A healthier Norfolk and Waveney

Our five year plan for improving health and care (2019 - 2024)
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Foreword

Norfolk and Waveney is a healthy and safe place to live. From King’s Lynn to Lowestoft, and Cromer to Thetford, we live and work in a diverse 2,900 square mile landscape of beautiful countryside, a major city, picturesque market towns, the Broads National Park and more than 100 miles of nationally celebrated coastline.

We have some big challenges, however, when it comes to our health and wellbeing. As our population grows, our lifestyles change, new technology is developed and our understanding of health and wellbeing evolves, it makes sense for us to take stock of where we are. We’re living longer (North Norfolk is now the oldest district in England), but we know not all of these extra years are spent in good health. We also know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer than it is in other areas. And our health and care staff and services are under real pressure.

We want to improve the health, wellbeing and care of people living in Norfolk and Waveney over the next five years. Our plan sets out our local goals, priorities and the actions we are going to take. It also explains how we will deliver the commitments made in the national NHS Long Term Plan for making health services fit for the future, which you can read here: www.longtermplan.nhs.uk.

We have to think big. Our plan isn’t just about the NHS. To really improve the health and wellbeing of people living locally we have to think much bigger. We need to think about social care and how health and social care work together. We need to think about mental as well as physical health care. We have to recognise that, vital though the NHS is, many things affect our health far more - what we eat and drink, whether we smoke and how active we are, whether we have close family and friends, our work and income, our housing and the wider environment all affect our health. Tackling these wider determinants of health, and doing more to prevent people getting ill, are priorities for our partnership.

We all have a role to play. As public services, working with local voluntary organisations and community groups, we can do more to help people keep healthy and well, prevent them from getting ill and make sure people get high quality, personalised and compassionate care when they need it. But as individuals, families and communities, we also all have a responsibility for our own health and wellbeing.

Thousands of people have contributed to this plan. We are grateful to them all. We will continue to involve patients, service users, carers, voluntary organisations and community groups, elected representatives and members of the public as we translate this plan into action.

Together we can create a healthier Norfolk and Waveney.

Rt Hon Patricia Hewitt
Independent Chair, Norfolk and Waveney Health and Care Partnership

Melanie Craig
Chief Officer, Norfolk and Waveney Clinical Commissioning Groups and Executive Lead, Norfolk and Waveney Health and Care Partnership
Who we are and what we want to achieve for the people of Norfolk and Waveney

Our partnership
The Norfolk and Waveney Health and Care Partnership brings together key organisations from across our health and care system to improve the health, wellbeing and care of the million people who live locally.

Working with our local health and wellbeing boards, district councils, voluntary sector organisations and the public we collectively take responsibility for delivering our national and local priorities across health and social care.

Our health and care system

As a partnership we work at three levels to commission and deliver health and care to our population:

‘Neighbourhood’ level – our 17 Primary Care Networks (PCNs).

These multi-disciplinary teams comprising of staff from different organisations will help to ensure people receive more joined-up and coordinated care, near to where they live, from primary and community care.

‘Place’ level – our current five Clinical Commissioning Group (CCG) areas.

Within each CCG area there is a Local Delivery Group (LDG) that brings together a broad group of providers and stakeholders, including the district councils and voluntary sector organisations.

‘System’ level – across Norfolk and Waveney.

A single conversation across the whole of Norfolk and Waveney to try and stop inconsistency and implement large-scale change.
Our goals – what we want to achieve as a partnership

Over and above everything else we want to achieve, we’ve set ourselves three goals:

1. **To make sure that people can live as healthy a life as possible.**

   This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. **To make sure that you only have to tell your story once.**

   Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. **To make Norfolk and Waveney the best place to work in health and care.**

   Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.
Our plan: the five big changes we are going to make

Our plan sets out a whole range of actions we are going to take to help us meet our goals and to address the challenges we face. But there are five big changes we are going to make in order to improve the health and wellbeing of people living locally. These fit neatly with the foundational commitments in the NHS Long Term Plan. We will continue to talk with local people, organisations and our workforce to develop and test out ideas as we make these changes.

1. **We will help people to make healthier choices to prevent them from getting ill and we will treat and manage illnesses early on**

We want to do much more in future to reach out to people who we know are likely to be at greater risk of becoming ill or their health deteriorating to the point they need urgent care. We have lots of data about the health of people living locally; if we used this more systematically we could do so much more to prevent people from getting ill, diagnose problems earlier and help people better manage any long-term conditions they may have.

**Modern technology provides us with new ways to provide this kind of proactive care.** We are already starting to use software to help us work like this and to make more intelligent decisions that improve the health and wellbeing of local people. Our priorities are to use this approach to diagnose and treat diabetes, respiratory disease and cardiovascular disease early on. This approach is called Population Health Management. We have lots of local expertise in this area – one of the leading pieces of software was developed by a GP in West Norfolk. Over the next 12 months we will roll out a single approach to Population Health Management and embed it as a fundamental part of how we plan services and care for people.

**To really improve the health and wellbeing of people living locally we need to look at everything that affects our health though, from housing and employment, to loneliness and air pollution.** The NHS is brilliant at treating people when they’re ill. But most of the things that influence whether or not we become ill are little or nothing to do with the NHS – such as where we live, our work, the air we breathe, or what we eat and drink.

District councils, for example, are vital partners. They have statutory responsibilities for economic development, housing, the local environment and leisure services – all of which are key to people’s health and wellbeing. This is why we are working with a much broader range of organisations to address these wider determinants of health, including district councils, schools, voluntary organisations and community groups.

**To help people make healthier choices we need to make the care and support people receive much more personalised.** We know that providing people with support tailored to them, their needs and their lifestyle is much more effective than a one-size-fits-all approach, which can fail to engage the people most in need of support, leading to inequalities in access and health outcomes.

**We are training our staff so that they can better help people to have the knowledge, skills, tools and confidence to manage their own health and wellbeing,** and to be active participants in their own care. Over 500 staff have already attended a two-day health coaching programme, with many more training days planned. And social care in Norfolk has a similar way of working called the “three conversation” approach, which is also about helping people to be independent, rather than being referred to services straight away.

**We want to step-up our infection prevention and control.** We are working together to increase the uptake of vaccines, particularly for flu, Human Papillomavirus (HPV) and Measles Mumps and Rubella (MMR). We are working with care homes to reduce the risk of dehydration from illnesses such as flu and norovirus. We are also working to optimise the use of and reduce the need for antibiotics.

These actions will help us to meet our goals:

- We know how important prevention is and all of these actions will help us to realise our goal of making sure that how healthy you are doesn’t depend on where you live.
- Reaching out to people who are at greater risk of becoming ill, rather than waiting for them to seek help, will assist us to address some of the significant health inequalities we have in Norfolk and Waveney. Diagnosing problems earlier will improve people’s health and their life expectancy.
- Working with district councils, voluntary organisations and community groups to keep people well and to address the wider determinants of health will be key to reducing health inequalities.
2. **Our GPs, nurses, social workers, mental health workers and other professionals will work together in teams, in the community, to provide people with more coordinated care**

Being cared for at home, near to family and friends, is almost always better for people than being in hospital or residential care. This is why we are investing more money in GP and community health services. We have, for example, already increased the number of appointments at GP surgeries – since September 2018 we have had over 70,000 extra appointments with GPs and nurses. We are going to be investing more over the next five years.

**We have set-up 17 teams made-up of different health and care professionals to provide people with more coordinated care.** These teams will include GPs, social workers, pharmacists, district nurses, mental health workers, physiotherapists and colleagues from the voluntary sector. We call these teams Primary Care Networks, or PCNs for short.

By creating teams of different professionals, and where possible locating them in the same buildings too, this will help to coordinate people’s care and reduce how often people have to tell their story. It will also mean our staff spend less time trying to get the information they need from patients, carers and other members of staff.

**Over the next five years we are going to develop these teams to include different health and care professionals.** This will mean that people will be able to get more services at their GP surgery or at another one nearby. So in future people will generally spend less time going to one of our three main hospitals for tests, to get results, for treatments and follow-up appointments.

Here are some of the health and care professionals who will be joining our PCNs over the next five years:

By April 2020, each PCN will have a clinical pharmacist who will help to assess and treat patients using their knowledge of medicines.

By April 2022, each PCN will have a team of health and care professionals to support people with their mental health and wellbeing.

By April 2023, each PCN will have:

- a nursing associate, which is a new role within the nursing team, and they will work with healthcare support workers and registered nurses to provide care to patients.
- volunteers working with them – we already have well established volunteer programmes in our hospitals and community healthcare, we want to create more volunteering opportunities in our GP surgeries and primary care – this is just part of our ambition to work more closely with voluntary, community and social enterprise organisations.

By April 2024, each PCN will have:

- two physician associates, who will support doctors in the diagnosis and management of patients, doing things such as taking medical histories, performing examinations, analysing test results and diagnosing illnesses.
- three advanced practice physiotherapists – these are specialist clinicians who have undertaken additional orthopaedic training and so are experts in injuries, diseases and problems with muscles, bones and joints.
- an advanced paramedic practitioner – they will work in the community and use their skills to assess and treat patients.

Our GP surgeries are also going to try new ways of working to help people get an appointment quicker and to make the most of all of the skills of everyone working in these new teams. The aim is to use the skills of our GPs and nurses where they can make the most difference.

For example, we know that particularly for people with the most complex health conditions it helps if they can see the same GP or professional at all their appointments. So we’re looking to pilot an approach whereby the 5% of patients at a GP surgery with the most complex needs and who have maybe five long-term conditions, such as diabetes or breathing problems, always see a GP and have a longer appointment.

**In future people will get help from community services within two hours if they are heading for a crisis.** We have already introduced pioneering ‘escalation and avoidance teams’ who arrange help for people heading for a crisis. They organise for people to be supported in their own homes, preventing them from going to hospital. We are going
to continue to develop these teams so that people get this urgent care within two hours from when they have been referred.

**We are improving support to people who live in care homes.** Older people living in care homes are more likely to have complex health needs and so need extra help to keep well and to manage their health conditions. We have already developed an Enhanced Health in Care Homes programme which has strengthened the quality of care in a number of our care homes. We will develop the programme so that it is fully rolled out to all care homes by 2021.

**These actions will help us to meet our goals:**

- By creating these teams of different professionals, and where possible locating them in the same buildings, it will help us to provide more coordinated care and reduce how often people have to tell their story, which local people have told us is a priority for them.

- By investing more in GP and community health services it will increase our capacity, reducing some of the pressure on our staff and making their working lives better. By making it easier for different health and professionals to work together, it will also remove some of the frustrating barriers our staff face when caring for people, which in turn will help to make their work feel more rewarding. On top of this there will be new career and development opportunities as we introduce new roles, like clinical pharmacists, advanced paramedic practitioners and more volunteering opportunities.

### 3. Our hospitals will work more closely together so people get treated quicker in an emergency and don’t have to wait as long for surgery and other planned care

The James Paget University Hospital, Norfolk and Norwich University Hospital and Queen Elizabeth Hospital are highly valued and play a major role in health services, but they are under unsustainable pressure. There have been big increases in the number of people visiting A&E and being admitted to hospital in an emergency.

Our hospitals should focus more closely on patients who need specialist or emergency care. When people do need to go to hospital, we want to make sure that our A&E departments are able to treat them swiftly and safely. And if people have to be admitted, we want to give them the care you need and get them home quickly. We know that most patients are more likely to recover better and more quickly from surgery or hospital treatment at home, in their own bed.

**In the future our three hospitals will work even closer together and operate more and more as one overall hospital system.** Investing more money into GP services and community healthcare will help to reduce the pressure on our hospitals. But there are also things that our hospitals can do to reduce the pressure they are under. We need to have three hospitals because of the size of Norfolk and Waveney and the number of people living here, and we are committed to maintaining their unique identity and the excellent care they provide to their local communities. Greater collaboration and co-operation between our hospitals will offer more benefits to patients and help maintain strong local services.

**To improve the care people receive at our hospitals we are already starting to join-up the teams who provide some of our specialist services.** We struggle to recruit the right staff for some specialties, so we are creating single clinical teams that work across more than one hospital. Our aim is to make these services more resilient and sustainable.

In early 2020 we plan to launch a single clinical team for urology services across our three acute hospital trusts, as well as a single team providing ENT (ear, nose and throat) services across the Norfolk and Norwich University Hospital and the James Paget University Hospital. These will be followed by single clinical teams for haematology and oncology working across the Norfolk and Norwich University Hospital and the James Paget University Hospital in spring 2020. Once these teams are established they will share expertise and equipment across the hospitals.

**Our next step is to develop a single Hospital Services Strategy for our three hospitals.** Whilst we have undertaken reviews of a number of services in recent years and have agreed to integrate several specialties, we are going to develop an ‘umbrella’ hospital services strategy. We will specifically aim to reduce the time it takes for patients to get the surgery and other planned care they need, to make sure services are more consistent and of the same high quality across Norfolk and Waveney. We’ll be talking with patients, carers and clinicians to develop our strategy, focusing on how we can get the best care for people, regardless of organisational boundaries.
We are investing in our hospital buildings to speed up people's care and so people don't have to wait as long for surgery and other planned care. So that we can treat people quicker we are investing £70 million to build three new Diagnostic and Assessment Centres, which will increase our capacity at our three hospitals to support earlier diagnosis of cancer, in particular for lung, prostate and colorectal cancers, and other diseases. We are already making additional investment in theatre capacity at the James Paget University Hospital, and this will be followed by the development of theatre capacity at the Norfolk and Norwich University Hospital next year.

We are also investing £40 million to update and modernise our mental health inpatient facilities to ensure we care for people in the best environments, a known factor to help improve people's mental wellbeing.

By April 2020, patients will benefit from Same Day Emergency Care service at our three main hospitals, 12 hours per day, 7 days per week. Under this way of working, patients presenting at hospital with certain conditions are rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, go home the same day their care is provided. These services treat a wide range of common conditions including deep vein thrombosis, pulmonary embolus, pneumonia, cellulitis and diabetes. We already have Same Day Emergency Care services, which are also known as ambulatory care, but these will be extended to provide a more comprehensive service.

We will reduce delays in patients being able to go home from hospital. As well as the enhanced primary and community services set out above, we will achieve this by placing therapy and social work teams at hospitals, setting an expectation that patients will have an agreed clinical care plan within 14 hours of admission, which will include an expected date of discharge, and multidisciplinary team reviews on all hospital wards, every morning.

Closer working with our local district councils will play an important part in this too. For example, we have District Direct housing advisors in each of our hospitals who provide expert advice and help to fast track minor adaptations to people’s homes so that they can be discharged from hospital.

These actions will help us to meet our goals:

- By joining-up some of the teams providing our specialist hospital services and increasingly working together as one overall hospital system, this will help us to provide more coordinated care and reduce how often people have to tell their story, which local people have told us is a priority for them.

- As our hospitals work more closely together this will help to make their specialist services more sustainable, which in turn will help to ease some of the pressure on our staff and make their working lives better. This collaboration across our three hospitals will create new career opportunities for our staff. It is likely also to help us attract new people to come and work in Norfolk and Waveney who are interested in working in across a whole system.

4. **We will work together to recruit more staff and we’ll invest more in the wellbeing and development of our workforce**

We are currently developing our workforce strategy for Norfolk and Waveney, which will be completed in early 2020. Having one strategy will enable us to work together to address our workforce challenges more effectively than any one organisation could on its own.

By ‘workforce’, we mean everyone who works in health and care in Norfolk and Waveney, both paid and unpaid, including the private and independent sector, unpaid carers and volunteers. We’re talking to our workforce through our We Care Together staff engagement programme so that our strategy is designed with our workforce.

We are already taking action though and we know some of the key steps we will be taking over the next five years:

**We are working together to ‘grow our own’ workforce.** We’re creating new opportunities for people living locally to start careers in health and care, both for young people finishing at our schools and colleges, and those wanting a career change later in life. These include apprenticeships and jobs at a variety of different levels, so that there are opportunities for anyone who wants to work in health and care.

**Training more nurses is a priority.** Although there are shortages in many registered professionals, the biggest shortfall is in registered nurses. The NHS Long Term Plan commits to training more nurses, with a 25% increase in the number of undergraduate nurse places. We are providing targeted support to help increase the number of clinical
placements which will be needed so that trainee nurses can get hands-on work experience at our hospitals, in the community and in GP surgeries. Every nurse or midwife graduating in Norfolk and Waveney will be offered a five-year NHS job guarantee within the region. We are also recruiting more nurses from abroad.

