activity reduction in NEL admissions and reduced bed days.	Primary, Community and Social Care	£(18.8)m	-
RightCare – Elective	• The total RightCare opportunity for all CCGs in the region is £48.4m (based on 2014/15 expenditure). This includes potential elective, non-elective and prescribing savings. Non-elective and prescribing savings were excluded to prevent double-counting as detailed on page 26. ***Risk: The RightCare opportunity represents national variations in CCG expenditure, not actual cost of provision. Also, it's possible that CCG expenditure in comparable CCGs could be less as a result of greater investment in other related services.*** ***Risk: this saving is based on tariff cost to CCG, not the provider cost (which is the true system cost).***	Prevention and Wellbeing	£9.1m	Elective: (7,378)
Demand Management – 1st to follow up	• This is the potential saving for specialties where the region has a higher first to follow-up ratio than the national benchmark. ***Risk: this saving is based on tariff cost to CCG, not the provider cost (which is the true system cost).***	Primary, Community and Social Care	£5.6m	OP: (76,566)
Demand Management – Preventable outpatient	• Preventable outpatient appointments are assumed to be those that are discharged without procedures or follow ups (excludes 2 week waits and urgent appointments). • The implementation of a triage intervention/referral management service is assumed to prevent such appointments. ***Risk: this saving is based on tariff cost to CCG, not the provider cost (which is the true system cost).***	Primary, Community and Social Care	£5.8m	OP: (42,771)
35% reduction in acute inpatient bed days	• The Oak review showed that 35% of patients in the acute hospitals no longer required acute services. Of this 15% was due to hospital process delays and 20% due to the lack of available discharge package. • We have removed the 20% reduction in NEL admissions within the calculation to prevent double-counting (assumed to impact spells with a low average LoS of 2 days). The remaining LoS results in a reduction of 12 wards across all providers at an annual saving of £2.0m per 30 bed ward.	Acute Care	£23.6m	OBD: (156,249)
Common offer – POLCV	• The total opportunity for common offer is £20m. The assumed saving relates to procedures that are subject to prior approval, but where prior approval was not obtained. ***Risk: a reduction in the number of POLCV procedures undertaken could increase the demand for social care services.*** ***Risk: this saving is based on tariff cost to CCG, not the provider cost (which is the true system cost).***	Acute Care	£2.2m	Elective: (2,459)

Solutions and Impact (continued)

in good health

	Assumptions and target	Workstream	Net impact of scheme	Impact on activity
Cuts in social care services to meet revenue shortfall	• Efficiency-based BAU savings for social care and non-NHS.		£45.5m	-
Savings from investment in Mental health	• 10% reduction in A&E attendances from the most complex cases. • 10% reduction in EL and NEL admissions from patients with LTCs with a mental health co-morbidity. • £4.5m saved from reduced LoS for people in hospital who require navigation and liaison. ***Risk: the LoS reduction is based on national evidence, there may be a double count with the Oak review LoS savings.***	Mental health	£8.4m	A&E: (395) NEL: (152)
Investment in Mental Health	• Calculated to deliver the national Five Year Forward View commitment to increase funding of mental health services.	Mental health	£(14.1)m	-
Investment in 5YFV Initiatives	• Calculated to deliver the national Five Year Forward View initiatives: Cancer task force £4.8m, Childhood obesity £3.3m.		£(8.2)m	-
Investment in LDR	• This is the revenue cost impact of the LDR, which is calculated net of relevant (i.e. EPR) existing IT revenue costs already included in the do-nothing case.	ICT	£(15.0)m	-
Acute diagnostics	• The acute providers require increased capacity for in CT and MR scanners (six each). The recurrent revenue cost impact is estimated at £7m.	Acute care	£(5.3)m	-
Provider reform (back office)	• Assumed 10% saving of (estimated) back office expenditure (including ICT and estates).		£9.7m	-
CCG reform	• Assumed 20% saving of "admin budget" expenditure.		£4.4m	-
STF Funding	• Based on fair share as advised by NHSE – available in 2020/21. £11m indicatively available for sustainability only in 17/18 and 18/19 subject to control totals being accepted.		£70.0m	-

RightCare opportunities

in good health

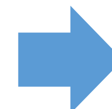
RightCare data for each of the CCGs in the region was used to help identify saving opportunities.

The potential savings presented here represent the difference to the top five similar CCGs.

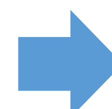
The potential savings are inflated to 2021 costs and assumed to be achieved at 80% of the total opportunity

The full RightCare opportunity totalled £48.4m. Prescribing (£16.8m) was removed due to a double count with non-provider QIPP. The balance was reduced by a further £1.1m through the quality checks outlined below.

	Area	2014/15 moderated saving (£m)
Elective	Cancer	5.0
	Circulation	2.8
	Endocrine and metabolic	0.5
	Gastro-intestinal	2.0
	Genito-urinary	1.0
	Respiratory	0.8
	Trauma & Orthopaedics	0.4
	Total	**12.4**
Non-elective	Cancer	2.2
	Circulation	5.5
	Endocrine and metabolic	0.5
	Gastro-instestinal	3.6
	Genito-urinary	0.7
	Respiratory	2.3
	Trauma & Orthopaedics	2.2
	MSK	0.5
	Neurological	1.9
	Total	**19.3**
Prescribing	**Prescribing**	**16.8**
	Total	**48.4**



£9.1m RightCare Elective solution (adjusted for inflation and 80% achievement)



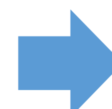
The following savings address this and will be subject to regular review:

£41.0m reduction in non-elective admissions

£4.1m A&E attendances without referral or follow-up

£5.6m first to follow up improvement

£5.8m preventable outpatient appointments



Forms part of the £19.7m prescribing saving within CCG non-provider QIPP.

RightCare data quality checks

- Take lower of Average or sum of CCGs savings to Top 5 similar CCGs. If % reduction seems too high, moderate savings accordingly; this mainly effects WN and GY&W (50% reduction applied).
- If savings only affect one CCG, then exclude from savings. Prescribing is excluded as it is assumed these will be within the CCG QIPPs.