**We are creating new roles.** Our immediate focus is on these three roles:

- **nursing associates** – this is a new role within the nursing team, and they will work with healthcare support workers and registered nurses to provide care to patients - we’ve started training over 280 nursing associates in the past two years
- **advanced care practitioners** – these are professionals who come from a range of backgrounds, including nursing, pharmacy, paramedics and occupational therapy, and are educated to masters level so that they have more skills and they can do more to care for patients
- **physician associates** – they will support doctors in the diagnosis and management of patients, doing things such as taking medical histories, performing examinations, analysing test results and diagnosing illnesses.

These new roles will also allow other professionals to focus on the patients that only they can help and make the best use of their skills. For example physician associates will see some of the patients that a GP would have, so GPs will be able to focus on the patients with the most complex health conditions.

**We also want to expand volunteering opportunities in health and care.** We already have well established volunteer programmes in our hospitals and community healthcare, we want to create more volunteering opportunities in our GP surgeries and primary care. We are exploring volunteering passports whereby once you are trained as a volunteer you are able to work across a number of organisations and different areas.

**We are up-skilling our workforce and providing staff with new opportunities.** We want to make sure staff have rewarding jobs, with opportunities to develop their skills and support to manage the complex and often stressful nature of delivering health and care. So, for example, we have started creating new opportunities for staff to get experience on rotation in other health and care organisations. We have plans to pilot more joint roles and rotations, for example so that advanced nurse practitioners can get experience in primary and community care.

**We are developing a leadership forum to help create a supportive culture for our health and care organisations.** We are committed to improving the culture of our health and care organisations and providing more support to our staff. We are creating leadership development programmes for a range of staff as part of our plans to strengthen and support good, compassionate and diverse leadership at all levels.

**Listening to our workforce.** We are committed to talking with and listening to our workforce about what they need, what we can do improve their working lives and how we can improve services. We have established We Care Together, which is our staff engagement programme for talking to our workforce as a whole about how we can work better together.

**We are working together to make Norfolk and Waveney a great place to live and work.** We know that people don’t choose where to live based solely on the jobs available. They are influenced by whether there is high quality and affordable housing, good public transport, roads and infrastructure, access to the arts, culture and leisure activities, great schools and many other things. The role of our councils is hugely important in making Norfolk and Waveney a place that health and care workers will want to come to.

As big employers, purchasers of goods and services, and as land owners, NHS and care organisations have an important part to play in their local communities as ‘anchor institutions’. There are opportunities for us to use our assets to create social value, promote inclusive growth and shape Norfolk and Waveney to be a better place to live and work.

**These actions will help us to meet our goals:**

- We know how important our workforce is – both paid and unpaid – and all of these actions will help us to address issues our staff have told us they face working in health and care. Recruiting more staff will help to reduce the pressure on our workforce. Creating new roles will provide new career and development opportunities. Improving the culture of our health and care organisations will mean our workforce is better supported to provide high quality, personalised and compassionate care.
5. **New technology will modernise our health and care services, making it quicker and easier for people to get the care they need**

*Virtually every aspect of modern life has been, and will continue to be, radically reshaped by innovation and technology – and health and care is no exception.* Over the next five years we will be taking action to make sure that we make the most of the opportunities that new technology offers to improve care and reduce the pressure on our services.

People sometimes assume that all our IT systems already speak to each other in the NHS and local councils. Or that our staff working in a hospital can see the same information as a patient’s GP can. But that’s not always the case. Most hospitals run anything up to 100 different IT systems, which don’t all talk to each other - let alone to the different systems used in GP surgeries and by social care teams. And lots of vital information about patients is still kept on paper. We want to use technology to make sure:

- People don’t have to repeat their story over and over again
- GPs, community nurses, social workers, ambulance paramedics and hospital staff all know what everyone else is doing to look after a particular person, so that they don’t waste time collecting information or risk prescribing medicines that don’t go with the other medicines they are already taking
- People can look at their own records and put in details of their conditions and how they prefer to be treated
- People can monitor their own condition at home, using simple automatic kits that can alert their doctor or community nurse if there’s a problem
- People get the care they need, it’s good quality care, and it’s cost effective
- We can measure health outcomes, to see if the treatment people received worked

**One of our top priorities is developing a single digital care record for all health and social care organisations in Norfolk and Waveney to use.** This will be a significant help to frontline health and care professionals, particularly when they are caring for someone in crisis or when an emergency response is needed. This is because they will know what medication a patient is taking, and they will know when the person last went to hospital, or to see their GP or to meet with their social worker.

**We are aligning our computer systems so that they work better together.** This will, for example, make it easier for GP surgeries to securely share information with each other, with hospital departments, social care and mental health teams. Doing this electronically, rather than via the post, fax or phone calls, will be safer and save a significant amount of time and money. Aligning our computer systems will also support our approach to Population Health Management and enable us to provide people with proactive care, as described above. This is a major programme of work that will have real benefits for people living locally.

**We are increasingly using apps, online support and technology to help people manage their own health,** in particular people with long-term conditions. Norfolk and Waveney was the first area in the East of England to launch the NHS App in April 2019. With the NHS App people can check their symptoms, book and cancel appointments at their GP surgery, order repeat prescriptions and view their medical record. Over the next five years we will be supporting more patients to use apps and online support like the MyCOPD App, our Diabetes App and online therapies. And patients will be able to have some appointments via video, from their own home, their GP surgery or a community hub.

**More and more we are using technology to help people stay living independently in their own homes.** Some of the equipment we use automatically detects hazards such as fire, floods, falls and carbon monoxide escapes. Other equipment can help people with forgetfulness and memory prompts or feeling secure in their home. There is also equipment which can be linked through to community alarm systems, so that people can get help quickly should they need it. We are investing more in this to help people stay healthy, well and living in their own homes.

**All GP surgeries will soon offer online consultations to their patients.** Online consultations are a way for people to contact their GP surgery without having to wait on the phone or take time out to go into the surgery. Using a smartphone, tablet or computer, people can contact their surgery about a new problem or an ongoing issue. They can ask questions or tell their GP about their symptoms. The surgery will make sure the person is dealt with by the right member of the team, so that people are seen as quickly and appropriately as possible. Sometimes this will
mean people will get call from a GP or nurse, and others times they might need to go to their GP surgery for an appointment.

One GP surgery in West Norfolk is already offering patients online consultations and it has had a huge impact, enabling patients to see a GP, or an appropriate clinician, either the same day or the following day. Two to four week waits for appointments have stopped.

**These actions will help us to meet our goals:**

- Creating a single digital care record for all health and social care organisations to use will help us to provide more coordinated care and reduce how often people have to tell their story, which local people have told us is a priority for them.
- Using new software will help us to reach out to people who are at greater risk of becoming ill, which in turn will help us to address some of the significant health inequalities we have in Norfolk and Waveney.
- Investing in new technology and aligning our computer systems will make the working lives of our staff much better. More reliable technology will enable people to do their jobs better, make work less stressful, ease the pressure on staff, and increase productivity and our capacity.

**Improving care for major health conditions**

Alongside these five big changes we’re making, our plan contains lots of actions we’re taking to improve care for major health conditions, such as cancer, diabetes, stroke and mental health, and for people at key points in their lives, such as when they are having a baby and at the end of their life. These include:

- **introducing a new test to help detect and diagnose bowel cancer earlier**, so we can treat people quicker and improve their health outcomes
- **rolling-out the NHS Diabetes Prevention Programme** across the whole of Norfolk and Waveney to provide personalised support to people to reduce their risk of developing the condition
- **working with the local Stroke Network to look at how we can improve rehabilitation** in the community for people who’ve had a stroke
- **setting-up mental health support teams in schools** to provide therapy and support to children at our primary, secondary and special schools
- **creating a Wellbeing Hub in Norwich** – at night-time it will be a safe place for people in significant distress, while during the day it will be a walk-in facility and community café, where people can find emotional support when they feel their anxieties or other mental health problems are escalating
- **improving how we support people with a personality disorder** by making sure they receive therapeutic care in the community at an early stage, so that they can manage their condition and are less likely to need to go to hospital
- **creating digital maternity care records** so that all pregnant women can see their care record on their smart phone, read accurate information about pregnancy and get critical reminders about screening, immunisations and appointments during pregnancy
- **making sure more people with a learning disability have a health check**, to help keep them healthy and well, and so any illnesses are picked-up and treated early on

You can find out about all the actions we’re taking to improve care for major health conditions in the chapters that follow.
The health and wellbeing of people living in Norfolk and Waveney


We are largely a rural county. People tend to live in the city of Norwich, in market towns - such as King’s Lynn, Aylsham, Dereham, Swaffham, Wymondham, Thetford, Fakenham and North Walsham - and in coastal towns - such as Great Yarmouth, Lowestoft, Cromer, Sheringham and Hunstanton.
Our population in Norfolk and Waveney is generally older and projected to increase at a greater rate than the rest of England, creating a challenge for our health and care system.

Almost all of the population increase over the last five years has been in the 65+ category and we expect this to continue, with a total increase of more than 110,000 by 2037, and numbers of people living beyond the age of 75 increasing significantly.
However, this is not spread evenly - Norwich has the youngest population and North Norfolk the oldest.

<table>
<thead>
<tr>
<th>Area</th>
<th>Average age 2011</th>
<th>Average age 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breckland</td>
<td>44.1</td>
<td>46.4</td>
</tr>
<tr>
<td>Broadland</td>
<td>46.0</td>
<td>48.0</td>
</tr>
<tr>
<td>Great Yarmouth</td>
<td>43.6</td>
<td>45.7</td>
</tr>
<tr>
<td>King’s Lynn and West Norfolk</td>
<td>45.2</td>
<td>47.4</td>
</tr>
<tr>
<td>North Norfolk</td>
<td>51.3</td>
<td>53.8</td>
</tr>
<tr>
<td>Norwich</td>
<td>34.2</td>
<td>33.3</td>
</tr>
<tr>
<td>Waveney</td>
<td>45.7</td>
<td>47.9</td>
</tr>
<tr>
<td>Norfolk</td>
<td>44.1</td>
<td>45.6</td>
</tr>
<tr>
<td>Suffolk</td>
<td>42.9</td>
<td>45.1</td>
</tr>
<tr>
<td>England</td>
<td>39.4</td>
<td>39.9</td>
</tr>
</tbody>
</table>

These changes in our population will increase the need for health and social care support as the likelihood of developing long-term conditions, frailty and the risk of emergency admissions increase with age.

We estimate that due to age alone between 2014 and 2025, we will see about 9,000 additional people with diabetes, more than 12,000 additional people with coronary heart disease, more than 5,000 additional people who have suffered a stroke and survived and almost 7,000 additional people with dementia.
People living with frailty (65+) and long-term conditions (LTC) (all ages) in Norfolk and Waveney

![Frailty Pyramid](image)

**People living with frailty and long-term conditions in Norfolk and Waveney**

- **8,600 severe frailty**
- **31,300 moderate frailty**
- **80,100 mild frailty**
- **123,900 fit**
- **243,900 population 65 and over**

**Increasing complexity and management**

- **3,600 with 7+ LTC**
- **34,200 with 4-6 LTC**
- **84,800 with 2-3 LTC**
- **84,200 with 1 LTC**
- **247,100 with no LTC**
- **454,200 patients admitted to hospital**

**Source:**
- Kent Integrated Dataset Electronic Frailty Index applied to local population data
- [Link](http://www.bgs.org.uk/powerpoint/17frailty/bash_economics.pdf)

**Unique patients admitted over a three year period 2013/14 to 2015/16**

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**Long-term conditions – estimate of people admitted to hospital with one or more long-term health condition by 2034-2036**

![Hospital Admissions by Age and Condition](image)

- **Zero long term conditions**
- **1 long term condition**
- **2 long term conditions**
- **3 long term conditions**
- **4-6 long term conditions**
- **7+ long term conditions**

**Age group (years):**

- 0-4
- 5-9
- 10-14
- 15-19
- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60-64
- 65-69
- 70-74
- 75-79
- 80-84
- 85-89
- 90+

**People admitted to hospital at least once in three years (thousands):**

- **4**
- **5**
- **6-7**
- **8+**

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**Note:**

- [Link](http://www.bgs.org.uk/powerpoint/17frailty/bash_economics.pdf)
Our services are under increasing pressure and have to adapt to caring for our growing and ageing population, who need a different type of care. If we don’t change how we work together to care for people, the pressure on our services will only increase. For example, we will continue to see increases in the number of people going to A&E and being admitted to hospital in an emergency.

<table>
<thead>
<tr>
<th>What has happened between 2011 and 2016</th>
<th>What is likely to happen between 2016 and 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age for the population of Norfolk has increased from 43 to 45.2</td>
<td>ONS principal projections</td>
</tr>
<tr>
<td>Median age for emergency admissions has increased from 62 to 64</td>
<td></td>
</tr>
<tr>
<td>Births from 10,600 to 10,200 per year</td>
<td>Births remained about the same 10,200 per year</td>
</tr>
<tr>
<td>20% A&amp;E attendances from about 204,000 to 245,000</td>
<td>27% A&amp;E attendances from about 245,000 to 313,000</td>
</tr>
<tr>
<td>30% A&amp;E ambulance arrival from 63,000 to 82,000</td>
<td>28% A&amp;E ambulance arrival from 82,000 to 105,000</td>
</tr>
<tr>
<td>12% Emergency admissions from 90,000 to 101,000</td>
<td>24% Emergency admissions from 101,000 to 125,000</td>
</tr>
<tr>
<td>Average ordinary admission from about 34,800 to 30,500</td>
<td>15% Average ordinary admission from about 30,500 to 26,000</td>
</tr>
<tr>
<td>12% Day case admissions from 125,400 to 158,600</td>
<td>41% Day case admissions from 158,600 to 224,100</td>
</tr>
<tr>
<td>10% 10,300 to 11,400 in 2016</td>
<td>Deaths will remain about the same 11,500 per year</td>
</tr>
</tbody>
</table>
Our mental wellbeing

Mental health conditions, especially depression and anxiety constitute a significant challenge for our local system, as are problems relating to drug and alcohol use.

In 2016/17 there were about 164,000 residents of Norfolk and Waveney admitted to hospital; of these about 48,000 people had a mental health related diagnosis.

About 22,735 people had a diagnosis of anxiety and depression – this is over 47% of those admitted to hospital with a mental health related diagnosis.

Of those with a diagnosis of anxiety and depression, 7,150 also had a diagnosis related to drug or alcohol use and 2,130 were admitted due to self-harm.

The number of people admitted with an alcohol or drug related diagnosis on the admission record was about 25,290 people.

Our children and young people

215,000 children and young people (0-19) live in Norfolk and Waveney. This number is expected to steadily increase as our population grows.

Of this number the following is known:

- 1,380 Looked After Children
- 721 on a child protection plan
- 2,208 children in need
- 2,068 part of targeted early help to families
- 4,223 with Education Health and Care plan and 16,756 support for special educational needs
- 191,900 aged 0 to 17
Our Joint Strategic Needs Assessments for Norfolk and Waveney

The Joint Strategic Needs Assessments (JSNA) for both Norfolk and Suffolk (to capture our Waveney population) look at the current and future health and care needs of local populations to inform and guide the planning and commissioning (buying) of health, wellbeing and social care services within a local authority area.

Key findings from the Norfolk JSNA tell us:

**People**

Across Norfolk the average **life expectancy** is approximately 80 years for men and 84 years for women.

South Norfolk has the highest life expectancy with Great Yarmouth the lowest.

The life expectancy gap between the most deprived areas of Norfolk and the least deprived areas is 7.0 years for men and 4.5 years for women.

More than 120,000 people in Norfolk live in areas categorised as the most deprived 20% in England. Mainly located in the urban areas of Norwich, Great Yarmouth, Thetford and King’s Lynn together with some identified **pockets of deprivation** in rural areas, coastal villages and market towns.

1.5 households are **homeless or in priority need** per 1,000 households (versus the rate for England of 2.4). However this rate varies across the county between Great Yarmouth at 2.5 and South Norfolk at 0.6.

**Employment** is slightly higher than that of England with about 79.4% (16-64 year olds) in employment compared to 78.5% for England.

**Unemployment** is at just over 4.7% versus England at 4.2%.

Norfolk’s **ethnic make-up** is characterised as predominantly White British, Norwich district has the highest level of other ethnicities.

Estimates of populations of **Lesbian Gay Bisexual or Trans (LGBT)** vary from between 2-7%.

**Childhood health and wellbeing**

15% of five-year olds show signs of **dental decay**

The percentage of 15 year olds who are **physically active** for at least one hour per day seven days per week was 14.3% in 2014/15.