Phasing of the deficit reduction

in good health

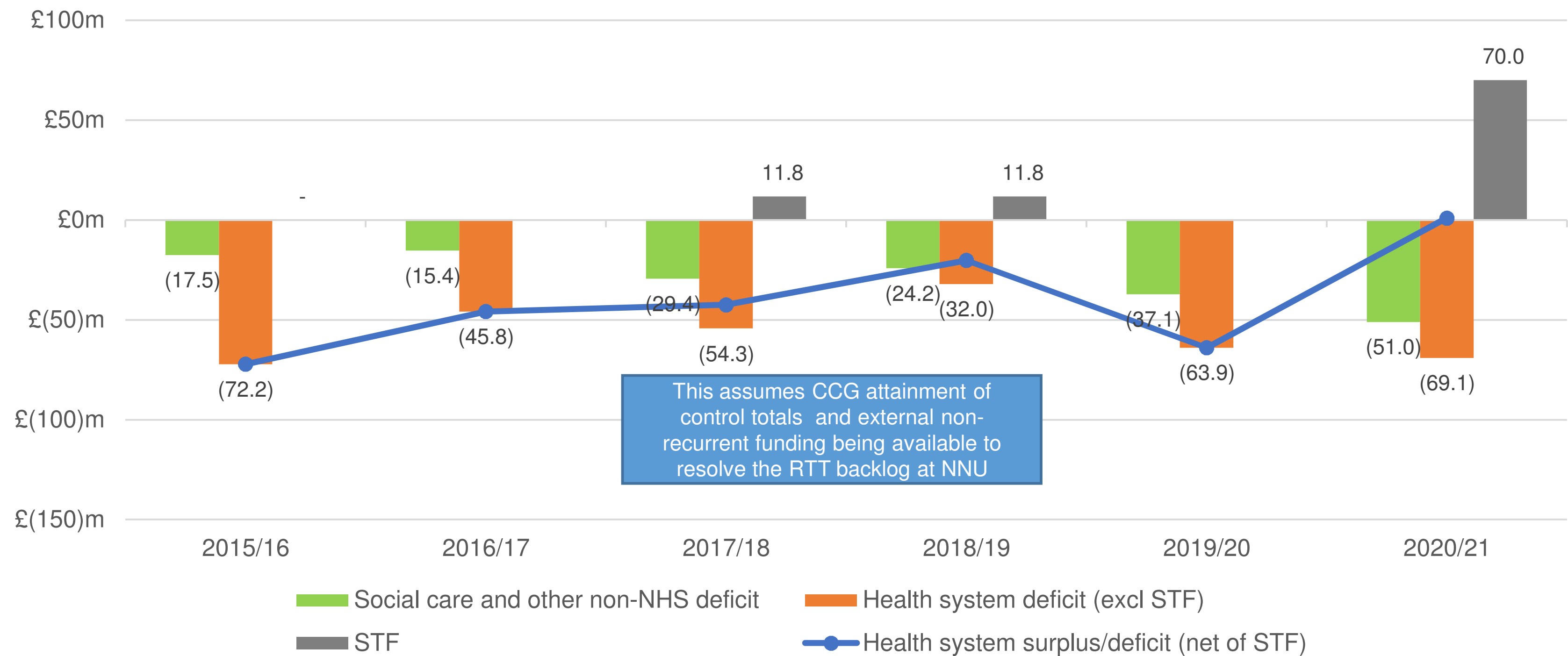
High-level scenario driven assessment of the deficit by year.

The proposed solutions bring the health system to a surplus position of £0.9m.

The implication by organisation is not yet understood. An augmented financial and activity model is required to complete this work robustly.

There has been no indication of System Transformation Fund (STF) funding expected in 2019/20 and therefore no such funding is included.

The graph below sets out a high-level, scenario driven assessment of the deficit by year. A priority for the system is to move quickly to a maturity of modelling that will link the critical path of interventions with granular phasing at an organisation level, that can be aggregated to track the implications for the system. We recognise this is a significant undertaking, and are assessing what help will be required to achieve this as a priority. We have been advised that additional STF monies are being held centrally in 2017/18. The Norfolk and Waveney indicative share of that fund is £19.7m. This has not been reflected in the numbers below and if received will improve the deficit in that year.



Phasing: The graph above sets out a high-level phasing of the solutions by year. Where phasing information is available from solutions, this has been used in the above analysis, however more work is required to make this assessment more robust. NNU has not yet been issued with a control total for 17/18 and 18/19 therefore making reconciliation with provider control totals impossible at this stage

Sensitivities

We have set out some high level sensitivities on this page, which focus on the following key risks to bringing the system back into balance by 2020/21 with the intention of scaling the size of the challenge against some of the potential risks:

- Achievement of productivity savings (through sensitising CIP achievement);
- Implementation delay (through delaying the shift left investment and delivery); and
- Cost saving assumptions (through sensitising the project cost saving from the acute workstream).

Sensitivity	Impact at 2020/21 (£m)	Assumption
Underachievement of CIP	-59.8	Providers achieve 1% CIP savings.
Greater achievement of CIP	+57.4	Providers achieve 3% CIP savings.
Shift left delay	-8.7	Out of hospital transformation is delayed by one year
Acute savings achieved at 50%	-12.9	Cost reductions in acute providers are achieved at 50% of the projected saving.

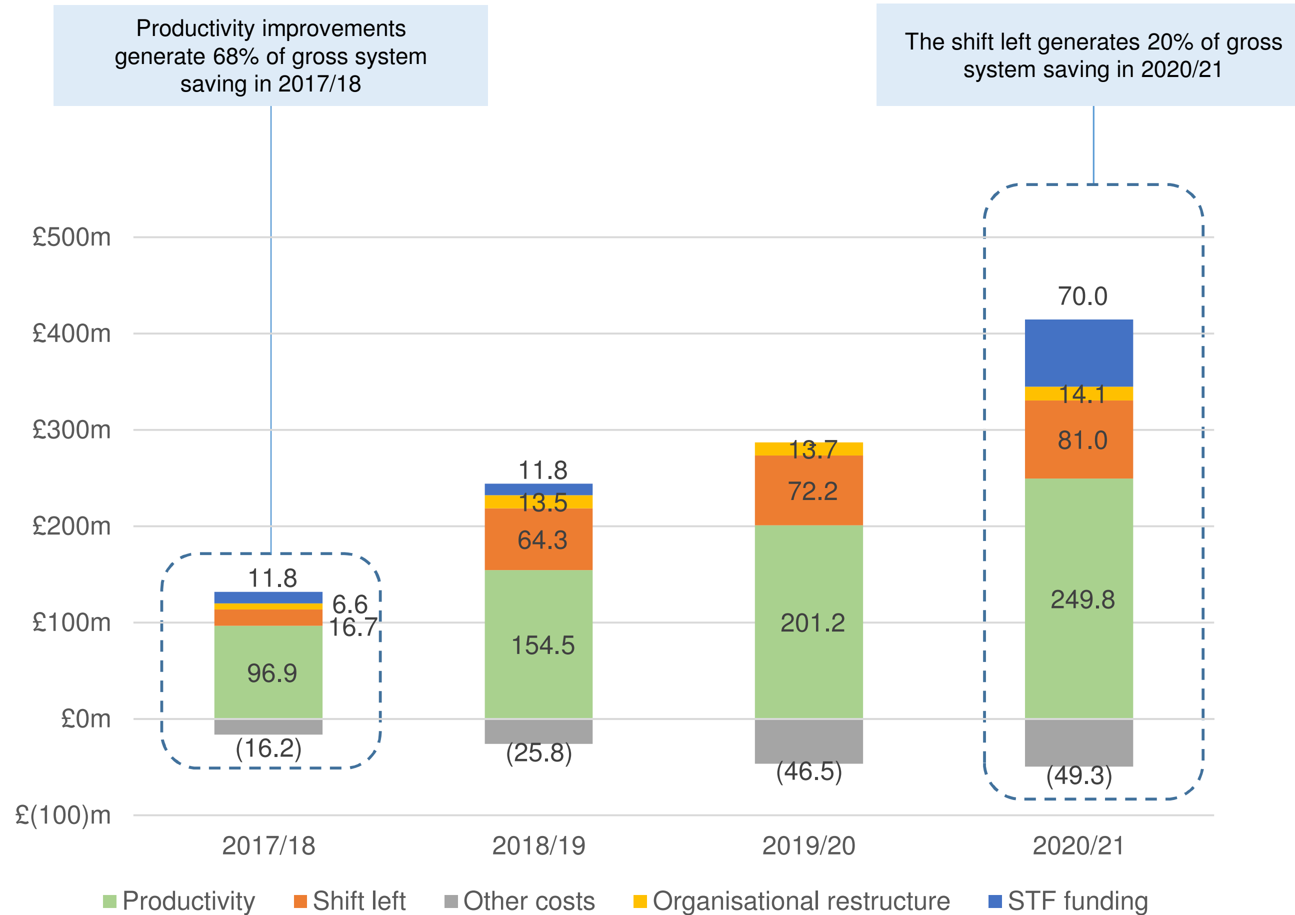
Solution phasing

The implementation of solutions has been phased over the five year plan.

The focus of financial savings in years 1 and 2 is on efficiency and productivity.

Service transformation is assumed to take longer to implement, with minimal impact in 2017/18.

There is no STF funding assumed for 2019/20, as national guidance has not yet been issued for this year.



The Do Nothing growth scenario doesn't take account of step changes in capacity, which would be required to meet the unchecked demand. If these were built in the impact of the 'Shift Left' would be much greater

The graph above sets out a high-level assessment of the solutions by year. Where phasing information is available from solutions, this has been used in the above analysis, however more work is required to make this assessment more robust.

Solutions and Impact: The shift left

in good health

The "shift left" solutions propose that acute activity is reduced across all Points of Delivery (PODs) by 2020/21.

The reduction in A&E attendances and non-elective admissions each significantly exceed the projected growth.

The financial bridge incorporates the investment in primary, community and social care required to achieve these reductions.

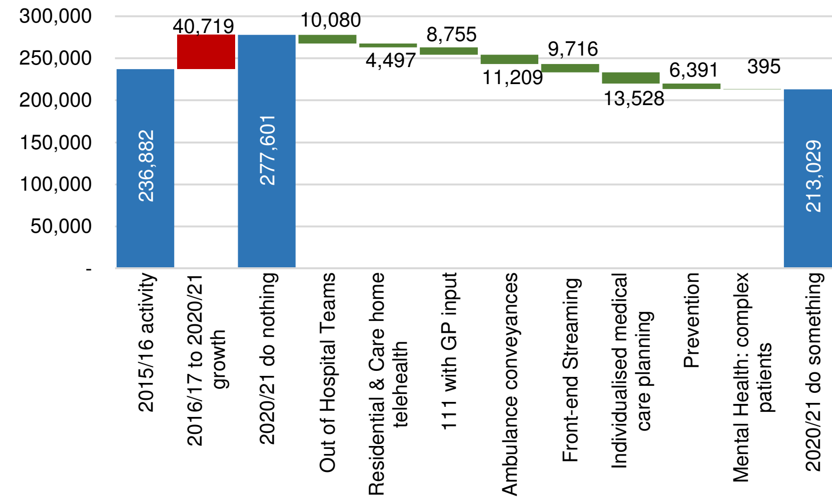
The charts on this page show the underlying movements in activity and therefore exclude actions required to reduce the RTT backlog.

Basis of activity calculations

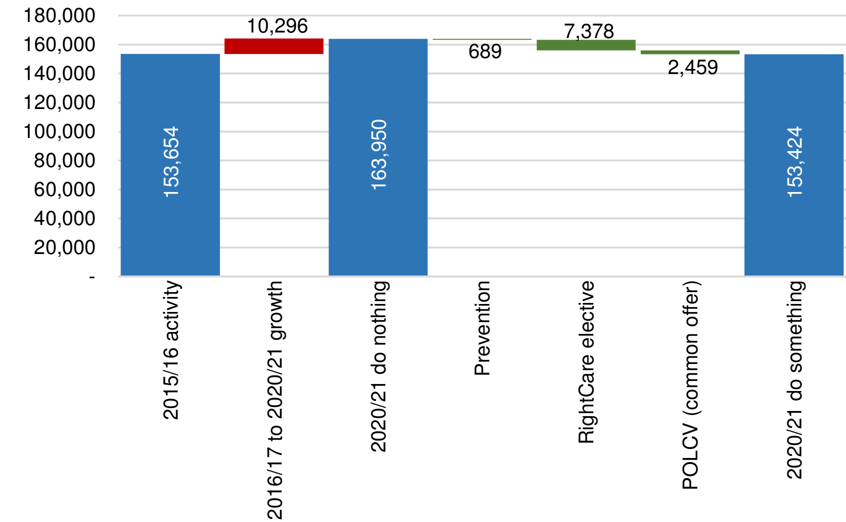
- The overall impact of each solution on activity has been estimated at POD level (not by specialty or Healthcare Resource Group (HRG)).
- The projected activity numbers are likely to change during contract negotiation, as further details of the solutions are established between CCGs and providers.