Norfolk has a higher than England rate of children who are looked after in care (**fostered, children’s homes or placed for adoption**); 1,180 children in 2018.

 c.15.2%, about 17,300 children (age 0-18) has **special educational needs or a disability**.

In 2011 approx. 5,712 young people aged between 0 and 24 years were providing **unpaid care** in Norfolk (6% of all Norfolk carers) – of these 1,752 were aged 0 to 15 year.

**Adult health and wellbeing**

**Smoking, alcohol and obesity** contribute about 23,000 hospital admissions per year. The area with the highest smoking prevalence is Breckland.

Two out of three adults are **overweight or obese**

Over 81,000 people have a **common mental health disorder** expected to increase by 1,400 by 2025. **Suicide rates** are similar to the rest of England whilst the number of emergency hospital stays for **self-harm** is better than the rest of England.

**Learning disability** prevalence (all ages) is higher in Norfolk than England as a whole.

Estimates suggest some 100,000 unpaid **adult carers**

2015 estimates suggest some 16,500 people with undiagnosed **Diabetes**. Estimated prevalence of undiagnosed and diagnosed diabetes for Norfolk is 9.3%, higher than the England average of 8.5%. **Cardiovascular disease** and **Cancer** have been decreasing generally over the past decade and continue to be better than the England average.

**Our older population**

Norfolk generally has an **older population** that is projected to increase at a greater rate than the rest of England.

Over the next ten years the population is expected to increase by 50,700 with most of the increase in the 65 and over age bands.

By 2041, the population aged 85+ is estimated to double in size.

North Norfolk has the highest prevalence of older age residents.
Key findings from the Suffolk JSNA tell us:

**People**

**Life expectancy** is higher than the average for England at 80.9 years for men in 2015-17, and 84.1 years for women over the same time frame.

**Deprivation** is increasing with 10.4% of households living in fuel poverty.

**Educational attainment** is relatively low but improving.

**Children**

Fewer than one fifth of 5-16 year olds do the recommended amount of daily physical activity

Some 17,260 children are living in low income families

One fifth of 5 years olds are overweight or obese.

One third of 11 year olds in Suffolk are overweight or obese.

**Adults health and wellbeing**

Men in Suffolk’s most deprived areas can expect to live on average for 7.4 years less than men in Suffolk’s least deprived areas.

In 2014, 4,500 people were newly diagnosed with Cancer in Suffolk; 50% of these diagnoses may have been preventable through not smoking, being a healthy weight, and eating a healthy diet.

**Social mobility** in Suffolk is low. In 2017, 4 out of the 7 Suffolk districts and boroughs were in the lowest 20% nationally for social mobility.

**Mental health** issues in Suffolk are increasing, reflected in rising rates of diagnosis and of self-harm

**Our older population**

1 in 5 people are currently aged 65 or older, in 20 years’ time this will be closer to 1 in 3.

Over the next 20 years the number of people aged 85 or over will almost treble.

The number of people living with dementia is expected to double in the next 15 years

**Waveney specific data**

The life expectancy gap between the most deprived areas of Waveney and the least deprived areas is 7.7 years for men and 5.6 years for women.

Waveney remains the second most deprived local authority in Suffolk and has seen an increase in relative deprivation levels from 2010 to 2015 in both the context of England as a whole and its statistical neighbours.

Waveney has 9 of the most deprived small areas (LSOA) in the 10% most deprived areas in England, and 8 LSOAs in the 11-20% most deprived areas in England

In 2014 Waveney rated was higher than the England average for children in low income families (under 16) at 22.7%

In 2015/16 Waveney rated ‘worse than’ or ‘higher than’ the England average in the following:

- Excess weight in adults
- Percentage of physically inactive adults
- Recorded diabetes Age 17+

In 2015/16, Waveney rated ‘better than’ or ‘similar to’ the England average in the following:

- Percentage of people aged 16-64 in employment
- All age emergency admissions for self-harm
- Smoking prevalence in adults
- Admission episodes for alcohol-related conditions
- Suicide rates

**Waveney specific data – older people**

Waveney rates ‘better than’ or ‘similar to’ the England average in the following:

- Emergency hospital admissions due to falls in people aged 65 and over (2015/16)
- Hip fractures in people aged 65 and over (2015/16)
- Excess winter deaths (age 85+) (2012-15)
- Rate of deaths from Cardiovascular Disease among people aged 65 years and over (2013-15)
- Rate of deaths from Cancer among people aged 65 years and over (2013-15)
- Rate of deaths from Respiratory disease among people aged 65 years and over (2013-15)
- Percentage of deaths in usual place of residence among people aged 65 years and over
Our Health and Wellbeing Boards

The Health and Wellbeing Board is the forum for system leaders across the wider local health and care system. The Board is responsible for producing a set of priorities for health improvement - the Joint Health and Wellbeing Strategy - which is based on the evidence of the assessment of needs in the Joint Strategic Needs Assessment (JSNA).

Across our Norfolk and Waveney system we have used the JSNA’s from both Norfolk and Suffolk respectively, and the priorities identified in their Joint Health and Wellbeing Board Strategies to inform our system plan.

Norfolk Joint Health and Wellbeing Board Strategy priorities:

**A single sustainable system** - working together, leading the change and using our resources in the most effective way; by

- Sharing our thinking, planning, opportunities and challenges.
- Engage with and listen to service users, residents and communities.
- Develop mechanisms and the sharing of information to target care where it is needed most.
- Undertake needs assessments to help us keep our Strategy on track
- Use partners’ existing plans, identifying the added value that collaboration can bring.

**Tackling inequalities** in communities – providing support for those in need and addressing wider factors that impact on wellbeing, such as housing and crime; by

- Improving locality working and sharing best practice.
- Providing and using the evidence to address needs and inequalities.
- Addressing the impact of crime, violence and injuries.
- Joining up development planning

**Prioritising prevention** – supporting people to be healthy, independent and resilient; by

- Developing a systematic approach for children and young people’s support and provision.
- Embedding prevention across all organisational strategies and policies.
- Providing joint accountability to prevent, reduce and delaying needs and associated costs.
- Promoting and supporting healthy lifestyles with our residents, service users and staff.

**Integrating ways of working** – collaborating in the delivery of people-centred care; by

- Making sure services are joined up, consistent and makes sense to those who use them.
- Promote the important role of carers and the support they may also require.
- Embedding integrated approaches in policy, strategy and commissioning plans.
Suffolk Joint Health and Wellbeing Board Strategy priorities:

Every child in Suffolk to have the best start in life; by

- Increasing the numbers of children who are a healthy weight.
- Enabling early intervention to support children who are vulnerable, including those experiencing adverse childhood experiences such as parental drug and alcohol misuse and domestic violence.
- Improving social mobility so that our children and young people realise their potential.

Older people have good quality of life; by

- Reducing the impact of frailty on the lives of older people.
- Providing a co-ordinated response to the challenges of dementia and depression in older people.
- Support carers more effectively.
- Ensure residents are supported at end of life.

People of working age are supported to optimise their health and wellbeing; by

- Preventing cardiovascular disease, including supporting people to be healthy at work.
- Effectively support those with chaotic lifestyles and high needs.
- Diagnose cancer earlier so that outcomes improve.

People in Suffolk have the opportunity to Improve their Mental Health and Wellbeing; by

- Ensuring residents have access to good quality, effective and equitable mental health services when they need them.
- Reduce the rate of suicide.
- Improve the mental health and emotional wellbeing of children and young people.
What local people would like to see in our plan

We’ve heard from and spoken to lots of local people and organisations about what they would like to see in our plan:

- We regularly talk to and hear from local people about the care they have received and their views on local services. So prior to any bespoke engagement about what should go in our plan, we collated what people have already told us over the past two years.

- Healthwatch Norfolk conducted some early engagement to help with the development of our plan in the spring of 2019. They conducted two surveys – one for the general public and one about long-term conditions – as well as six workshops across Norfolk and Waveney. 610 people completed the surveys and 101 people attended the workshops.

- So that people could continue to contribute throughout the development of our plan, we set-up a website to crowdsource ideas from the public as well as leaflets and opportunities to contribute in paper form. We also held various meetings with local groups and workshops with the voluntary sector.

- We crowdsourced ideas from our workforce too. Everyone working in health care across Norfolk and Waveney – both paid and unpaid – were asked for their ideas through our We Care Together staff engagement programme. The plan was also discussed by health and care professionals at forums and meetings, including our Clinical and Care Transformation Group.

Here’s a summary of what people have told us:

- **Integrating care:** People want more joined-up and coordinated care, and they want us to make quicker progress with how we work better together. As well as improving care, closer working between different health and care organisations will save time and money. It’s important that we support the cultural and behavioural change needed to create more seamless care.

- **Prevention:** We should have a real focus on prevention in our plan. “The earlier you deal with issues, the cheaper and more effective it is”. Our approach to prevention should have a focus on children and young people, coupled with support for parents and carers, on building active and involved communities, as well as addressing the wider determinants of health, such as housing.

- **Technology:** Getting our digital ‘offer’ right has the potential to transform our system. If we get this wrong, it has the potential to undermine everything else we want to achieve. We should focus on digital transformation and with real pace.

- **Workforce:** Addressing our workforce challenges also has to be a priority. We cannot provide the high quality, compassionate and person-centred care we want if we do not recruit new people to work in the health and care sector, as well as do much more to retain our existing workforce.

- **Primary care:** Our public has mixed experiences of being able to access primary care – on the whole people can get an appointment at their GP surgery in an emergency, but for some getting more routine appointments is a problem. Many people are happy to see different professionals, but being able to see a named GP or the same nurse is particularly important for those with long-term conditions.

- **Community care:** Developing our Primary Care Networks provides us with a real opportunity to improve care and prevent people from unnecessarily going to hospital. We need to invest more in primary care to improve the quality of care people receive and to help take pressure off others parts of the system.

- **Mental health care:** Our public are clear that this is a priority area for Norfolk and Waveney. People of all ages should be able to get the help and support they need quickly and easily, so that their mental health needs are treated early. We should increase our focus on prevention and wellbeing, provide appropriate support for people in crisis and effective inpatient care.
Hospital care: People generally like the current model of going to local services for simple procedures and treatments, and attending specialist centres for more complex procedures. For example, people currently receive more routine cardiology services at the Queen Elizabeth Hospital, but travel to Papworth Hospital for more specialist treatment. People also want to be treated quicker in an emergency and not have to wait as long for surgery.

Working with VCSE organisations: We should work more closely with local community groups, voluntary organisations and faith groups. The NHS can’t cure everything, we need to work together to keep people healthy, well and active, and care for them when they need help. We need to work together as equal partners.

Travel: It’s important we consider travel and transport to and from health services and activities which keep people healthy and well. The rural nature of parts of Norfolk and Waveney, and the cost transport can be barriers to people getting to services and living healthy lifestyles.

Each chapter of our plan has more detail about what people have told us. We have also produced a separate report called ‘What have local people told us they would like to see in our five year plan for health and care?’ which provides more feedback and insight. You can read it here: www.norfolkandwaveneypartnership.org.uk/publication.
Quality and patient safety

We know that the Norfolk and Waveney health and care system is facing significant financial and operational pressures, with some organisations struggling to maintain standards of care. It is vital that we focus on improving quality and delivering better value for people using our services, so that we can keep our patients safe and satisfied with the care they receive.

Our health and care system is committed to improving the quality of services and enhancing the quality outcomes for our population; this includes services delivered by our larger providers, but also smaller and defined services that are pivotal to the delivery of primary and community-based care. A partnership approach to quality across the provider and commissioner system enables a far greater level of consistency, improved use of resources and skills and the ability to enhance the offer to work in support of and in partnership across our system with the collective aim of improving quality.

The previous approach to the oversight of quality within the system has been transactional and contractually driven; this has not consistently delivered the excellent quality care and outcomes that we expect. We believe that our goals to make sure people can live as healthy a life as possible and for Norfolk and Waveney to be the best place to work in health and care, will enable us to successfully address quality and is at the heart of our commitment on our journey to achieve excellent CQC ratings across all providers.

NHS Patient Safety Strategy

The NHS Patient Safety Strategy (published July 2019) sets out how nationally the NHS will continue to improve patient safety and prevent harm. Across our system we will deliver the key improvements described within the national strategy including:

- Implementing the Patient Safety Incident Response Framework (PSIRF) by summer 2021
- Reporting through the new Patient Safety Incident Management System (PSIMS) by March 2021
- Implementation of medical examiner scrutiny of non-coronial deaths, through establishing acute trust-based medical examiner scrutiny of all deaths in acute hospitals by April 2020, and all deaths by April 2021
- Ensuring patient representatives sit on safety-related committees by no later than April 2021.

Infection Prevention and Control

Our ambitions

- We must meet national targets for influenza vaccination coverage.
- We must meet 80% target for the vaccination of health care staff in all NHS trusts.
- We must prevent and control outbreaks of flu-like illness and gastroenteritis in care homes, schools and hospitals.

We are fully committed to the prevention of Health Care Associated Infections (HCAIs) and to ensuring compliance with the Health Act (2008) code of practice for the prevention and control of healthcare associated infection (DH, 2008) across all commissioned and provided services.

Infection prevention and control is everyone’s responsibility and to support this approach, the Infection Prevention and Control (IP&C) team for the Norfolk and Waveney CCGs works collaboratively with teams across our health and care partnership. Infection prevention and control is about preventing infections as much as possible, particularly those that are associated with healthcare. Advice and support is available to all health and care staff from our IP&C teams across Norfolk and Waveney.

Hand hygiene remains the single most important thing we can all do to prevent the spread of infection and this is embedded in our training programmes, information, advice and campaigns. Reducing the threat of antimicrobial resistance (AMR) and reducing harm from sepsis remains high on the national and local agenda.
Our key priorities for infection management including workforce development are focused on; (1) antimicrobial resistance; (2) management of sepsis, including National Early Warning Score and Paediatric Early Warning Score; and (3) minimising the spread of respiratory and gastrointestinal viruses, with a particular emphasis on reducing staff sickness absence.

1. Antimicrobial Resistance (AMR)

Tackling AMR is a global concern for human health. Working as a system is essential to ensure antibiotics remain effective and so we can continue to be able to treat our patients where there is a clinical need. Benchmarking of antimicrobial prescribing at GP surgery, primary care network and place level is already in place, along with other measures including a common antibiotic formulary to improve effective use where clinically appropriate. We are developing an antimicrobial resistance plan for Norfolk and Waveney to deliver the gram negative blood stream infection reduction programme of 25% by March 2021 and 50% reduction by March 2024.

2. Management of Sepsis

Within the last two years all providers have implemented guidance and developed policies and procedures for responding appropriately to adults and children in deterioration. This year we will; evaluate the effectiveness of these policies on patient care through audits and review of the data; focus on sharing the learning from cases of sepsis across providers; and continue our campaign to raise awareness of sepsis with providers and patients/public.

3. Minimising the spread of respiratory and gastrointestinal viruses

Respiratory and gastrointestinal viruses put additional pressure on NHS services over the winter. These illnesses impact on bed capacity by increasing demand at the same time as leading to ward and care home closures. They also contribute to increased staff sickness. We are continuing to embed best practice on reducing the spread of infections with targeted communications including a Norfolk and Waveney Flu Plan, vaccinations and training across health and care providers and schools.

Key actions from 2019 onwards include:

- Fortnightly meetings in place to ensure a coordinated approach to influenza planning.
- Care home influenza outbreak response teams established across all CCGs.
- An influenza vaccination campaign aimed at the general population and targeted at GP surgeries with low uptake.
- Ensure NHS trusts and care organisations meet staff influenza vaccination targets.
- With the support of patients, service users and carers, run communications campaigns aimed at the general public, care homes and schools to prevent spread of gastrointestinal and flu-like illness.
- The flu vaccination delivery programme will be monitored through the Winter Resilience meeting in all patient groups, including pregnant women and respiratory patients.
- Healthcare provider’s vaccination programmes will be monitored.
- Care home respiratory study day arranged.
- Support to care home staff and acute trust staff to ensure effective and timely admission/discharge, cross organisationally during outbreaks, flu and norovirus.
- One winter communications plan has been developed for Norfolk and Waveney and is being implemented.
- Coordination of a Norfolk and Waveney scheme which will provide certification of achievement to care homes for staff flu vaccination compliance. The scheme is endorsed by NHSE.
- The Care Home Flu response service both through East Coast Community Healthcare and Norfolk Community Health and Care has commenced one month early following reports of early flu cases in Australia. This early start is replicated by the regional Public Health England flu response team.
- All three of acute hospitals will have point of care testing for flu in place this year.

Unwarranted Variation

A key priority for us is addressing unwarranted clinical and care variation, whether that relates to the accessibility of health and care services, the clinical effectiveness of the provision available or the cost effectiveness of the use of
the resources. We are already using benchmarking mechanisms such as Model Hospital, RightCare and GIRFT at STP workstream and service level to look at variation within providers and across pathways. Other surveillance methods including primary care dashboards and activity data are in place.

Approaches to tackling unwarranted variation include programmes of work to address high dose opiate prescribing, improved prescribing through our Prescription Ordering Direct service, appropriate referrals to hospitals and the reduction in the numbers of heart attacks. These approaches also enable the system to provide direct support where needed, such the use of public campaigns, quality improvement programmes and targeted investment in improvement capacity and capability.

A system wide quality dashboard is being developed to provide oversight of key quality outcome measures to enable visible and transparent reporting at STP level. Key measurable metrics will be enhanced through the use of local intelligence from various sources, including NHS Choices, complaints, Healthwatch, patient engagement and social media. It is vital that the system remains mindful of the ways in which quality is monitored, measured and reported and ultimately recognise that delivering and receiving assurance based on what is reported or known, does not ensure that quality services are indeed being delivered to our population. We will focus on quality improvement approaches as a system to deliver the intended outcomes.

Providers in Special Measures

Our system has three large providers in Special Measures – NNUH, QEH and NSFT - and some smaller, independent contractors, including residential care providers, learning disability hospital providers and GP surgeries rated as Inadequate by the CQC. Comprehensive Oversight and Assurance Groups are in place for the larger providers; however bespoke arrangements are in place for the smaller providers in Special Measures. These include direct and focussed support programmes for GP surgeries from the Chief Nurse team, host commissioner arrangements for quality scrutiny and oversight for providers such as complex learning disability providers and system led ‘wrap around’ support and direction for residential and home care providers, in conjunction with the clinical Chief Nurse team (including infection, prevention and control, prescribing and Quality in Care clinicians), the local authorities and community health services.

Decisions are made in partnership as to the impact to service users and system resilience of providers placed in Special Measures with regard to the continued commissioning of services, the level of direct intervention required, and where necessary planning for alternative provision for service users. Our acute services integration and transformation is focused on improving specific patient pathways and making these improvements together as a multi-professional partnership with patients actively involved. NSFT is working more closely with community providers, such as Norfolk Community Health and Care, to transform patient pathways and provide joined up support for the developing PCNs. Integration of pathways will improve quality for patients and enable our trusts in special measures to further strengthen delivery of care. We are increasing opportunities for staff to train together, to work in joint roles and experience rotations to embed a positive culture for improvement.

Adopting and spreading best practice from our providers rated as ‘Outstanding’

We also have a number of providers that are rated as Outstanding by the Care Quality Commission and we recognise the importance, not only of focusing on providers in Special Measures, but also of sharing best practice and quality improvement programmes across the system.

There are a number of key themes that have enabled our providers to improve the quality of care, including those documented in CQC publications. We will use the experiences of our Good/Outstanding providers and work together as a system to support our trusts in Special Measures. We will use the CQC Well-Led framework to guide the work that we do in our system quality surveillance forum with our providers that will replace the previous clinical quality review regime. The improvement themes we will use are set out as follows:
Vision – Our partnership’s goals and vision for the future will be used to provide an overarching ambition that we aspire to as a system. The importance of communicating our vision has been highlighted in our system-wide conversation with our workforce, called #WeCareTogether, and we will use this platform and other communication methods to continue to bring our vision to life. While each provider has its own organisational vision to guide the contributions of their staff, it is key to that our workforce understands what we are collectively striving for, how our plans align and their contribution.

Culture – In addition to our #WeCareTogether platform each organisation has developed plans to improve its internal staff engagement activities to really listen to staff and understand more about what it’s like for them and what they need to do their job. Staff satisfaction is directly related to patient experience and is an important measure that we will monitor together. Collectively we will share the progress and learning on how to improve staff experience and take forward our system actions aligned to the people plan. We will continue the momentum of our system wide engagement across Norfolk and Waveney, connecting our people to our vision and supporting providers with their own staff engagement by sharing learning. We will be rolling out health coaching training to all staff which will also underpin a more empowering way of working with patients and service users.

Leadership – Developing leadership at all levels is vital. Our emerging workforce strategy sets out our plans to develop a system wide leadership forum, alongside leadership training and development opportunities. Clinical and care leadership will also be aligned to this development for consistency of approach and we are already seeing the benefits of system wide clinical and care leaders taking responsibility for integration and the transformation of patient pathways, such as the integration of social care and community management teams, acute care transformation of defined patients pathways and the development of our primary care networks.

Innovation and Collaboration – We will increase the pace and spread of quality improvement training and share best practice examples that are being implemented around patient care across the system. Digital transformation and shared records is one of our top priorities to enable larger scale innovation and collaboration. We will also spread models of engagement such as ‘Always Events’ and service redesign projects with patients, service users and families to encourage more opportunities for engagement to happen. Collaboration with key stakeholders from social care, education, the voluntary, independent and charity sector will also be used to highlight how we have achieved successful engagement to improve care.

Going the Extra Mile – We are seeing some excellent examples of patient satisfaction which demonstrate how our staff really put patients and service users at the centre of care. We will spread these best practice examples such as Personalised Care Planning, patient stories, user group activities, positive comments received in friends and family feedback that can easily be replicated. We have seen how powerful positive feedback can be on staff morale; ‘Going the extra mile’ is about how the small things can make a big difference.

Line of Sight – We will improve our system wide line of sight of our provider’s performance through the development of dashboards, forums and communication networks so that we target support and interventions in a coordinated way. We will promote best practice in this, for example back to floor sessions for senior leaders, self-assessment tools/checks using CQC standards for care and development for middle managers around keeping connected with their teams.

Use of Data – We will ensure that providers are using qualitative outcome measures, audits, Learning from Incidents, Mortality Reviews, Model Hospital, GIRFT and other tools to benchmark their current practice across pathways and compare nationally to continuously improve outcomes for our patients and service users. We will share best practice examples in population health management and how this data is helping us to highlight inequalities and areas where we can take quick action to make improvements.
**Our approach to Quality Improvement**

Quality Improvement (QI) methodologies aim to make healthcare safer, more effective, patient-centred, timely, efficient and equitable. Our ambition is to build on our current successes and embed a system wide culture for QI across health and care. Training for QI has been well received by our staff; they have told us that they value the time out of their role to learn key skills in quality improvement so that they can be used to improve some of the things that they do every day and ultimately improve care for patients.

Our acute and community trusts are all implementing a variety of approaches for QI and we will be aligning our offer so that staff from all organisations across health and care can access training in their local area and have the opportunity to train with multi-professional staff. For example:

NCH&C and IC24 both use a bespoke Quality Champions Programme. They have trained over 200 staff so far and in September 2019 they started delivering the programme jointly for the first time. Primary care staff and volunteers have also been able to join.

NSFT enable service users to access their Institute of Healthcare Improvement QI training programme and have trained 180 staff (with a further 100 are in progress). They also have three QI coaches and have developed a pocket QI programme. NSFT will be training an additional 400 staff next year.

NNUH and QEH have trained QI experts in Quality, Service Improvement and Redesign (QSIR) and NNUH is also launching a Quality Improvement Academy. JPUH are implementing the ‘Model for Improvement’ methodology, with an ambition to build capability across clinical areas in 2019/20 by sharing existing projects and training 80 staff over the next 6-8 months. They are building a QI culture and community to enable collaboration and co-design with staff, patients and strategic partners, supported by their quality improvement hub and senior leaders.

A number of improvements in care and processes have been implemented across Norfolk and Waveney as a result of the QI approaches in place.

The Norfolk and Waveney Local Workforce Action Board (LWAB) have agreed to deliver a quality improvement project across Norfolk and Waveney. The aims of the project are:

1. Increase the spread and adoption of QI activity to improve patient care and pathways and increase staff satisfaction
2. Map current levels and types of activities in primary care, secondary care, social care, local authority, voluntary sector and prisons
3. Develop a database to record and share quality improvement projects and successes
4. Develop a system wide QI faculty to train staff, share best practice and evidence impact

This project will build on the best practice from across our system and build a partnership to deliver resources, training and expertise, share ideas and innovation, and to empower our staff to deliver change and improve patient care on a wider scale.

**Research and Innovation**

Research is a key component of creating an innovative and continuous improvement culture for health and care systems. We recognise that new ideas are required to add value for safety, effectiveness and experience, not only for patients but also for staff, so that we can continuously improve the quality of care against a background of increased demand, complexity of need and rising expectations. There is also going to be changes as a result of advances in technology and genomic medicine, which will have an impact on patient care and pathways. So we need to work with academia to encourage and enable NHS colleagues and patients and their carers to be generating ideas that add value for safe, timely, effective, efficient, and equitable person centred care. Our work with the University of East Anglia (UEA) has and will continue to help us generate innovative ideas, evaluate changes we make and provide an opportunity to discuss the future of health and care.
We are committed to increasing research activity and ensuring our health and care organisations are engaged in research locally to provide robust evidence in practice and to contribute to developing an expert workforce. In 2018/19 NCH&C was the third highest recruiting ‘care’ trust in England. 1,176 participants in total took part in portfolio and non-portfolio research. Our local system was involved in the set-up and running of 39 research studies during the course of the year, in a variety of clinical specialities, including dental, children’s health and wellbeing, Parkinson’s disease, epilepsy, falls prevention in care homes and dementia. The National Institute for Health Research (NIHR) supported 74% of these studies through its research networks.

Stroke and Acquired Brain Injury and rehabilitation are key areas of research and we have supported clinicians in developing research ideas through fellowships and innovation working with the Acquired Brain Injury Rehabilitation Alliance at UEA. We are currently working jointly with the UEA to set up a gait analysis unit which will offer further research opportunities and better care for patients.

We are actively engaged with the University of East Anglia (UEA) and our clinicians are involved in development of research ideas, generated through our workstreams, including rehabilitation, medicines management, frailty, nutrition, concussion, workforce and palliative care. Several research proposals are now being taken forward to the implementation stage and the focus is on supporting the health and social care system to benefit patients. Examples include DNA testing of patients for their suitability to specific medication, de-prescribing of medication in elderly patients, vitamin D screening, supporting people’s decision to go into care home and preventing deconditioning of in-patients.
Our system plan – how will we deliver?

Healthier communities – Prioritising prevention and personalisation

Prevention is recognised as critical to the long-term sustainability of our health and wellbeing system in Norfolk and Waveney and has been prioritised in the Health and Wellbeing Board strategies for Norfolk and Suffolk to be at the heart of everything we do.

Prevention is a key foundational commitment of the NHS Long Term Plan and, alongside our commitment to addressing the wider determinants of health, forms a key component of our strategic direction.

Our ambition is to support people to live longer, healthier lives through helping them make healthier choices and treating avoidable illness early on. This includes:

- Creating healthy environments for children and young people to thrive in resilient, safe families
- Helping people to look after themselves and make healthy choices
- Improving mental health and wellbeing
- Supporting older people to live healthy lives and remain independent for longer
- Supporting a healthy environment, including healthy communities
- Ensuring early treatment and intervention when needed
- Moving to more personalised, tailored support and care
- Reducing the impact of alcohol, drugs and violence
- Planning and preparing to respond and recover from emergency incidents (e.g. flooding, extreme weather)

Prevention runs as a thread throughout this document. This chapter focuses on preventing people from becoming ill in the first place (primary prevention) and our plans to ensure early treatment and intervention for specific diseases (secondary prevention) feature in the relevant sections of our plan.

Our prevention priorities

Our priorities for prevention in Norfolk and Waveney over the next five years extend beyond the prevention priorities of the NHS Long Term Plan to include:

Infection Prevention and Control

- Optimise the use and reduce the need for antibiotics.
- Improve the uptake of the flu vaccination for at-risk groups (e.g. pregnant women and patients with COPD) and for frontline staff (e.g. staff in care homes, the ambulance and mental health trusts) and in geographical areas where uptake is lower.
- Improve the uptake of Human Papillomavirus (HPV) and Measles Mumps and Rubella (MMR) vaccines.
- Continue to provide a service for management of flu and other disease outbreaks in care homes.
- Work with care homes to reduce the risk of dehydration from illnesses such as flu and norovirus.

Healthy Behaviours

- Implementing a new systems approach to promoting healthy behaviour, targeted at higher risk groups, using digital information, advice and guidance and including development of integrated working with community resources such as libraries, leisure centres, schools etc.
- Smoking – Targeting stop smoking programmes for those most in need, including pregnant women and routine and manual workers, implementing our local tobacco control strategies, including implementing Smoke Free NHS sites. Developing additional stop smoking support for people admitted to hospital and in specialist mental health services.
- Obesity – Supporting the continued delivery of the NHS diabetes prevention programme and developing weight management services in primary care.
- Physical Activity – Tackling sedentary lifestyles by embedding opportunities to be active into communities, services and strategy, and by working with partners such as Active Norfolk and One Life Suffolk.
- Sexual Health – Improving the quality of contraceptive advice in primary care and improving access to early (under 10 weeks) terminations.
- Drugs – Improving the physical and mental health of people with substance misuse issues.
- Alcohol – Seeking regional funding to provide a specialist alcohol team in the James Paget Hospital, which has the highest rates of alcohol dependence-related admissions for Norfolk and Waveney. Develop our partnership approaches to reducing alcohol harm by participating in theme-based Alcohol Clear reviews – using a framework to assess our local arrangements for specific cohorts (e.g. maternity) and developing plans to improve them.
- Healthy ageing – Promoting a positive view of ageing, encouraging continued activity, healthy eating, encouraging a health approach to alcohol, volunteering and physical activity.
- Mental health – Developing a prevention and wellbeing strategy through the implementation of the Prevention Concordat for Better Mental Health, strengthening resources in local communities, implementing our Suicide Prevention Strategy.
- Cancer screening – Addressing recent falling trends for cervical and breast cancer screening across the whole Norfolk and Waveney, as well as reducing inequalities in cancer screening uptake in hard to reach groups.
- Developing health coaching and behaviour change skills in our workforce – training staff to engage and empower patients and service users to take greater control of their own health.

**Population Health Management – Better care for major health conditions**

Implementing a system strategy for population health management focussing on interventions that can prevent or delay loss of health, targeting clusters of conditions where management and care can be optimised, and building on our existing “Right Care” programmes to reduce unwarranted variation in care, including:

- Diabetes - early diagnosis, self-care and optimised management through the implementation of our Diabetes strategy
- Respiratory disease – early detection and diagnosis of respiratory problems and optimising management of Asthma and COPD through the development of a Community Respiratory service, improving uptake of Pulmonary Rehabilitation, roll-out of the “MYCOPD” app to help patients manage their own condition, a staff training “Spirometry” programme, full deployment of the British Thoracic Society approved discharge bundles across the STP and improving referral links to Stop Smoking services.
- Cardiovascular Disease – including the roll-out of a Community Pharmacy based project to support the early identification and treatment of Atrial Fibrillation (AF) and Hypertension in conjunction with the Public Health “Get Checked” campaign. Development of a testing service for familial hypercholesterolemia.
- Programmes led by our Primary Care Networks based on locally identified priorities

**Community, tackling health inequalities and addressing the wider determinants of health**

- Working with our Primary Care Networks and Local Delivery Groups (which are inclusive of wider partners such as the VCSE sector) to build on our existing social prescribing programme.
- Increasing proactive referral for benefits advice and warm homes grants.
- Supporting violence reduction across our system – including the training of Domestic Abuse Champions.
- Working in conjunction with Health and Wellbeing Board partners to address the wider determinants of health and health inequalities.
- Using data on health needs and population health management analysis to prioritise future investment and undertaking health equity audits to identify unmet need.
- Air Pollution – Developing strategies to reduce air pollution in the key areas affected by poor air quality.
- Climate Change – Reducing carbon emissions, improving air quality and adopting best practice standards to reduce waste, water, carbon and single-use plastics. Planning and preparing for responses to protect our communities from risks to health (e.g. flooding, extreme weather) as part of our Local Resilience Fora.
Personalisation is a key element to our ongoing approach, including targeted and increasingly personalised advice and care, supported by our use of technology and innovation.

Our whole system, ‘population health’ approach to prevention is to focus on actions that are evidence-based and will have the biggest impact for our population, targeting and supporting those most at risk to reduce health inequalities, unwarranted variation and the demand for health and social care services.

This approach extends wider than the NHS, working with partners in the community (including local authorities, the voluntary sector and local communities) to commission integrated services and influence the wider determinants of health, such as housing and the environment, and maximise the way we use our existing assets to improve health and wellbeing.