Indicative contribution of existing plans in shifting activity left

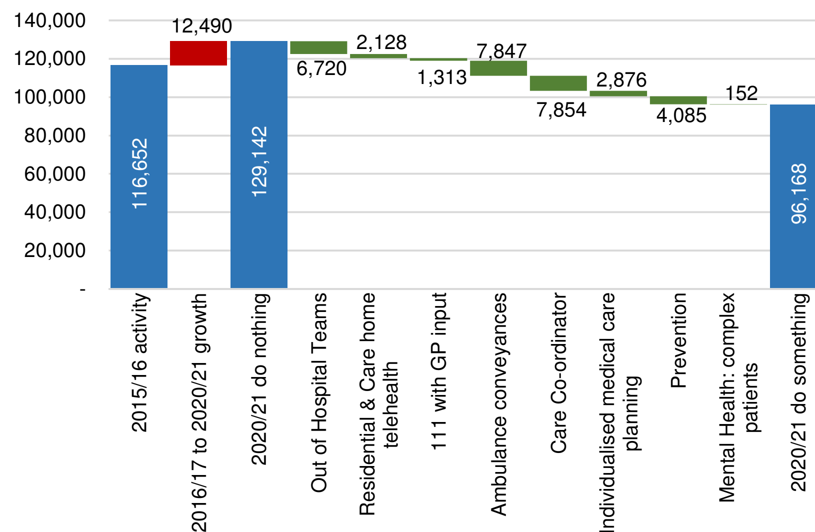
A&E attendances



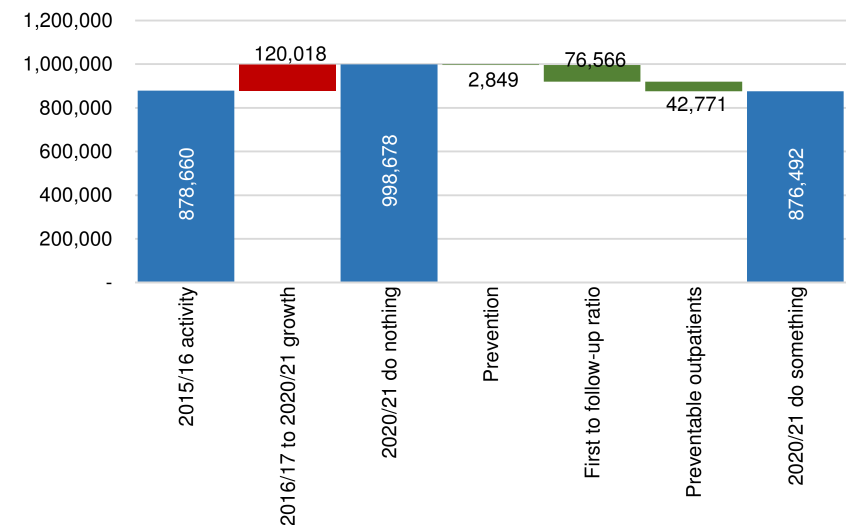
Elective spells



Non-elective spells



Outpatient appointments

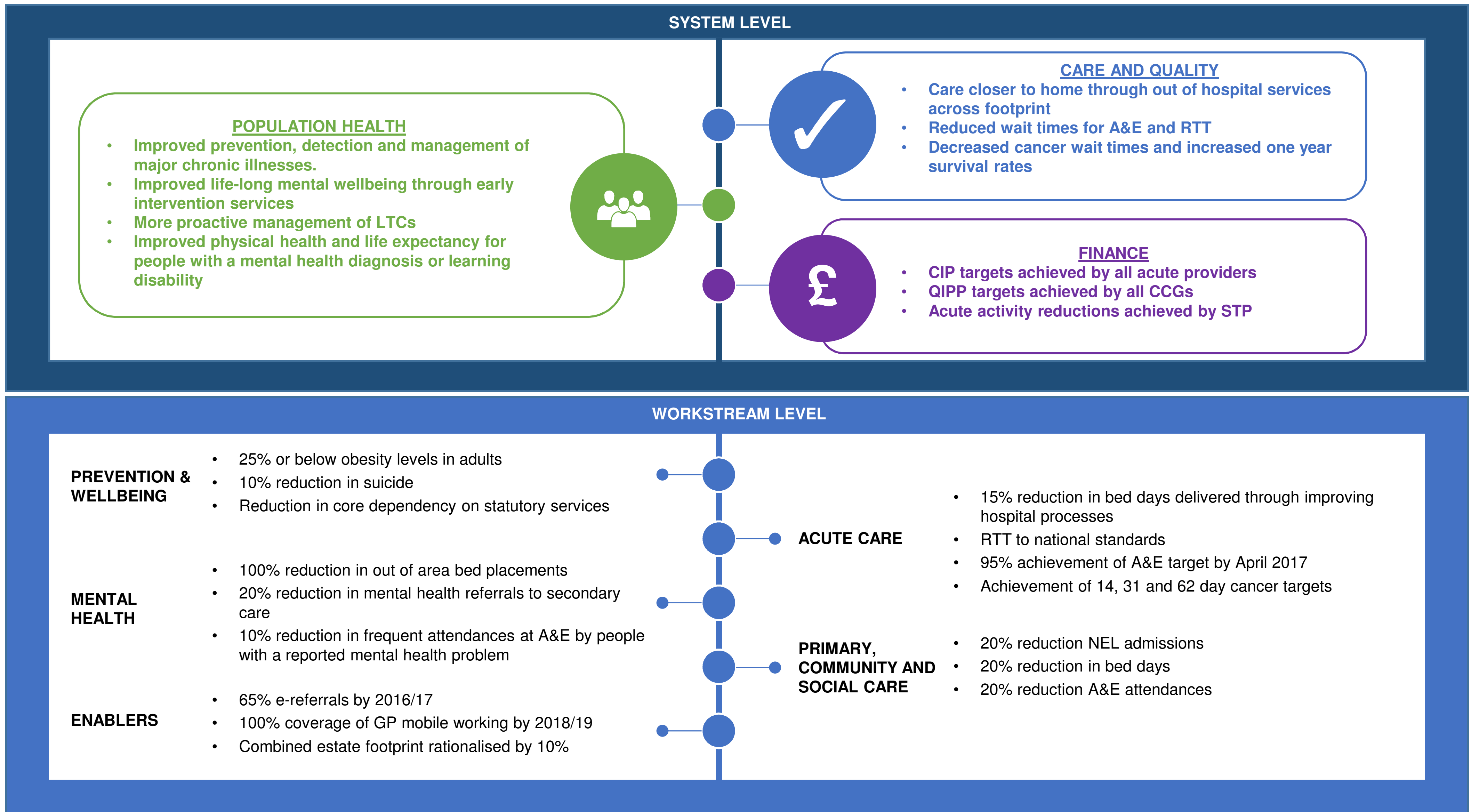


Delivering the STP

Measuring Progress

The STP leadership are focussed upon delivering the aspiration set out in the plans for the benefit of the populations of Norfolk and Waveney. Evaluating and measuring the success of the transformation programme will be undertaken at two levels.

1. A selection of system-wide metrics have been identified spanning the three key STP areas of population health, care and quality, and finance. These metrics will be used to give the system common purpose and can be used to communicate the challenge through organisations and to the public.
2. Underpinning the system metrics, specific key measures have been identified for each workstream. These will be used to monitor the progress of the critical projects within each workstream and will be used to hold Senior Responsible Officers to account to the STP executive.



Building Norfolk & Waveney STP System Leadership and Support

in good health

There is a good understanding of the key issues facing the footprint and a high level of consensus regarding the actions required to address these.

Further work is required in the next three months to establish both the programme governance and programme management necessary to drive change

NHS commissioners in N&W have published a single set of commissioning intentions for 2017/18 and 18/19. There is no consensus currently regarding full integrated commissioning of health and care but a willingness to explore this further

A new integrated care model is essential to achieve the changes required in the next five years although the exact form is yet to be agreed

Considerable progress has been made in the last three months in bringing the statutory bodies together to agree this plan and there is a clear consensus across the system that:

- It is critical to provide significant investment in prevention, primary, community and mental health services and new ways of working with the third sector to achieve the improvements in access, quality, outcomes and cost required in the next five years;
- Integrated, place based, teams of health and care professionals with responsibility for physical and mental health at a local level is the best way to keep people fit and well in their own community. Although further work is required, facilitated workshops and planning events to date indicate this is expected to result in the introduction of new care models underpinned by suitable organisational forms;
- Value based payment where providers share in the upside and downside of risk through whole population budgets will be an important development and an enabler and catalyst for change in N&W; and
- Support services must be provided in the most efficient configuration possible to maximise the budget available for health and care. At a practical level this means services will be shared and managed across the whole system unless a formal options appraisal shows this to be the wrong approach.
- At this stage the full implications for each organisation, the critical path and the timetable for many of the changes agreed remain unclear, however there is system-wide agreement on the key challenges facing the system and the direction of travel. One of the key challenges between now and the end of the year is to build on the high level consensus which exists to agree the critical path, investment and impact of the plans in each of the next five years. The absence of this detail at this stage puts us behind some of the other footprints nationally but is consistent with what we agreed as realistic with NHSE in July 2016. To address this we plan to review our existing programme governance and programme management arrangements to ensure they are fit for purpose and support both the level and pace of change required.
- The NHS commissioners in N&W have recently published a single set of commissioning intentions for the next two years and are strongly committed to working with providers to share risk as new care models are introduced and financial flows change. This has been welcomed by the provider sector, especially the three acute providers, which are now exploring how they might contract collaboratively. At this stage there is no formal agreement regarding a move towards integrated commissioning for health and care although it will continue to be explored. The system has yet to consider the implications of moving to a single control total for 2017/18 and 18/19.
- The three acute providers in N&W have a history of working closely together through joint appointments and sharing clinical support services such as pathology. In August 2016 the footprint commissioned a formal review of clinical, operational and financial sustainability for seven services. The conclusions and recommendations from this work will be presented to the Executive Board and Trust Boards in November 2016. It is anticipated that this will lead to even closer collaboration between the three Trusts in order to maintain services, improve quality and address the RTT backlog at Norfolk & Norwich University Hospitals. To this end the three acute trusts have agreed to establish the Norfolk Hospitals Group to accelerate the scale and pace of collaboration. This builds on existing strong relationships (NNUH currently supports both neighbouring hospitals in over 20 separate specialties and there is already a pathology partnership in place).