Our health and care system has been given the challenge to demonstrate we are prioritising prevention in our policies and strategies and in our decision making, promoting the health of all our residents, including our own workforce.

**Prevention opportunities across Norfolk and Waveney**

Most of the top risk factors for ill health are behaviour related, which means we have the chance to change how we behave to reduce or prevent illness. We also have opportunities to reduce unwarranted variation across our system and work harder to address the health inequalities we face across Norfolk and Waveney.

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**Attribution of risk factors to causes of death in East of England, 2016**

(Source: Global Burden of Disease Study)

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Our services in Norfolk and Waveney are faced with responding to illnesses associated with the more sedentary lifestyles many of us now have and the diet we choose. The long-term impact of obesity and the increase in disease related to this, such as diabetes, stroke and cancers, continues to grow. For example, by 2020 based on current trends and forecasts, obesity will be responsible for more than 7,000 people with heart disease, 100,000 people with hypertension and 50,000 people with diabetes.

The impact of smoking-related illness has fallen as fewer people smoke, but smoking is still responsible for more than 11,000 hospital admissions each year and remains the single largest risk factor contributing to deaths and also health inequalities. Alcohol consumption is the biggest risk factor of ill-health, premature death and disability for
younger adults (aged 15-49 years). 1 in every 100 adults in Norfolk and Waveney is dependent upon alcohol.

High Blood pressure is the third main risk factor after smoking and poor diet, increasing the risk of developing heart disease, stroke, kidney disease and dementia. It is estimated that more than 110,000 people in Norfolk and Waveney are unaware that they have high blood pressure and are therefore at higher risk of developing these diseases. (Public Health Information Team and https://fingertips.phe.org.uk/profile-group/cardiovascular-disease-diabetes-kidney-disease)

Health Behaviours in Norfolk and Waveney

There are lifestyle prevention opportunities in Norfolk and Waveney (adults 18+)

- More than 120,000 smokers
- More than 340,000 adults do not eat a good diet
- More than 200,000 adults drink more than the recommended amount
- More than 180,000 adults do no exercise
- More than 500,000 adults with excess weight

What will be different

Currently we are formulating a list of potential outcomes that will be used to measure our ‘success’ in delivering the prevention and personalisation priorities outlined above. Examples of these include:

- Prevention embedded in all policies
- Workforce upskilled in behaviour change support
- Improvement in uptake for flu vaccinations in at-risk groups and front-line staff
- Improved uptake for cervical screening
- Reduction in admissions / A&E attendance due to respiratory conditions
- Reduction in smoking prevalence (e.g. Smoking at time of delivery SATOD)
- More people diagnosed and appropriately treated for hypertension and AF
- Reduction in avoidable deaths due to CVD and Alcohol related conditions
- Reduction in suicide rate
- Reduction in domestic abuse incidents
- Improvement in years of healthy life expectancy
- Reduction in unwarranted variation
- An increased number of people living with positive or better wellbeing
Tackling inequalities in communities

Our first goal is to make sure that people can live as healthy a life as possible.

| If our most deprived areas experienced the same rates as the rest of Norfolk and Waveney then each year over 400 children would be of healthy weight, there would be 1,000 fewer emergency admissions for older people and 60 fewer deaths due to preventable causes |

Health inequalities are avoidable and unfair differences in the health status between groups of people or communities. They include inequality in health outcomes by socioeconomic status or level of deprivation, or by characteristics such as gender, ethnic group or sexual orientation (NHS England).

Geographically, there are parts of Norfolk and Waveney where people’s health and wellbeing is significantly poorer than others. We know, for instance, that people living in parts of Lowestoft, Great Yarmouth, King’s Lynn and Norwich have poorer health, and on average die younger than people who live in better-off parts of Norfolk and Waveney. There are also significant pockets of deprivation in our rural remote farming areas, particularly in the Brecks and the Fens, in coastal villages and market towns. For example, people living in these area experience issues such as poverty, housing and fuel poverty, employment and access to transport. These, combined with limited digital access, social isolation and difficulties accessing routine health services, can significantly and negatively impact on their health.

Our work to reduce health inequalities will also address the needs of other specific groups of people living in Norfolk and Waveney (such as minority ethnic groups, the homeless, travellers, LGBTI and others with protected characteristics) who experience health inequalities.

Life Expectancy

Overall Norfolk and Waveney is a relatively healthy and safe place to live, with life expectancy at birth for men and women slightly above the national average, having increased steadily for decades. However, life expectancy has levelled out for men and is not increasing as fast as the rest of England for men and women. There are particular opportunities for improvement to be found in Great Yarmouth, Norwich and Waveney, where life expectancy for both men and women is not improving as fast as England (Director of Public Health, Annual Report for Norfolk, 2018).

Deaths from cancer, cardiovascular disease and respiratory illnesses play a significant part in the life expectancy gap between more deprived and less deprived in our STP (see segmentation model in Appendices). There is also a strong association between deprivation and poor health and wellbeing outcomes. For example, people likely to end their lives by suicide, people with drug and alcohol problems being admitted to hospital and smoking in pregnancy.

<table>
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<th>Life expectancy by local authority area in Norfolk and Waveney</th>
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<td><strong>Indicator</strong></td>
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<td>Life expectancy at birth (Male)</td>
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<td>Life expectancy at birth (Female)</td>
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(Source: PHE, Fingertips [https://fingertips.phe.org.uk](https://fingertips.phe.org.uk))
Living a healthy life is as important as living a long life. From the age of 65 years, on average people will spend about half of their remaining years in ill health. Across Norfolk and Suffolk the number of years people spend in poor health has increased for both males and females and the numbers of years lived in good health has declined (see Appendices for further data).

Further analysis is available at PCN level, identifying the local areas which experience the poorer outcomes (see Appendices).

The wider determinants of health

We know the conditions in which we live and work (the wider determinants of health), particularly education, jobs, housing and social networks, make a large contribution to variation in health outcomes. We see variation across Norfolk and Waveney in these determinants. These social and environmental factors are so important that it is vital that the NHS works with local government and local communities to work together to reduce health inequalities.

In 2017 more than 150,000 people in Norfolk and Waveney lived in areas categorised as the most deprived 20% in England.

Key Indicators for Wider determinants of health by Local Authority area in Norfolk and Waveney

(Source: PHE, Fingertips https://fingertips.phe.org.uk)
How we plan to address health inequalities

We will be taking a “place based” approach to addressing health inequalities, taking a three-pronged approach as per the population intervention triangle (see figure below), working with local authorities, communities and tailoring health services.

Source: PHE, “Place Based approaches to reduce health inequalities”, 2019

At Civic level: Working with local authorities to address the wider determinants of health, including as part of our Health and Wellbeing Board strategies. Our NHS organisations will be acting as “anchor organisations”, part of their communities, supporting and promoting an Inclusive growth strategy for economic and business growth in rural parts of Norfolk and Waveney, creating social value, encouraging business, safe and warm housing, infrastructure and jobs across the county, developing the digital connectivity, developing our wider workforce and improving social mobility, developing links with planning, licencing, and wider prevention campaigns such as “Healthy Ageing” and Active Travel.

At Community level: Using population health management approaches, our Local Delivery Groups and PCNs will be developing place-based approaches to improving care and reducing health inequalities, building on local assets such as leadership and existing infrastructure (for example working with local libraries to support digital inclusion), empowering community champions, integrating approaches in conjunction with other agencies including local authorities, VCSE organisations and members of the community (for example developing our social prescribing offer).

At service level: Services will address unwarranted variation, undertaking health equity audits to identify unmet needs of vulnerable groups and removing barriers to accessing services, such as physical, language, attitudinal, information, distance to travel. To increase uptake of vaccines and screening we will work with experts in Public Health England and NHS England to provide specialist advice. Our population health management approach will involve using data and information to identify needs, optimise care, proactively offering personalised care to vulnerable/harder to reach individuals.

At every level we will be using our local data and information in our JSNA to identify local priorities and unmet need and adopting evidence-based interventions. This will include undertaking health equity audits and measuring and reporting on progress.

Throughout this document there are examples of actions being taken in line with the “Menu of Evidence Based Interventions for Addressing Health Inequalities” (PHE, 2019), for example social prescribing, diabetes prevention
programme, hypertension and atrial fibrillation identification and treatment, uptake of cancer screening and vaccination programmes.

Our approach will include consideration of how we can best use our resources to target them in accordance with need (Proportionate Universalism) and ensuring our actions don’t make inequalities worse (undertaking Health Impact Assessments for changes we make). We will be using the full suite of resources available through Public Health England to support us to deliver this approach.

Social care and the wider determinants of health and wellbeing

Our priorities for social care in Norfolk

1. Tackling health inequalities across Norfolk

Adult Social Services in Norfolk continues to strengthen its work to tackle inequalities across Norfolk. This is addressed through a comprehensive programme of prevention and community development, which includes tackling social isolation, social prescribing and underpinned by Living Well: 3 Conversations approach to social work. ‘Living Well’ is our Norfolk model of social work constituting a major cultural change for the whole department, with practitioners now enabled to use a conversational strengths-based approach to support people to be independent, resilient and well for longer. It has been truly co-produced with staff and maximises the investment towards prevention in new services.

Norfolk County Council’s (NCC) prevention work combines universal information and advice, available to all, with interventions focusing on personalisation, and locality or community strengths, which target health inequalities. The development of solutions bespoke to an individual’s situation and what is available within their communities, requires NCC social care staff to be embedded as part of these communities.

Alongside the primary aim of supporting preventative work with individuals, this also enables a richer overview of local needs which can be fed into commissioning, delivery of services and allocation of resources to address gaps in provision or to identify where additional services would redress health inequality and the associated symptoms of this within social care.

This priority area and its targeted approach to prevention and reducing health inequalities directly feeds into our overarching system goal: “To make sure that people can live as healthy a life as possible”.

2. Workforce

Norfolk County Council plays a leading role in the system-wide workforce strategy as detailed in the local challenges section below – this is a key priority for the organisation. NCC focus continuously on recruitment and retention in Adult Social Services, particularly in parts of Norfolk where it is difficult to attract staff. Equally as important is the work to support the wider independent care sector to build its workforce. On any one day in Norfolk, there are 14,000 vacancies in the care market – an issue which has a major impact on the effectiveness of the health and social care system.

This priority area directly feeds into our overarching system goal: “To make Norfolk and Waveney the best place to work in health and care”.

3. Integration

A priority for Norfolk County Council is developing the social care offer to Primary Care Networks (PCNs) as they develop across the system. This offer will be developed in conjunction with the PCNs, responsive to the identified needs of local populations to ensure social care and community health integrates with primary care to enable people in these communities to access services they need seamlessly.

Integrated Community Equipment Service (ICES) and Integrated Care Co-ordinators (ICCs) both offer models of progressing integrated working to provide a seamless interface between health and social care systems for people using services, a priority for NCC.

- ICES provides an integrated equipment service for use by acute hospital, social care and community health staff and represents a significant success for integrated working, providing a seamless service to people requiring equipment regardless of the referral route.
• ICCs occupy a key role in advancing integration between social care and health services in Norfolk. ICCs have existed, in some form, in some localities, for over eight years. All ICCs have access to both health and social care case management systems, which allows them to see the breadth of a person’s care and support needs.

A Section 75 agreement exists between Norfolk Community Health and Care and Norfolk County Council, the arrangements for which can include pooling of resources and delegating of certain NHS and local authority health-related functions to other partner/s. Across Norfolk this is a critical foundation for integrated working, providing an infrastructure to support integration of service development and delivery.

This priority area and the targeted focus on integration and collaboration directly feeds into our overarching system goal: “To make sure that you only have to tell your story once”.

Our priorities for social care in Suffolk

Suffolk’s emerging vision for Adult and Community Services (ACS) is to be a good social care service, working in new ways with partnerships and people to develop better outcomes in peoples’ lives. The approach is similar to Norfolk’s with the aim of providing the right care, in the right place, at the right time, to ensure people can be as independent as possible as long as possible.

Suffolk aim to deliver their vision via three transformation programmes:

• **Adult Alliances** seeks to drive local integration with health and other partners to ensure services are joined up, and can deliver effectively and efficiently to meet people’s needs and give them as much independence as possible. This includes integrated governance, joint planning and commissioning, shared resources, and joint operational teams.

• **Learning Disability and Autism** seeks to reshape services in conjunction with service users, their families, and other stakeholders to provide better outcomes, based on ensuring that the right services are provided to deliver progression and independence, and that these are delivered in an efficient way.

• **Demand Management** is an overarching approach to providing care in a new way, which promotes independence and reduces the reliance on long term care. This program has a number of strands including:
  - A programme of targeted and focused reviews of care
  - Improving practice based on the Signs of Safety Methodology
  - Improving our digital care / assistive technology offer
  - Improving our information and guidance to the public
  - Improving our offer at the ‘front door’ and doing more to help people to help themselves if possible.

Our local system – Norfolk

As Norfolk’s population has grown year on year, and with this the proportion of 85+ and those with dementia increases compared to other areas, the demand on Norfolk Social Care increases.

• Each year, NCC receives 25,000+ new requests for support

• Gross expenditure is £420m, net investment in excess of £240m. This has grown 13.3% over last 7 years

• Annual funding has reduced by £204m since 2010 and revenue support grant will potentially fall a further £39m to zero in 2020/21

• In addition, NCC encounters yearly pressures relating to increases in demand and price inflation in market

• Since 2010, there has been a requirement to deliver savings of £364m, including £246m efficiencies

• At any one time, support is offered to 11,000+ people in long-term services, of these, one third are in residential nursing care setting, two thirds are in community. This equals £300 million pounds per year on long-term services, compared with overspends against our budget in four of the last seven years.
This spend on residential nursing intense care packages contradicts what people tell us they want – care closer to home and more tailored to their needs.

Our local system – Suffolk

Suffolk is also facing increasing demand from an aging population. In 20 years’ time one in three Suffolk residents will be over age 65 resulting in an increased pressure on health and social care. This together with increasing financial constraints means systems must rethink how we provide care and help people to remain as independent as possible for as long as possible.

Long-term trends are for a reduction in the use of residential care and an increase in home care and supported housing. However there is also a shortage of specialist provision, for example for those with dementia who have complex needs, and those with Learning Disabilities and challenging behaviour.

The net spend on Adult Social Care in Suffolk is £240 million, of which £210 million is spent on care purchasing. Gross spend including services funded from customer contributions and specific funding sources is £314 million. In recent years the care purchasing budget has been overspent due to demand pressures and the rising cost of care purchasing, but this has been off-set though underspends elsewhere and use of non-recurring resources. Spend on adult social care has risen by over 18% since 2012/12.

Across Suffolk County Council (SCC) as a whole funding has been reduced. The Revenue Support Grant started in 2013/14 at £135m and has since dropped by £119m to £16m in 2019/20; its future is uncertain from 2021/22. SCC has saved a total of £283m since 2011, though transformation, service redesign, and other measures.

In 2018/19 SCC received 39,914 requests for support from new clients of which 11,462 were from people aged 18-64 and 28,452 for older people (65+). At any given point SCC support around 9,800 long-term service users, of which around 30% are in residential nursing care. The total number of people who accessed long-term support during the year 1st April 2018 – 31st March 2019 was 12,465.

Our local successes – Norfolk

Social prescribing

In Norfolk, social prescribing services have been set up as a two-year pilot, beginning in July 2018, and funded by Adult Social Services Improved Better Care Fund (iBCF) monies and Public Health. The iBCF is the additional £2billion for adult social care announced at the Spring Budget 2017 to meet adult social care needs, reduce pressure on the NHS and support the local social care provider market.

The vision for social prescribing in Norfolk is as a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services to help them meet their needs. It seeks to address people’s needs in a holistic way and support individuals to take greater control of their own health. This recognises that people’s health is determined by a range of social, economic and environmental factors, in addition to physiological factors. Social prescribing schemes ‘connect’ people with other organisations or activities that can help them to reduce or resolve their problems. It is also intended that social prescribing services will reduce avoidable demand on social care provision.

Thorough effective partnership working and a positive approach to integration, social prescribing is now available across the whole of Norfolk, with referral pathways from GP surgeries, Norfolk County Council and, in some areas, via Early Help Hubs. There are five locality models: North Norfolk, Great Yarmouth, Norwich and Broadland, West and Breckland, and South.

Whilst the services are mainly focused on improving individual wellbeing it is also intended that these services may reduce or delay more formal packages of care and or unwanted/untimely admission to care facilities.