System Direction of Travel

Current State

- Building consensus on ambitions, priorities and targets across the STP footprint
- Plans emerging for key investment areas and the future service provision models
- Engagement from all leaders and organisations
- Single set of commissioning intentions
- Increasing provider collaboration
- Duplication in support functions and scope to find organisational efficiencies

Future State

- Significant cultural shift to working at scale and in collaboration, where appropriate
- Clear narrative driving engagement throughout organisations, from leadership to front line workforce
- Integrated, place based teams of health and care professionals underpinned by suitable organisational forms to drive outcomes that matter to the people of Norfolk and Waveney
- Formal partnerships and joint-working relationships, including collaboration amongst the three acute providers to improve quality and achieve national targets
- Aligned financial incentives and payment structures
- Efficient system with reduced duplication

Communications and Engagement

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Where we are – Our Approach

Utilising our combined previous engagement

As an explicit requirement of our approach, all of the partners involved in producing the STP have actively engaged with the public, their patients, service users, staff and the organisations with which they work. As a consequence we have built upon the wealth of evidence from research, consultations and broader engagement activity conducted over the past 2 years to assess the views of local populations of their health and social care services and crucially how they could be improved. This evidence has already been used to make some immediate changes to the services we provide, as well as providing vital underpinning intelligence for the production of the STP.

Working more closely together

Over the past few months we have begun to work more closely together to collectively communicate the challenges facing health and social care services in Norfolk and Waveney, and how people can get involved in helping us tackle those challenges. This work has been coordinated by a group of communications and engagement professionals from all the partners involved in developing the plan, including Healthwatch.

How we have communicated and engaged with the public and organisations to date:

- Produced ‘In Good Health’, a summary document for the public which succinctly describes the challenges and potential solutions facing health and social care in Norfolk and Waveney.
- Published ‘In Good Health’, answers to frequently asked questions and other information about the development of our STP on Healthwatch Norfolk’s website, where people can also register to receive updates.
- We held a media briefing on 7 October 2016 about ‘In Good Health’ and our progress with developing our plan, resulting in coverage on BBC Look East, Mustard TV, BBC Radio Norfolk and in the EDP.
- Created an online discussion forum so that people can share their ideas for tackling the challenges we face. This has been promoted by all the partners involved, including Healthwatch, and sent to Your Voice members (a panel of residents who help to shape local public services).
- Held face-to-face discussions with some patient groups.
- Conducted interviews and briefings with the local media.
- Regularly reported to, and discussed our work with NHS boards, CCG governing bodies, Local Authority Health Overview and Scrutiny Panel and our Health and Wellbeing Board.
- Briefed local councillors and discussed our work with them, including specific sessions about the STP for County Councillors, and town and parish councillors.
- Sent a written briefing to our MPs.
- Created a Clinical Care Reference Group so that the experiences and ideas of our clinicians are at the heart of our plan.
- Updated staff about progress – each organisation has taken responsibility for keeping their staff informed – we’re now coordinating our messages so that staff get consistent messages at the same time.

Moving Forward – Our Priorities

Building consensus amongst the partner organisations involved

We have regularly updated the governing bodies of all the organisations involved. In mid-October 2016 we formally asked each of the governing boards and bodies of the statutory partner organisations to endorse:

1. The case for change, noting the implications of “do nothing”
2. The high level ambition, direction of travel and system priorities described, noting the progress made since 30th June 2016
3. The proposed approach to communications and engagement
4. The intention to further develop these plans over the next six months in conjunction with the public, service users and providers.

Overall we have a collective understanding of the challenges we face and a broad consensus about the direction we need to take to tackle these challenges.

Engagement with clinicians and the wider workforce

The STP Executive are committed to the very highest levels of clinical leadership and engagement. As a consequence the Clinical Care Reference Group is in the process of appointing a clinical chair and will continue to be a vital forum for engaging with clinicians to co-design and test solutions going forward. Linked to key programme milestones, a rich series of clinical engagement sessions including roadshows and workshops will be held to ensure the plans are well understood and supported by the broad base of clinical professions across health and social care. Finally as a commitment to clinical leadership and oversight, senior clinical representatives from the STP footprint will continue to sit on the STP Executive.

Plans for communicating and engaging with the public, patients, staff and other stakeholders

We have a comprehensive and coordinated plan to further engage local people and organisations in developing our proposals. Our plan covers communicating and engaging with the public, patients, clinicians, staff, local organisations, NHS boards, CCG governing bodies, councillors, MPs, our Health Overview and Scrutiny Panels and our Health and Wellbeing Boards.

During November and December 2016 we will:

- Publish a summary of our plan and this document on Healthwatch Norfolk’s website, once we have received feedback from NHS England.
- Use a wide range of tools and approaches to discuss our vision for health and social care services in five years time and the high level proposals set out in this document, including face-to-face meetings, surveys, online discussion forums and social media.

From January 2017, we will:

- Engage people and organisations in the development of specific proposals for changing services. Our programme of engagement will correlate with the phased implementation of changes set out in this document. Detailed communications and engagement plans will form part of the PID for each project. We will hold stakeholder workshops and involve local groups who represent people with specific conditions in developing relevant proposals.

Once we have developed more detailed proposals, we will conduct formal consultations about changes to services, where appropriate and following national guidance. We will coordinate our consultations, with the relevant commissioners and providers of services taking the lead. Over the course of the next five years, we will continue to regularly update the public and our stakeholders with our progress, let them know what we’ve done with their feedback and explain our next steps.

Next steps

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LEADERSHIP & GOVERNANCE

We N&W STP will be underpinned by a Memorandum of Understanding (MOU) that cements the partnership. The MOU defines the relationship behaviours and the system assurance needed to progress our more detailed plans. This work will continue through November.

We propose a stronger role for the Health & Wellbeing Board and will ensure that we liaise closely with the Health Overview and Scrutiny Committees as the STP plans develop and as we move towards local implementation.

Organisations have consider impact upon organisational form and will further explore and formalise joint working and collaboration, including around development of new care models.

In order to support a more collaborative commissioning approach across N&W the 5 CCGs are exploring a mechanism for establishing a structure to jointly commission services.

To ensure we complete the planning, consultation and assurance activity we are addressing the following:

- System leadership and service design & coordination;
- System financial and data requirements;
- System wide Project Management Office (PMO) function to support the governance, communications, detailed planning and assurance.

RESOURCES

We will have dedicated resources in place to support the delivery of the STP, with an overall programme budget to be agreed. We will have dedicated project, financial and analytical capacity & capability.

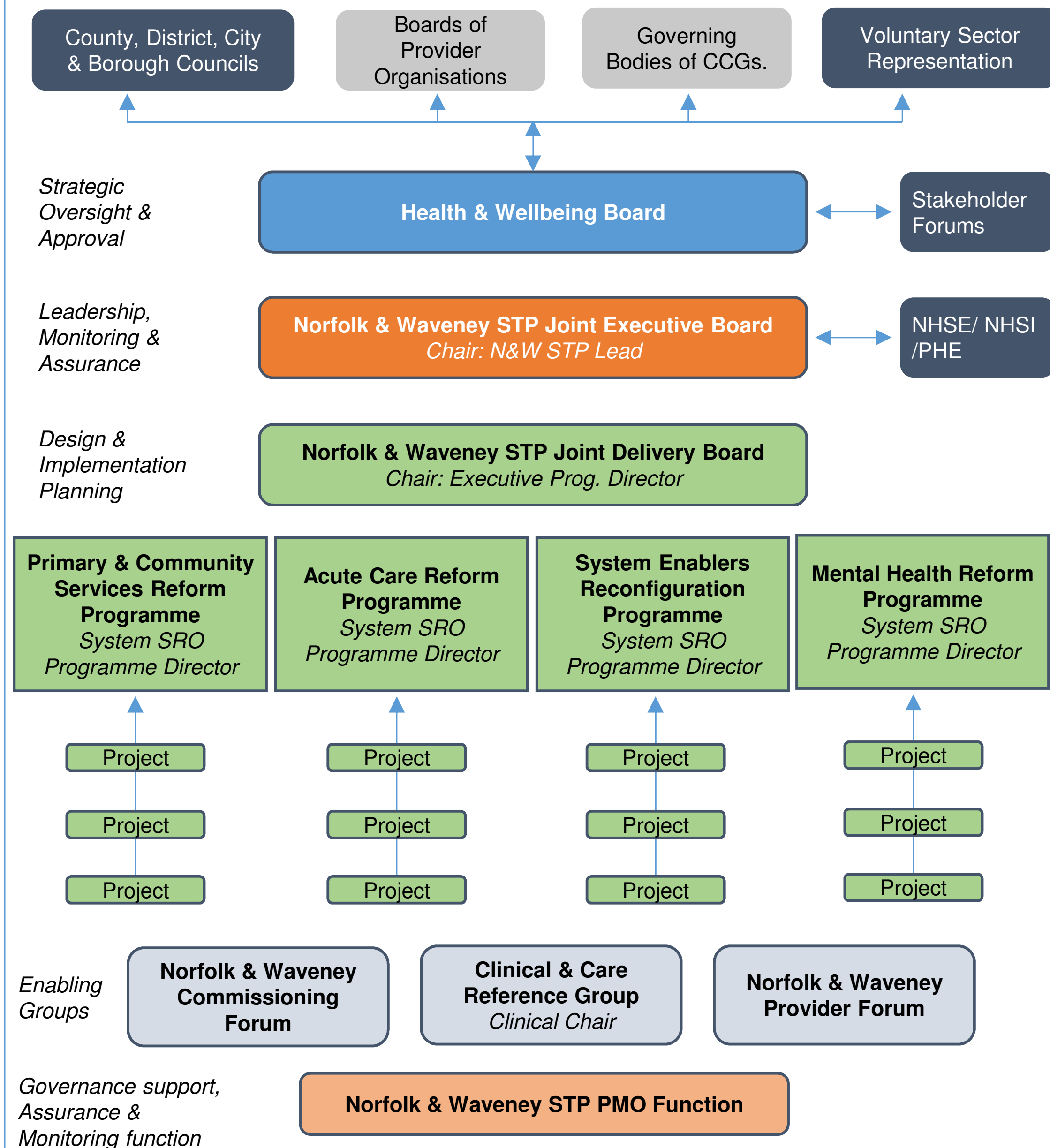
Each programme of work will have a Senior Responsible Officer (SRO). Some programmes have shared leadership, where a mixed skillset is required. All of these individuals are senior Executive level - Chief Executives, Medical Directors, Social Care Directors or Finance Directors - ensuring leadership of the highest quality. Each SRO will be supported by a dedicated programme resource, and in some cases a broader team of support. A programme budget for 2016/17 will be allocated to each of the workstreams based on their proposed requirements. STP partner organisations are also giving in kind to each of the workstreams to ensure high quality plans can be delivered at pace.

We will look to see programme delivery, oversight and support, including ensuring all aspects of the STP are on track and, in particular, ensuring the strategies for key enablers (ICT, workforce, culture and organisational development, and estates) are supporting of the STP's vision;

We will work to foster system leadership and a quality improvement culture (including the use of tools such as Right Care);

We will ensure the right level of co-production, engagement and communications are threaded throughout the emerging plans;

PROPOSED GOVERNANCE STRUCTURE



Key Risks and Issues

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Key Issue	Mitigating Actions	External Dependencies
5-year phasing issue – high level scenario-driven phasing assumptions could be materially different to individual and system-level control totals in a given year.	Move quickly to maturity of modelling that will link the critical path of interventions with granular phasing at an organisation level.	
Key Risks	**Mitigating Actions**	**External Dependencies**
Workforce capacity and/or skill set insufficient to deliver quality service during transformation Recruitment and retention of expert clinical staff through a period of significant change, particularly in primary care and while reducing agency spend. Recruitment and retention risks also extend to the independent care sector.	Engagement and co-production with staff via Clinical and Professional Design Authority. Guarantee regarding staff redeployment in case of service redesign. Dedicated workforce workstream, with priority reduction of agency spend via dedicated system workforce bank. Workforce elements of primary care strategy. On-going engagement with Health Education England.	National messages regarding new roles and engagement with key leadership e.g. LMC.
External Governance: accountable organisations are constrained by governance and regulation and cannot drive the change required Specifically between local authority and NHS organisations, and between different NHS organisations. Regulation not supporting collaborative working.	All members of the transformation board to agree the principle that collaborative working is fundamental to the success of any significant transformation.	Regulator permission for individual organisations to have short term flexibility on financial or performance targets. Potential for system wide targets (financial and clinical).
Political and Public: Insufficient scale of transformation Inadequate political engagement and support leading to risk averse behaviour and lowering of ambition.	Early engagement with local politicians in STP process. Workstream established and developing plan for engagement and communications processes.	Regulatory support for consultation and engagement on difficult decisions. National engagement re. level of change required across systems and sharing of level of ambition alongside key messages to provide context for local challenges.
Political and Public: Public objections to the plans developed impact timeline or scale of transformation	Key role of patients and public in co-production and the training of workstream leaders on co-production principles. All workstreams to develop proactive patient and public engagement via the engagement workstream, development of champions and effective media strategy.	NHSE and NHSI support on consistent messaging and that the options on the table need to be resolved. Clear expectations around engagement and consultation processes within defined timetables for transformation. Expert input may be required at key points.
Culture and Alignment: Organisational culture and direction not aligned with system wide goals Achieving and maintaining a common purpose and alignment across system and organisations at every level is key	Effective leadership from Executive Board ensuring full organisational involvement. OD and leadership development enabling work to invite and capture energy and innovation of frontline staff. System leadership coaching programmes for aspiring directors and senior clinicians. To include stretch project, buddying and peer mentoring initiatives.	Regulatory support to develop a system wide culture and approach which may move from collaboration to a more formal structure based upon system value-add. Support drive and ambition to develop internally rather than through external regulation and pressure.
Capacity for Change: Inadequate capacity and capability to deliver required change at pace due to lack of resource, time, or leadership capability	Adequate resourcing of the N&W STP plan with time and resource from partner organisations. Possible short-term, temporary use of external support/advisors whilst substantive personnel are appointed	Availability of funding for the remainder of 2016/17 Access to vanguard outputs and lessons. Access via national team to specialist expertise in health and care transformation, particularly in relation to new models of care. Regulatory support for changes and recognition of pressures on individual organisations and leaders from the change process.