Integrated Care Co-ordinators (ICCs)
ICCs occupy a key role in advancing integration between social care and community health services in Norfolk. All ICCs have access to both health and social care case management systems, which allows them to see the breadth of a person’s care and support needs.

ICCs generally have responsibility for managing patient lists for multi-disciplinary team meetings in primary care, including providing updates about the care and support in place. This enables them to work with the professionals and the person to ensure that there is a good package of support around a service user, reducing duplication between services. This integrated approach allows for the person’s experience of the interface between their health and social care interventions to be better supported and as seamless as possible.

ICCs are funded primarily by the CCGs through the BCF, with contributions from NCH&C and NCC. Across the system, ICCs are linking with the NCC funded social prescribing service.

In addition to the ICC role in primary and community care, there is potential for development of increased joined up working with ICCs based within our Escalation Avoidance Teams.

**Integrated Community Equipment Services (ICES)**

ICES provides an integrated equipment service for use by acute hospital, social care and community health staff and represents a significant success for integrated working. The identification and use of equipment to help people to continue to live at home is a vital tool for health and social care services, and is maximised when health and care work together.

Delivery of ICES remains good. Waveney health and social care localities joined the contract in 2018/19, meaning that the whole of the Great Yarmouth and Waveney is now covered by a single equipment service, ensuring a more consistent and efficient service.

The service has continued to develop further during 2019-20, evolving in line with changing demand and continuing to provide a vital mechanism for admission avoidance, facilitating hospital discharge in a timely fashion and contributing to reablement to support people in the community.

**Our local challenges – Norfolk**

In addition to the financial and demographic challenges, and the specific challenge of Norfolk’s relatively high numbers of older people in permanent care, as outlined above, a key challenge is workforce. Recruitment and retention is a key priority for NCC across its own staff and into the care market. The use of agency and locum staff is high and impacts negatively on good patient care.

The Adult Social Care department in Norfolk has played an active role in our partnership’s joint approach to workforce challenges.

Some specific examples of social care initiatives include:

- **Section 75 agreement** between Norfolk Community Health and Care and NCC with shared senior management posts across 4/5 of the county, five years in operation.

- **Development of key new roles** – Integrated OT Manager, Principal OT, Director of Social Work, Assistant Director LD to embed the social care ethos as strong partners for Integration.

- **Recently successful European Social Funding Bid** which together with match funding from partnership organisations will support a total skills project value of £7,580,000 to improve qualifications in adult social care. Named the Developing Skills in Health and Social Care; this is a joint programme between Norfolk and Suffolk County Councils. The project will deliver:
  - An entry level health and social care qualification which embeds the functional skills that often present a barrier to skills development and progression
  - Level 2 and Level 3 qualifications tailored to meet skills gaps across the sector
  - A career progression mentoring programme to support staff onto progressively higher qualification programmes
An Aspiring Leadership programme which is bespoke to the specific needs of the care sector

The programme gives individuals working in lower paid jobs the opportunity to develop their skills and have access to further and higher education, enabling them to improve their earning potential and achieve career progression, and supporting them to move out of in-work poverty.

As well as support to individuals in the workforce, the higher take up of qualifications should lead to better recruitment and retention rates, better quality of care, and improved leadership and management skills to help sustainability within the care market.

For other Norfolk initiatives see social care Appendices Norfolk - appendix 6.

Our local successes – Suffolk

Suffolk sees its greatest success as the strength of its partnerships. A strong relationship with health services, the voluntary sector, the care market and district and borough councils continues to focus on outcomes for people as opposed to organisational interests. This is leading to improved system indicators, for example a reduction in Delayed Transfer of Care; i.e. those individuals who no longer require an inpatient bed but whose discharge is delayed due to external factors such as suitable accommodation.

A further success for Suffolk is the improvement in the number of ‘good’ and ‘outstanding’ providers in Suffolk. This is now close to 88%, and puts Suffolk fifth in the national rankings, and the only large Local Authority in the top five. Relationships with the care market have been transformed focusing on partnerships, outcomes, and targeted support. This is helping to mitigate a perceived fragility in the market, develop new services, and improve outcomes.

Suffolk has successfully implemented a new social care case management system across Adults and Children’s Services, via a fully integrated finance system, and portals for customers, professionals, and providers. This is a practice lead system and linked to developing Signs of Safety and changing practice in the workforce. This resulted in an immediate improvement in how data was collected and stored, moving from spreadsheets and inconsistent data quality, to system-based data being stored in a data warehouse, allowing us to build complex data sets using internal and partner data.

Workforce has seen a significant programme of investment and development. Whist the adoption of Signs of Safety as a practice model is a five year programme initial training and the development and embedding work is already underway. Support for team managers is being provided though executive coaching to help them develop in their roles.

Our local challenges – Suffolk

The main challenge facing Suffolk, similar to Norfolk, remains the increasing level of demand within a tight financial climate. To continue with the same models of care is unsustainable and there is need to deliver all three transformation programmes to ensure a stable care market delivering high quality care to those who need it.

A further critical challenge is workforce. Again similar to Norfolk, Suffolk as an employer has had some difficulties in recruiting, especially for senior qualified roles. Problems are greater in the care market, where low levels of pay, and competition from retail and hospitality sectors, has made retaining and recruiting staff hard. This is a national problem, but is felt acutely in some parts of Suffolk. The issue is being addressed via a system-wide recruitment strategy, developing joint posts with health, and ‘growing our own’, such as through apprenticeships. As set out above significant funding to invest in developing care market staff has been secured jointly with Norfolk. This will be utilised alongside the existing support and development offer for care market providers.

Finally, whilst the care market performs well in terms of quality, Suffolk has not met its aspiration that 100% will be good or outstanding. As it is nationally, the care market in Suffolk is fragile, with many providers making low returns, and some having high level of debt or lease commitments to service. Suffolk’s care market made up of many local small providers (for example only 10% of home care providers are regional or national providers) which reduced the impact of any one provider failure, but this remains a risk. The new model of service development and contract management has created a better understanding of the care market, and allowed for the identification and offer of support to those at risk.
The national priorities we must deliver

Care Act 2014

The Care Act 2014, the biggest social care legislative changes for years, emphasises the social work ethos, safeguarding, quality and places firm duties on local authorities, including responsibilities for the community and care provision in its widest sense. Enshrined in law is a duty to promote an effective and efficient operation of the care market as a whole. We have ambitious national targets, for example:

- A minimum of 85% of regulated providers to be rated as Good or Outstanding by April 2020

Norfolk County Council Adult Safeguarding and Quality take a lead role in supporting care providers who have adverse Care Quality Commission inspections through to finding alternatives for residents when a home closes (See Social Care Appendices Norfolk - CQC Inspection Dashboard & Appendix 3 – Quality and Risk Dashboard). This activity is undertaken in a joined-up way with health colleagues in order to achieve seamless transition for individuals.

Joint work with health colleagues in relation to care provision includes a joint modelling exercise has been completed to project future demand for number and type of beds, a joint bed tracking initiative and an evolving joint approach to the provision of continuing and ongoing care.

In Suffolk, Service Development and Contract Management teams take a lead role in working with providers that need support, building up strong relationships with them, using risk-based prioritisation, and calling in specialist support form safeguarding and the Provider Support Team when required. This approach has been successful in raising the CQC ratings of providers, and Suffolk is now fifth nationally for the number of providers rated good or outstanding, at almost 88%.

For more information see Social Care Appendices Norfolk – The Market Position Statement. To note: Suffolk County Council is currently engaging with its provider to refresh its Market Position Statement.

Better Care Fund and Improved Better Care Fund

The Better Care Fund (BCF) provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

Both Suffolk and Norfolk have agreed plans for the 2019/20 Better Care Fund with partners, and are using these to support service delivery, meet nationally mandated targets, and support integration with health and other partners.

How are we going to deliver in Norfolk?

Our strategy: Norfolk’s over-arching strategy for the next five years is Promoting Independence, which aims to:

Strengthen prevention and early help – empowering and enabling people to live independently for as long as possible

Support people to stay independent for longer – for people who are most likely to develop particular needs, intervening earlier with support to avoid people losing their independence and becoming reliant on formal services.

Support people living with complex needs – minimising the effects of living with complex needs so people can retain independence and control. For some people, moving into residential care or to housing where there are staff close by will be the right choice at the right time, but such decisions should be made with good information and not in a crisis.

Our priorities underpinning this strategy are:

1. Strengthen social work so that it prevents, reduces and delays need
2. Strong partners for integrated working
3. Supporting the Social Care market
4. Accelerate the use of technology
5. Safeguarding people
6. A positive working culture which promotes people’s independence and uses public resources fairly

Why this strategy is right for Norfolk

Compared with other similar counties, Norfolk has many more working age people in permanent residential care, and still a relatively high number of older people in permanent care, although the trend has reduced.

This is at odds with what people tell us they want, and in the context of continued rising demand and fragility in the care market, it is essential to invest in prevention and early help in the community, and to support people to stay independent without the need for formal services for as long as they are able.

Our specific objectives for the next 3-5 years are:

1. To increase the number of people aged 65+ who are able to stay in their own homes, with support, and reducing the proportion of people who are in permanent residential accommodation.

   Our objective is to bring us into line with other similar counties, and improve associated outcome and quality measures. This means achieving the rate of admission (per 100,000 of population) set out below.

<table>
<thead>
<tr>
<th>Result 2018/19</th>
<th>Target 2019/20</th>
<th>Target 2020/21</th>
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<tbody>
<tr>
<td>568.5</td>
<td>571.1</td>
<td>551.1</td>
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2. To increase the number of working aged adults (18 to 64) who are able to live independent lives.

   Historic admissions to residential care for people aged 18-64 were very high in Norfolk at nearly three times the family group average. Improvements have seen year-on-year reductions but most recently, the rate has increased. The target (expressed as a rate per 100,000 of population) represents a move to what we anticipate the median rate of Norfolk’s ‘family group’ of statistically similar councils will be by 2021.

<table>
<thead>
<tr>
<th>Result 2018/19</th>
<th>Target 2019/20</th>
<th>Target 2020/21</th>
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</thead>
<tbody>
<tr>
<td>28.5</td>
<td>22.7</td>
<td>16.9</td>
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</table>

Key activities to achieve these are:

**Embedding a strengths-based way of working.** Through Living Well, 3 Conversations, social care teams working with people, listening to them, understanding their strengths and finding ways to support them to be independent.

**Making sure there is the right mix of care in the independent sector.** There is a pressing need for health and social care commissioners to work with the market to shape provision. The current pattern of care provision from the 900 individual providers in the market does not match the needs of the people we are supporting. It is difficult to make care home placements for older people in nursing care and residential care placements for people with dementia and associated challenging behaviours. There are also difficulties in finding home care in rural parts of Norfolk.
Continuing to invest in reablement. For every £1 invested in reablement (home based in special units) the return is around £4.

Strengthening admission avoidance. Through establishing consistent admission avoidance models in each locality, and continuing to maximise Swifts and Night owls which each year prevent admissions to hospital.

Investing in digital technology. Expanding assistive technology, exploiting health and social care data to anticipate and intervene earlier.

Transforming support for Norfolk’s 99,000 informal carers. Intelligence shows that a significant proportion of our admissions to hospital and subsequent move to residential homes are because of carer breakdown. Earlier support for carers will help them to maintain their caring role.

Leading the development of new housing options for people. NCC has committed a £30 million capital fund to facilitate a ten-year programme to develop 2,842 Extra Care units, to support older people to stay independent in their local communities.

Recruiting and keeping people in the care workforce. On any one day there are 14,000 vacancies in the care sector in Norfolk. Care providers often find themselves competing with retail to attract and keep staff. We need continually to support independent care providers to promote caring as a valued and meaningful job – and often a stepping stone to a career in health and social care.

Better support for people with autism. Whilst we have now a solid collaborative partnership and a strategy, we need to improve the experience of health and social care for people with autism. Our priority is to cut the waiting time for diagnosis.

Giving people with learning disabilities more choice and control. We are changing traditional day services to give people more opportunities to take part in different social activities in their communities; developing more accommodation options, ensuring a smoother transition between children and adults services.

Strengthen personalisation. Re-visiting our strategy for personalisation through co-production; giving more people the opportunity to have direct payments, and to find new ways to commission bespoke personalised support services.

Better Care Fund 2019/20

There is a requirement to deliver against Better Care Fund targets, including:

- Reduction in admissions to long term residential care – as per the Promoting Independence strategy above
- Reduction in Non-Elective Admissions (NEA)
- Reduction in Delayed Transfers of Care (DTOC)

Work to achieve targets for both Non-Elective Admissions and Delayed Transfers of Care will be supported by iBCF funded schemes, including: Accommodation Based Reablement, Enhanced Home Support Service and Trusted Assessment Facilitators in the three acute hospitals. All of these are integrated crisis intervention services supporting both admission avoidance and timely discharge from hospital. These schemes will continue as pilots for the planned duration, which includes scheduled evaluations and decisions about longer term continuation.

How are we going to deliver in Suffolk?

The key to building on successes in the Suffolk system and delivering the vision is through the transformation programmes outlined earlier. Plans are in place for three years, but the underpinning principles of providing the right service, in the right place, at the right time, and so giving people as much independence as possible will continue to be the way forward in the longer term. As set out above there are three transformation programmes, Adults Alliance, Learning Disability and Autism, and Demand Management. Although separate programmes with separate governance and leadership they all have some key similarities:
Embedding a strengths-based way of working. Implementing Signs of Safety as our practice model, and supporting the development of this through training, peer support, and coaching for staff and managers.

Developing the care market. The new model of contract management and service development has helped build relationships and understanding with the care market. SCC has undertaken significant new procurements for home care and supported housing, and are working with the care market to deliver a better housing offer, alongside new contracts for residential and nursing care. Suffolk is also developing a Care Market Strategy with care providers to set the vision for the care market in the future.

Focus on partnerships. SCC has strengthened its partnerships with CCGs and other health partners though its locality model, with Area Directors managing services and relationships in a geography aligned to CCGs boundaries. This has enhanced capacity to develop partnership solutions, for example in the management of winter pressures.

Co-production with service users and their families. SCC has involved people and their families in service design and in making individual care arrangements, this has been a particular feature of ‘improving advice, guidance and signposting’ as outlined below.

Improving advice, guidance, and signposting. An Independence and Wellbeing Service has been implemented to support those who contact the Council requiring help, this allows for a quicker assessment and the ability to identify those who needs can be met through Tier One support without needing formal care. SCC is also developing their website and other ways off communicating with people.

Investing in digital technology. Rolling out a new digital care offer and investing in skilled staff to support this. Working with health partners to improve data and help plan and deliver services better.

Investing in the infrastructure. Working with the NHS to develop more housing for people with Learning Disabilities and Autism and developing plans for a significant investment in Extra Care Housing. SCC is also looking to use some of the Council’s land to allow for care facilities to be built where there are gaps.

How we engage with the public, stakeholders and staff, and how we will engage going forward

Norfolk

Engagement with all three groups has been key to developing the Promoting Independence strategy. Norfolk County Council will continue the current engagement, interfacing with public, stakeholders and staff in different ways, including:

- Direct engagement with individuals and communities via assessors, community connectors, community development workers and various contracts with the voluntary sector
- Commissioning based on understanding gained from people, carers and communities using services
- Stakeholder groups established, including “Making it Real”, LD Partnership Board and Autism Partnership Board
- Direct consultation with support from UEA to check the impact of our operational Section 75 agreement between NCH&C and NCC.

In addition, there is specific engagement plans with regards to our housing strategy:

- New options in specialist housing for older people will feature in engagement and communication campaigns promoting the concept and benefits of independent living. As part of this, focus groups will be held with members of the community to understand what is important to them.
- As significant landowners, holders of public estates hold a vital role as enablers to unlock land for housing, including for example, affordable housing for workforces and specialist extra care housing, so Norfolk County Council are playing a key role in the Norfolk and Waveney Estates Strategy.

Suffolk
The priority setting and budget setting for Suffolk County Council always takes place in the public domain. Engagement with partners is mainly carried out at a local level though our local partnerships with health, district and borough councils and other stakeholders, such as the voluntary sector.

SCC aims to work at a locality level to engage communities and service users. All service developments and procurements are produced in discussion with service users and their representative organisations. For example an in-depth survey of users’ experiences by Healthwatch informed our model of home care.
Population health management

Population Health Management (PHM) is the method by which we will use data insights to improve both health outcomes for our patients and to make the best use of our resources, thereby achieving the following aims:

- Reduce the cost of health care and improve productivity
- Improve the health and wellbeing of the population
- Enhance experience of care
- Address health and care inequalities
- Increase the wellbeing and engagement of the workforce

We already have excellent examples of how PHM has helped to improve outcomes for patients with risk factors associated with diabetes and cardiovascular disease, and to find frail patients before a crisis happens, our ambition is to build on this practice and other projects to develop the infrastructure to support the systematic use of PHM across Norfolk and Waveney, within the local geographies and at GP surgery level.