Key Risks and Issues

in good health

Key Risks	Mitigating Actions	External Dependencies
Aligning Financial Incentives: **Transformation priorities are hindered by the incentives alignment or by perverse financial incentives.** The sovereignty of individual boards prevents organisations from supporting change which might negatively affect their organisation.	Use of system control total to manage risk Contracting workstream actively investigating the best methods of contracting and incentives to support the functional change required.	Clear guidance from the regulators (NHSE and NHSI) re: managing the balance between the "sovereignty" of individual boards and the system. For example in relation to changes which are in the interest of the system but have a negative impact upon one party (for example divestment from the acute sector following the introduction of new care models which would result in an increase in a providers)
Availability of funding to pump-prime the investment required to support new care models and/or cover double running costs in the short-term A shortage of revenue funding impacts on the pace or level at which targeted investment in new care models occurs	Investigate short-term "tactical" savings to build a "war-chest" from which to fund double running costs. Use half of the 1% top-sliced from CCG allocations to pay for transformation as per the national planning guidance for 17/18 and 18/19. Reinvest savings to fund further transformation. Access to STF funding in 17/18 and 18/19 to pump-prime investment in integrated place based teams which will manage the physical, mental and social care of those at greatest need Access to STF funding in 17/18 and 18/19 to pump-prime investment in additional primary care workforce	Agreement from regulators that some system-wide savings brought forward can be used to pump-prime strategic investments Availability of STF in 17/18 and 18/19
Availability of capital funding for investment in IT A shortage of capital limits investment in the IT infrastructure which underpins new ways of working including the move to an integrated care record and interoperable Primary and Acute Care System (PACS).	Prioritise use of extant capital allocations Potential use of social impact bonds Consider potential outsourcing or joint venture arrangements which reduce the up-front capital requirement	Reliance on flexibility within existing allocations Willingness of regulators to support potential third-party arrangements and joint ventures
The RTT backlog at the NNU poses a significant financial and operational challenge to the system that could materially impact the financial control totals and STP deficit position of Year 2 and 3 of the plan.	With the support of NHSI IST & commissioners investigate the extent to which capacity at James Paget and / or Queen Elizabeth can be used in the short-medium term to help clear the RTT backlog, as well as recourse to other external additional capacity.	Support from NHSI and non-recurrent funding of £11m required
Consolidation plans, including shared back office functions, have insufficient detail and ownership.	STP programme will establish and fund a team to drive this work and link with other workstreams where appropriate. Further developments around organisational forms will incorporate consolidation of back office functions.	Support from NHSE and cabinet where appropriate
Some of the assumed savings in the current plan are based on tariff rather than savings which can be realised by the system.	Rapid work in November and December to quantify realisable savings associated with RightCare and Demand Management. Savings moderated to some degree to cover risk of delivery.	Fixed costs.
The financial requirements and impact of a number of solutions are based on the best available data at this time. These require further detail and assurance for robustness.	As each intervention is progressed through a formal PID process the underpinning evidence will be stress tested and veracity of value assured.	
A CCG QIPP delivery in 17/18 and 18/19 over 4% is assumed in order to hit the CCG control totals – where specific schemes are not yet identified	Rapid work is required to identify granular schemes to deliver the specific interventions that are required	

Appendices

A: Estates Strategy

B: Investments Summary

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Appendix A: Estates Strategy

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STP Estates Strategy

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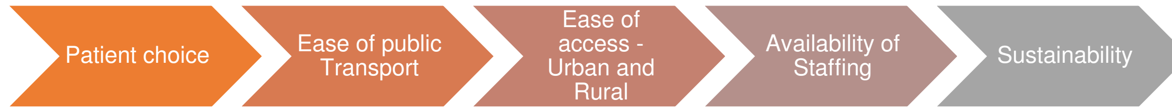
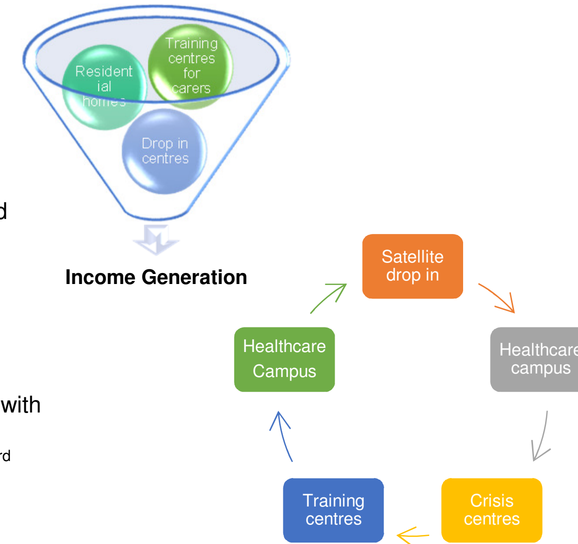
1 Space utilisation and funding





Review co-location of staff across multiple community support mechanisms to support out of hospital care

- Assess use of spare capacity in primary care and community facilities for services and staff
- Engage with council estates teams to assess opportunities for co-location/ spare capacity
- Assess potential to establish revenue creating centres of excellence for community carer support (revenue generated through.3rd party and charity funding)
- Develop the existing OPE & Integrated Community joint collaboration/

Identify value and funding opportunities to enable alignment of estate to service requirements through:

- Opportunities to reduce footprint, increase utilisation and **release capital proceeds** with respect to sites
- Assess identified surplus land for supported living to support **mental health services**
- Assess use of third party funding across the STP where this assists projects at existing facilities or land , access to CIL/S106 funding. Work with Finance to develop new models
- **Agree to prevent new builds** from third parties to support full use of existing buildings with identified spare capacity. Sell existing plots to 3rd parties for income generation.
- Assess use of STP wide procurement for estates related services to achieve economies of scale (e.g. Hard/ Soft FM contracts)
- Assess potential of estates related back office co-location and centralisation of resource to reduce overhead and duplication

Clinical , Primary and Community "hubs" will need clear definition and understanding for patients the hubs of all sizes are to be developed to bring clinical and mental healthcare to the areas where it is need. The consolidation of estate will allow to identify low cost and sustainable locations.