To enable us to achieve this we have plans in place for the leadership, technology development, capability and interventions, current progress includes:

**Leadership for PHM**

- System leadership and decision making on PHM is driven by our joint-Senior Responsible Officers (SRO) in our partnership; the Director of Workforce and the Chief Information Officer (CIO).
- We have a PHM steering group with representatives from each organisation across Norfolk and Waveney, and a second group which focuses on primary care PHM led by Norfolk’s Deputy Director of Public Health, who is also a member of the PHM steering group. PHM is a quarterly item on the work plan for the Clinical and Care Transformation Group (CCTG); both chairs of the PHM groups are members of the CCTG.
- We have supported the continuous development of a PHM tool that is being used across the country – Eclipse / NHS Pathways. This has been developed by a GP in the West Norfolk area of our system. We are also using the foundation of this excellent tool for our Connected Care Record.

**Technology**

- Digitised health and care providers and common health and care record – The main focus for digitisation is the acute Electronic Patient Record (EPR) programme, which is now in specification and Outline Business Case phase. Our Norfolk and Waveney Connected Care Record project is in progress and we expect our first pilot to be live prior to Christmas 2019.
- Integrated data architecture and a single version of the truth - Our digital strategy will deliver a virtual data source through interoperable clinical systems, real-time data feeds – led by a Data Architect lead that will be in place in December 2019.
- Information Governance that ensures data is shared safely, securely and legally – We are building on existing information governance agreements – Data Protection Impact Assessments (DPIA) and Data Sharing Agreement (DSA), led by a system Information Governance Group.

**Capability**
• We have a Norfolk and Waveney Business Intelligence (BI) and Data Group which will develop system-wide capability and capacity in analytics and data sciences, providing support to use software/tools and development of specialist skills.

• We will have a system Head of Insights and Analytics in place for December 2019.

• We will use the expertise within Norfolk and Waveney to grow the capability within our workforce to understand health and wellbeing needs of the population.

• Expertise for the interpretation of the data is available and will be increased as we mature.

Interventions

• We already have tools in place to deliver care in new and proactive models in GP surgeries.

• Our Primary and Social Care PHM group, supported by our commissioners, County Council, PCNs and Public Health England are already beginning to develop models and interventions a PCN level.

• We have Population Health profiles at PCN level to support prioritisation of PHM projects and have co-ordinated the existing resources available to support PCN leads to develop their approaches, including access to segmentation and risk stratification tools.

• We are preparing guidance to support PCNs to systematically assess their local priorities and we are sharing the good practice that is emerging from across our system through the development of local case studies.

Case Studies

West Norfolk CCG developed a Population Health Management approach based on a “Plan, Do, Study, Act” cycle.

Plan – Population variances can be identified using risk stratification tools such as RightCare or areas of concern can be identified by clinical colleagues, for example a PCN can identify an area of variance. Through the use of the population health database it is possible to perform a “deeper dive” into this area of concern at a population segmentation level to provide anonymous patient level analysis that is both up to date and meaningful. This data is then evaluated alongside our expert clinical colleagues to create localised insightful analysis at the start of the planning cycle and can be used to plan an informed project from the outset. Analysis is not just limited to one area of interest, multiple areas of interest can be analysed alongside each other to ensure a more holistic approach during the planning stages.

Do – Once a clearly identified cohort of patients has been identified within an area of opportunity, the clinical team will assess the population segmentation data and agree what their project of ‘change’ is wanting to achieve. This
allows a set of standardised care processes and treatment targets to be defined in order to achieve the desired change. The PHM BI tool is used again to assess the cohort of patients against these newly defined care processes and treatment targets to understand the action(s) required and the most appropriate healthcare professional to perform the action(s).

**Call to Action** – Once standardised care processes and treatment targets have been agreed and the programme of change has been fully understood, the project can start. The cohort of patients and associated care processes and treatment targets are provided to primary care using the clinical system “NHS Pathways”. They are identified via a bespoke alert screen alongside the existing primary care systems, such as Emis and SystmOne. The cohort of patients are monitored and the agreed care processes and treatment targets are actioned. Using clearly defined protocols for escalation and de-escalation we can ensure that the right patients are being seen by the most appropriate clinician at the right time. Real time data is captured from the primary care system to enable continuous monitoring of the cohort of patients throughout the duration of the project.

**Evaluate** – Once the project has started, ongoing evaluation commences. The impact of the project is measured against the originally set measurable of the change, as well as identification of any lessons learnt and future opportunities. To measure the impact of the project, the PHM BI tool is used to benchmark the project’s cohort of patients prior to the change, during and after the change. The PHM BI tool enables the benchmarking of criteria such as diagnosis rates, the number of clinical tests undertaken, changes in results of clinical tests, acute hospital attendances, medications and changes of medications.

**Swaffham and Downham PCN - Diabetes project**

Swaffham and Downham PCN has been formed by seven GP surgeries across a diverse population within West Norfolk. There are 41,178 patients of whom 3,430 patients have diabetes. Last year the region was average for diabetes monitoring and three treatment target attainment (national diabetes audit data).

Type 2 diabetes is an important condition because of the associated risk of adverse clinical outcomes in the longer term. Diabetes remains a significant factor contributing to premature mortality, cardiovascular disease (heart disease and stroke), lower limb amputation, end stage renal disease and visual impairment and blindness, throughout the UK.

Preventing these long-term complications requires intensive multifactorial risk factor management across lifestyle and biometric parameters, in particular, blood glucose, blood pressure and cholesterol.

The diabetes project allows accurate identification of those patients with the highest needs allowing them to receive increased monitoring, prioritised remote reviews and improved implementation of care ensuring their outcomes are optimised. Effective Population Healthcare Management can be effectively delivered across Primary Care Networks.

The centrally assured alerts and the national prescribing safety indicators are run each week, allowing identification of patients in need of review. This dynamic implementation of the patient and prescribing safety alerts allows the shift from a reactive healthcare approach to a far more proactive approach. Vulnerable patients and clinical scenarios are identified automatically enabling rapid review and intervention. This facilitates effective proactive clinical management of patients, supporting people to live well for longer, improving life-expectancy and reducing the risk of serious longer-term adverse clinical outcomes.

This is an enhanced monitoring programme to enable three main processes:

1. Providing accurate, timely and current information to each GP surgery on their diabetes population including information on monitoring, attainment of treatment targets, and compliance with any current Local Diabetes Programmes (e.g. education etc.)

2. Allowing rapid identification of those patients at highest risk to enable prioritisation of these individuals and enhanced support.
3. Enabling integrated care, remote reviews and efficient utilisation of the extended healthcare team through the creation of a dynamic centralised database.
Better care for people – Integrating ways of working

Adult Learning Disabilities, Autism and ADHD

Our local priorities for Adult Learning Disabilities, Autism and ADHD

To ensure we deliver the vision of our local learning disability and autism strategies there is significant work underway across our system. This work captures our local priorities and national requirements for adult learning disabilities, autism and ADHD. It recognises the feedback we have received from the public, patients and staff, and, it feeds into our overarching system goals of workforce, integration and reducing unwarranted variation.

Our priorities are for adult Learning Disabilities, Autism and ADHD are:

- To reduce the waiting times for an autism or ADHD diagnosis and collaborating to create an integrated neurodevelopmental disorder pathway for adults, so that there is a consistent approach across Norfolk and Waveney.
- To improve the response when someone with a learning disability or autism needs a rapid response from mental health services to prevent escalating need.
- To develop a behavioural support strategy and deliver a programme of training to improve skills across the social care, NHS and independent sector workforces when supporting people with behaviours of concern. This will contribute to Norfolk and Waveney being the best place for health and care professionals to work.
- To implement a single point of access across specialist learning disability health and care services, to support our preventative focus and ensure people get to the right provision at the right time. Coordinating this across specialist learning disability services is a step towards a wider system integration and the Norfolk and Waveney STP goal of people only telling their story once.
- To implement the learning disability quality improvement plan to ensure how healthy you are does not depend on where you live in Norfolk and Waveney:
  - Increase number of LeDeR reviews completed to address health inequalities.
  - Increase the update and quality of learning disability health checks to intervene early and prevent physical health deterioration.
- To develop and implement an accommodation strategy for people with learning disabilities to increase choice and reduce reliance on residential care and ensure a consistent offer is available wherever you are in Norfolk or Waveney.
- To work with our providers to ensure that day services promote skills, education and employment.

Our local system

There are over 19,000 adults with a learning disability in Norfolk and Waveney, of whom almost 3,000 are expected to have a moderate learning disability and over 800 a severe learning disability. Running alongside this it is estimated that 1.1 percent of the population of Norfolk and Waveney is autistic, this is over 9,000 adults.

Norfolk County Council, Suffolk County Council (for Waveney) and the CCGs commission services to diagnose and support adults with learning disabilities autism and other neuro-developmental disorders (NDD). Services are delivered by a range of providers, both in the NHS and in the independent and private sectors.

People with learning disabilities, autism and ADHD should have access to the same mental and physical health services as the rest of the Norfolk and Waveney population. Our specialist services for people with learning disabilities work with these services to help them make changes that enable people to access them.

Adults with Learning Disabilities

When people with learning disabilities have physical and mental health needs that require specialist treatment we
have a range of services that provide treatment, care and support. In the community Norfolk Community Health and Care NHS Trust (Norfolk) and Norfolk and Suffolk Foundation Trust (NSFT) (Waveney) employ specialist clinicians to meet the physical and mental health needs of people with learning disabilities.

In the event that someone requires a specialist mental health assessment or inpatient treatment, this is provided by Hertfordshire Partnership University NHS Foundation Trust.

Norfolk County Council and Suffolk County Council (Waveney) also commission services in the community to support people with learning disabilities, including social activities, skills development, support with work and employment, supported housing and longer term residential care.

Our CCGs commission Learning Disability and Autism health checks in Primary Care on behalf of NHS England and NHS Improvement. Patients are eligible for an annual health check from the age of 14 so that potential health issues can be identified early on, leading to better health and wellbeing and an improved quality of life. Following the health check patients will also be sign posted to public health lifestyle services and social prescribing.

LeDeR programme

The Learning Disabilities Mortality Review (LeDeR) programme was established in 2015 to support local areas across England to review the deaths of people with a learning disability, to draw out learning from those deaths and to put that learning into practice. Norfolk and Waveney has produced its first annual report in 2019. Pneumonia, aspiration pneumonia and epilepsy were causes of death more frequently reported in people with severe or profound and multiple learning disabilities. It is of great concern that the latest LeDeR report cites deaths reviewed where there were concerns about the quality of care, and an average age of death that is 23 years younger than the general population for men with a learning disability and 27 years younger for women.

There is evidence of some progress against the themes from the retrospective review, but also evidence that further work is needed. There is a quality improvement plan that uses this data. The plan will ensure that we turn learning into effective service change.

Autistic Adults

Norfolk County Council commissions a service to diagnose autism in adults on behalf of itself and the CCGs. The service offers assessment and diagnosis and pre and post diagnostic support. In Waveney the CCG purchases diagnostic assessments when these are required. People using the service in Norfolk experience significant waits (please see the section below on our local challenges) and addressing this is a local priority.

Norfolk County Council and Suffolk County Council (for Waveney) offers autistic adults social work assessment and support. Autistic adults who meet social care eligibility criteria have access to a range of services, including a new employment focused service alongside support at home or supported housing.

Our principle provider of mental health services, NSFT, offers mental health support to autistic adults and is able to make changes to the way it delivers treatment and support to meet their specific needs. It does this by using the green light tool kit, introduced by the Department of Health in 2004 to support local efforts to improve mental health services for people who also had a learning disability and or/autism. NSFT has received national recognition for doing so.

ADHD

NSFT delivers adult Attention Deficit Hyperactivity Disorder (ADHD) services across Norfolk and Waveney. The service provides initial assessment and diagnosis and initiation of medication with the aim of reducing the impact of ADHD on the people they diagnose.
As described above, if they need mental health support adults with ADHD can access this from NSFT. If someone with ADHD has eligible care needs, they can also access a range of social care supports, including support to obtain and sustain employment.

Estimations of Adult ADHD in Norfolk and Waveney are difficult to ascertain. Nationally it is estimated that about 0.6–1.2% of adults retain a full ADHD diagnosis by age 25 years and a larger percentage (2–4%) have ADHD in partial remission. This is consistent with population surveys in adult populations that estimate prevalence of ADHD in adults to be between 3 and 4%.

The national priorities we must deliver

The Long Term Plan and its subsequent implementation framework outlines the following commitments for adults with learning disabilities, autism and ADHD. These also relate to national requirement to reduce the number of people with learning disability and autism in hospital places as a result of mental health needs or behaviours of concern (often known as the transforming care programme). The priorities are:

- Increased uptake of health checks for people with learning disabilities (target 75 percent)
- Involving people with lived experience in checking the quality of their care
- Reduced use of specialist learning disability inpatient beds (an expectation that there will be no more than 15 CCG funded inpatient beds across Norfolk and Waveney in 2020 and 11 in 2024
- The reduction in inpatient placements will be supported by improved 7 day a week crisis and forensic support
- Ensuring that local mainstream health services make changes to the way they deliver services so that more people with autism and learning disabilities can use them
- Aligning local plans for learning disabilities and autism with local mental health strategies
- Stopping the over medication of people with learning disabilities (the STOMP programme)
- Taking action to tackle the causes of morbidity and preventable death in people with a learning disability and autistic people (the LeDeR programme)
- Making use of the ‘reasonable adjustment’ digital flag in the health care record
- Ensuring health and care is person centred and offering personal health budgets
- Ensuring the learning disability improvement standards are introduced.

We anticipate new national requirements over the next 12 months, including that:

- The review of the national autism strategy will identify further areas for improvement and action
- There will be new responsibilities for all CCGs to quality assure all specialist learning disability inpatient provision in their area through a new ‘named’ commissioner role.
Our learning disability and autism strategies

Our local learning disability and autism strategies (attached as appendices) set out our vision for services in Norfolk and Waveney. The strategies capture both our local and national priorities.

The visions set out in all three documents are used as tests against which actions, plans and proposals are tested. Each change we make should take us closer to each of these visions:

- **Suffolk learning disability strategy vision**
  - All autistic people, their parents/carers are accepted, understood and treated as equal members of the community. That there is a greater awareness and understanding of autism by people that live and work in Norfolk. That this understanding will enable autistic people to have the same opportunities as everyone else to live a fulfilling and rewarding life and achieve their life’s ambitions.

- **Norfolk learning disability strategy vision**
  - That all people with a learning disability have the ambition, choice and opportunity to be equal members of the Norfolk Community.

- **The Norfolk All Age Autism Strategy Vision**
  - People with learning disabilities live good lives as part of their community, with the right support, at the right time, from the right people.

Our local successes

- In the past year both a local learning disability strategy and an autism strategy have been published in Norfolk. Both were developed through engagement with people and families and implementation is being supported by the Norfolk Autism Partnership and the Norfolk Learning Disabilities Partnership Board. Both strategies have strong visions for future services that the two partnership boards will work with partners to achieve.

- Suffolk has a strong learning disability strategy and an active partnership board supporting its implementation. Work on the development of an Autism Network / Partnership for Suffolk is underway to oversee the creation of a co-produced autism strategy.

- Suffolk has produced a special educational needs and disabilities (SEND) strategy that covers Waveney and there is a draft strategy in place for Norfolk.

- The Norfolk Autism Partnership has launched autism awareness training through a new e-learning module and developed a 1 day course that is being delivered to all frontline social care staff.

- Our first annual Norfolk and Waveney LeDeR (learning disabilities mortality review) has been produced and there is an active group responsible to implementing the learning. Key areas identified include: mental capacity act, pneumonia, sepsis and dysphagia in people with learning disabilities.

- Norfolk and Waveney CCGs have commissioned Improved Access services which provide pre-bookable routine appointments at evenings and weekends. This means that people with a learning disability or autism can be flexible about when and where they receive their LD health check and/or routine care.
  - Thorpewood Medical Group in Norwich have specifically put on Saturday health checks clinics.
The Beaches Medical Centre in Great Yarmouth and Waveney and Thorpewood Medical Group in Norwich have moved to delivering health checks outside of primary care for example directly into care homes.