2 Driving the tactical to transformation change

Enabling Implications for Future Estate

1. Grow capacity of out of hospital network to support reduction of A&E attendance, acute bed days, increase primary care capacity and provide mental health support:
   a) Assess creation of Wellbeing hubs in Kings Lynn/ Great Yarmouth/ Central Norfolk, Norwich to act as access point to all primary care and community/mental health services (three locations identified for review, NCH & Julian Hospital, West Norfolk King Lynn and JPH healthcare village)
   b) Review the existing utilisation of the Primary Care estate building on and expanding the scope of Primary Care Estate Strategy report by North Norfolk.
   c) Build on review of Wellbeing hubs and primary care and assess potential for a STP wide hub and spoke model for the non-acute estate, aligning with One Public Estate and community support services to enhance out of hospital network
   d) Develop and redesign ED to relieve pressure on QEH KL, NN and JPH, potential ACAD based in Greater Norwich area – cheaper than being based at NN
   e) Assess use of MCP contracting to support hub and spoke model
2. Assess non-acute estate for opportunities to accommodate high cost acute specialities and outpatients not requiring acute care, out of the Acute setting:
   a) Linking into acute services review, assess viability of creating specialist diagnostic hubs within existing community and realign capital projects and activities across the three acute hospitals

Consolidation of Estates

Establishment of Estates Implementation team to drive consolidation review of Health & OPE real estate portfolio

Secure funding for team

Develop plans for centralisation and space utilisation

Identify sites for investment to generate revenue.

Holding plan on disposals

Drive Quick wins and funding models

During planning phase identify quick wins for workstreams to meet their aims.

Develop specification and criteria for 3rd party funding models

Develop OPE funding models

Develop localised projects for quick wins.

Develop new estates infrastructure

Centralise key resources to support STP wide projects

New structure to drive 10% savings from ERIC returns

Develop facilities services sourced from satellite locations

STP Estates Strategy

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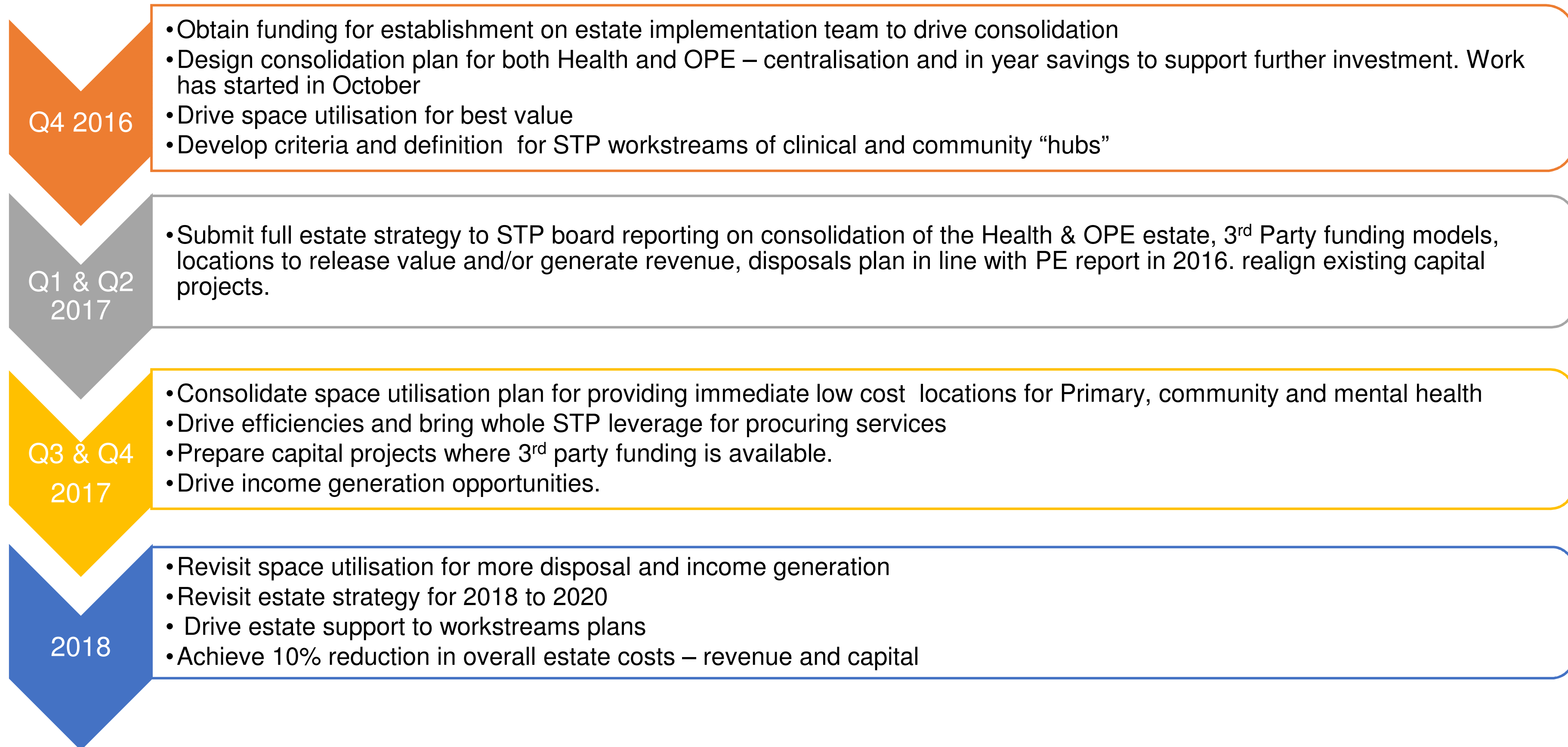
3

Driving the tactical to transformation change - Milestones



Appendix B: Investments Summary

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Investment Summary

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The table below outlines the planned investments (both recurrent and non recurrent) over the period of the STP plan, building to the 2020/21 level of investment.

Investment	Assumptions and target	Workstream	Investment
Investment in prevention	• Investment required in social care to deliver the prevention and wellbeing programme. This has been assessed by NCC for each scheme, based on Public Health England evidence.	Prevention and Wellbeing	£(4.2)m
Investment in Primary Care	• This investment is part of the requirement to support the 20% reduction in NEL admissions and 20% reduction in bed days. It is calculated at the level required to support the national funding commitments of the GP Five Year Forward View.	Primary, Community and Social Care	£(15.0)m
Investment in Community / Social Care	• This is part of the requirement to support the 20% activity reduction in NEL admissions and reduced bed days.	Primary, Community and Social Care	£(18.8)m
Investment in Mental Health	• Calculated to deliver the national Five Year Forward View commitment to increase funding of mental health services.	Mental Health	£(14.1)m
Investment in 5YFV Initiatives	• Calculated to deliver the national Five Year Forward View initiatives: Cancer task force £4.8m, Childhood obesity £3.3m.		£(8.2)m
Investment in LDR	• This is the revenue cost impact of the LDR, which is calculated net of relevant (i.e. EPR) existing IT revenue costs already included in the do-nothing case.	ICT	£(15.0)m
Acute diagnostics	• The acute providers require increased capacity for in CT and MR scanners (six each). The recurrent revenue cost impact is estimated at £5.3m.	Acute Care	£(5.3)m
		Total Investment	£(80.6)m
		Total Recurrent Investment	£(78.0)m