Our local challenges

- There is currently limited coordination within neurodevelopmental disorder (NDD) services, including those for people with autism and ADHD. Services are commissioned separately and do not work together. People tell us that this leads to a fragmented experience of services.
- Our learning disability community teams have worked hard to reduce waiting times but there is still work to do. Last year over 80 people were waiting over a year for first contact and this has been reduced to 14.
- There are also long waits for autism and ADHD diagnosis. The longest waits for adult autism diagnosis being over 200 weeks, with over 440 people currently waiting. Demand for ADHD diagnosis has also increased, with over 1200 referrals between March 2018 and August 2019. Longest waits are around a year and a half for the adult ADHD provision.
- Significant improvement is needed to ensure that people with learning disabilities have the annual health check in primary care to which they are entitled and that the check is delivered with a high standard of quality. The national target for this is that 75% of people on a practice’s learning disability register will have an annual health check. Data for 2018/19 in Norfolk and Waveney showed a 62% uptake of health checks (the target was 55% in 2018/19).

What the public tell us

There was extensive engagement to support the development of both the Norfolk (My Life, My Ambition, My Future) and Suffolk learning disability strategies, with the Suffolk strategy covering the Waveney area. Similarly the Norfolk all age autism strategy was co-produced with autistic people, families, providers and practitioners (My Autism, Our Lives, Our Norfolk) Work is underway to create an Autism Partnership in Suffolk to oversee the creation of an Autism strategy.

The learning disability strategies both tell us how important it is that people can be active in their local community, have meaningful relationships and have access the right support at the right time. The all age autism strategy focuses on raising awareness of autism, improving access to diagnosis and support and influencing the wider community to create an “Autism Inclusive and Accessible Norfolk”. Feedback through the learning disability and autism partnership networks and through a focused session with groups talking about the Long Term Plan tells us that people are particularly concerned about:

- Waiting times for assessment and diagnosis
- Being excluded from services that are delivered using technology or in venues that are not accessible or confidential
- Limited support to have a healthy lifestyle
- Mainstream health services not making reasonable adaptation
- Health checks being of variable quality

Engagement work on neurodevelopment pathways (such as Autism and ADHD) with members of the public told us that:

- People find it difficult to find the right support for services and that these are not easily accessible.
• They have been subjected to a range of prejudices about their needs and presenting behaviours and that neurodevelopment conditions still remain misunderstood within health and care.

• Girls and women are overlooked and underdiagnosed.

• For people with neurodevelopment disorders diagnosis is a crucial milestone and important to help people to take control of their lives.

• Adults receiving a diagnosis tend to have also experiences wider mental health problems and that sometimes their mental health needs have reached crisis points before their neurodevelopmental needs have been diagnosed.

What our stakeholders and our staff tell us

Providers, practitioners and clinicians tell us that there is an opportunity to improve services through more joined up commissioning and improved clinical alignment. One particular area of opportunity is to improve the experience of young people transitioning between children’s and adult services through earlier planning and improved alignment between services.

How are we going to deliver?

Each of our priorities have detailed local delivery plans and achievement of these are monitored by our local programme boards.

Improving our neurodevelopmental disorder pathway

We will respond to people’s experience of neurodevelopmental disorder services by:

• Taking action now to reduce waiting times for assessment and diagnosis

• Co-producing a more coordinated and integrated approach.

Waits for autism assessment and diagnosis are too long and we are working with the provider of autism assessment and diagnosis to reduce the number of people of waiting from over 440 to 150 during 2020. Norfolk County Council and the CCGs commission the assessment and diagnosis service together and are currently working to develop a plan to reduce waiting lists further in 2021.

The CCGs and Norfolk County Council are also working on a plan to co-produce a new integrated neurodevelopmental disorder pathway with the support and input from our autism partnership board. This plan for how this will be carried out will be in place by early 2020. This work will be undertaken with colleagues in Children and Young People’s services, so that there is an all age approach.

The new pathway will start to be implemented in 2021.

Case history

Currently Emily might wait over 200 weeks for an autism assessment and diagnosis, after which there may be further waits for mental health treatment or social care assessment.

In the future she will be offered information and advice before her assessment, which she will receive within 12 weeks of referral.

After a diagnosis of autism, she can have up to three sessions of one to one support to understand the diagnosis and develop a personal plan. Her family will be offered autism awareness training.
If Emily needs further support after her diagnosis there will be clear pathways to ensure timely access to social work assessment and mental health treatment.

**Improving services for people with learning disabilities and / or autism who also have mental health needs and / or behaviours of concern**

Commissioners, providers and Norfolk and Suffolk County Councils are working together to develop a new coordinated pathway for people with learning disabilities and / or autism with mental health needs and / or behaviours of concern across Norfolk and Waveney.

The intention is to make improvements to existing services in 2020, including:

- Working with existing providers to ensure that their services are more aligned and coordinated.
- Working with our local providers to improve the quality of existing specialist hospital placements.
- Developing and implementing a behavior support strategy based on the roll out of positive behavior support training. This will include staff working in NHS providers, social care and in community providers such as supported housing and day services.

During 2020 we will work with people, families, providers and practitioners to develop a new whole system approach, which will be implemented from 2021. We will work with the newly established engagement group that supports the transforming care board to develop the underpinning principles. Project groups made up of clinicians and commissioners will work with stakeholders including the engagement group, to design the model and service.

The aim is to:

- Provide enhanced and skilled step up support for people in crisis and ensure the right hospital treatment is available when needed.
- Ensure we have the right skills to support people whose behaviour is especially challenging and that this support is available 7 days a week.
- Improve our services for people with learning disabilities and / or autism who are in contact with the criminal justice system.

In the future our services will work together to provide a quicker more targeted response when there are behaviours of concern.

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**Case history**

Mark has a complex learning disability and finds verbal communication difficult. He lives at home with his family but has enjoyed regularly participating in day time activities. His family and the service he goes to during the day have contacted the social care team to raise concerns about changes in his behavior, particularly towards family members and other people using services.

The social worker talks to a positive behavior specialist in the Integrated Community Learning Disability Team. They meet with Mark, his family and the services he attends to understand what might be causing the change in Mark’s behavior.

The behavior support specialist creates a behavior support plan and provides advice, guidance and training to his...
family and care providers about the plan and what they need to do to support Mark. His family and the provider make the changes including in the behavior support plan and concerns about Mark’s behavior reduce. He is able to return to the activities he has always enjoyed.

**Improved access to physical health care for people with learning disabilities**

Alongside the creation of a new pathway for people with mental health needs or behaviours of concern, we shall also work with the providers of our specialist community health learning disability teams in Norfolk and Waveney to redesign their service.

A key principle will be that specialist teams provide care and treatment when people need specialist care and treatment. The teams will support primary care when people’s physical health care needs could be not met in mainstream services.

We anticipate that the future service will include a new role, which will work with mainstream services to help them to make changes and provide training so that they can work with people with learning disabilities and/or autism. We will also develop a single point of access to ensure that people are able to access the right support, from the right professional at the right time.

A new action group has been established to respond to LeDeR reviews and implement immediate actions across Norfolk and Waveney. This group will be active through the period of the long term plan, working across the system to make changes that will reduce the health inequalities experienced by people with learning disabilities.

**Improved community services for people with learning disabilities and autism**

The CCG is working with Norfolk and Suffolk County Councils to develop and improve community services. In Norfolk we are working with our day service providers to remodel our day activity offer. Engagement in 2019 has led to the development of a three pathway approach:

- **Pathway 1 - Wellbeing Pathway** will support people with complex and challenging needs, which often require specialist equipment and facilities as well as specially trained staff. This pathway is for people who are more dependent on care, whose outcome is not work and employment, but is about meaningful activity, social support and care.

- **Pathway 2 - Promoting Independence Pathway** will support people to develop life skills; providing greater opportunities to access mainstream activities and take part in training or learning activities. Life Skills include: cooking, shopping, use of technology, using public transport, social and personal customs.

- **Pathway 3 - Skills and Employment Pathway** will support people into employment through a tailored employment and outcomes plan. This will include volunteering placements, work experience and training and education as a step to paid employment.

We will work with providers to support them to make the changes needed to implement this new approach during 2020 and 2021.

We will also be publishing and implementing a new accommodation strategy for people with learning disabilities in 2020. This will be implemented over the lifetime of the long term plan. There will be a strategy for Norfolk and a strategy for Suffolk that covers Waveney. It will describe the future supported housing models we plan to develop and identify where there are new services we want to commission.

Across Norfolk we will be launching a behavioural support strategy in 2020 and it will be implemented in 2020 and 2021. The strategy will describe how we plan to embed skills to support with behaviours of concern in our whole workforce, in the community, NHS and in Norfolk County Council. It is anticipated that a workforce skilled in positive behavior support will be built in to NHS and community contracts in 2022 and 2023.

Suffolk is developing and implementing a workforce skills plan for learning disabilities, with a focus on enhancing the skills and capacity within community services. It is building on the “learning disabilities core skills, education and
training framework”. It will support community providers to access the right type and level of support to best meet the needs of the people they support, underpinned by guidance in the framework.

How we will ensure this is clinically led

Our approach to engagement is to listen to the views of all stakeholders, people, families, clinicians and practitioners. We shall ensure that clinicians are active participants in all that we do and are central to the design and delivery of existing and new services by ensuring they are involved and shape our engagement activity and participate in our project and steering groups and our governance boards.

Clinical oversight of the learning disability, autism and ADHD programme is within the portfolio of Norfolk and Waveney Clinical Commissioning Group’s Chief Nurse. The Chief Nurse is supported by a Director level Senior Nurse to ensure sufficient focus. Both are members of the Transforming Care Health and Wellbeing Board, which takes a broad view of learning disabilities and autism and coordinates the programme of work across health and care. There is a jointly appointed assistant director for learning disability and autism commissioning that works across Norfolk County Council and the Clinical Commissioning Group to ensure work is well coordinated.

Reports and updates are provided to the quality committee where changes are proposed and significant decisions are made via executive meetings and Governing Bodies.

There is a joint learning disability and autism quality improvement plan. This includes the learning from the LeDeR reviews, learning disability strategy and autism strategy. Implementation of this via the learning into action group which consists of clinicians, local authority and experts by experience.

What is the impact on the wider determinants of health?

A choice of good quality homes and housing that support and enable independence are priorities for both our local autism and learning disability strategies. People told us about the importance of a home that enables them to feel safe, independent and connected with their local community. Norfolk County Council and Suffolk County councils are developing new accommodation strategies for learning disabilities and working with partners to improve access to general needs housing.

People with learning disabilities and autism in Norfolk and Suffolk as less likely to have paid work than in other parts of the country. Norfolk County Council will be working with the day service market to remodel their services so that they have a greater focus on wellbeing, employment and skills. There will be a new contract in year one and implementation in years 2 and 3 of the plan. In Waveney, the new Work Well Suffolk employment service is due to be launched at the beginning of 2020.

How will we engage going forward?

Our learning disability and autism partnership boards are key partners in helping us develop our engagement approach to all of our new developments. They use their own networks to ensure we engage widely and advise us about how, where and when we can most effectively co-produce.

The Norfolk Autism Partnership Board was launched in 2018 and has active working groups, including one focusing on autism diagnosis and assessment which will support the development of a new neuro-developmental disorder pathway and another focused on supporting and developing engagement strategies.

The Learning Disability Partnership Board continues to develop its approach so that it is an active, independent place to support engagement and to provide scrutiny and challenge. There is no equivalent board, at this time, in Suffolk covering Waveney.
What does this mean for our workforce?

There are a number of workforce implications and issues that will need to be addressed in taking forward this work:

- We have an aging workforce which potentially creates skills gaps in some disciplines, in particular learning disability nursing.
- There are challenges in recruiting to many health and social care roles within learning disability and autism services across Norfolk and Waveney, in clinical, social work and care sector roles.
- The new models being proposed will require skills that do not exist within our current workforce in particular supporting complex needs including behaviour support and assessment. Whilst we are developing a strategy to support the roll out of positive behaviour support across our system this will need to be an ongoing piece of work.
- Our specialist learning disability and autism services need to work with mainstream services in Norfolk and Waveney so that more people can access mainstream physical and mental health services.

There is a workforce development plan in place to develop market skills to work with people with mental health problems and behaviours of concern and Norfolk County Council is leading work to develop a market facing behavioural support strategy in year one of the long term plan, with the roll out of training during years 2 and 3 of the plan.

The recently awarded European Social Fund monies for the Developing Skills for Health and Social Care programme across Norfolk and Suffolk will offer a range of modules/qualifications. These include learning disability and autism. The project board is currently in discussions to agree the development of Learning Disability and Autism modules that fit with the core skills framework competencies. The aim is to offer a blended learning approach, using work-based and distance learning and utilising digital technology in order to minimise traditional barriers to accessing learning, such as transport issues and work release.

Together these approaches will ensure that we are working towards our goal of being the best place to work in health and care professionals.

What does this mean for our technology?

In order to meet the ambition and expectations of both our national and local requirements we have the following opportunities and challenges to address:

- Under the accessible information standard all NHS and publicly funding social care organisations are required to ensure that communicate with people in way that meets their specific needs. (See https://www.england.nhs.uk/ourwork/accessibleinfo/). Across our health and care system we will need to ensure that the systems used to capture individual’s health and care records and produce letters, plans and reports are able to produce them in a flexible formats such as easy read and large print.

- Ability to share and coordinate information across health and care partners in and out of hours to ensure an integrated experience of care (in and out of hours). Currently specialist learning disability community services record on systems not used or accessible by mainstream physical and mental health services out of hours.

- Technology support for a single point of access for specialist learning disability services across multiple partners will be required. It will need to interact with the different patient record and recording systems used across social care, primary care, mental health services and hospitals. It is needed to ensure that people access the right service at the right time and so that individuals, practitioners and clinicians do not need to navigate multiple points of access to ensure people get the care, treatment and support that they need.
• National roll out of the reasonable adjustment flag, which is a note on an individual’s record of any changes they need in the way a service is delivered, such as large print appointment letters, longer appointments or interpreters e.g. Makaton.

What does this mean for our buildings?

Over the next three years we will be reviewing our existing specialist hospital accommodation serving Norfolk and Waveney, to see if it will be able to meet future needs. There is also an opportunity to improve coordination through increased co-location of services. More widely, mainstream health and social care estate will need to consider the reasonable adaptation it needs to make to support people with learning disability and autism.
Cancer

Our local priorities for Cancer

Our priorities for cancer care in Norfolk and Waveney are to prevent as many people as possible from developing cancer, but for those that do, to deliver the improvements outlined in the NHS Long Term Plan around increasing cancer survival and increasing the number of cancers diagnosed at an earlier stage:

“From 2028 55,000 more people in England will survive at least five years following a cancer diagnosis” To achieve this about 70% of cancer patients would survive for five years after their diagnosis instead of the current level of 55.5% in England (2015). Our current five-year survival in Norfolk and Waveney is 53.8%.

“By 2028 75% of cancers are diagnosed at an early stage (stage 1 or 2)” Currently the proportion of cancer patients diagnosed at stages 1 and 2 is in Norfolk and Waveney is 53.5%.

The above priorities contribute to our system-wide goals in the following ways:

Our priorities are in line with national NHS cancer objectives and link to our wider system goals in the following ways:

- **To make sure that people can live as healthy a life as possible** - Health inequalities relate to those differences in health between groups of people that are may be avoidable or unfair. We aim to address these inequalities to both reduce the risks of getting cancer and improve the chance of successful treatment and survival.

- **I only have to tell my story once** - This is especially important for people affected by cancer as repeating their story can be stressful and anxiety provoking. We are working in partnership with primary and secondary care providers and the voluntary sector to provide a more structured approach to supportive cancer care and to improve communication about cancer care and treatments.

- **For Norfolk and Waveney to be the best place to work in health and care** - We know that due to our increasingly old population we will need more staff to diagnose, treat and care for people affected by cancer. We need to both retain our current staff as well as planning for this additional workload to ensure that our system is an attractive place to work. We are working in partnership with the East of England Cancer Alliance and our STP workforce leads to understand our workforce requirements and forward plan for these.

Our local system

Our cancer diagnostic and treatment pathways are provided in partnership between hospitals called Cancer Units, Specialist Centres and Tertiary (very specialist) Centres.

Our local Specialist Cancer Centre is the Norfolk and Norwich University Hospital (NNUH) and referring Cancer Units are the James Paget University Hospital (JPUH) in Great Yarmouth and the Queen Elizabeth’s Hospital (QEH) in King’s Lynn. There are also a smaller number of patients who go to Addenbrookes, West Suffolk and Ipswich Hospitals. Tertiary cancer care is provided in Addenbrookes, Birmingham and London. Community based cancer care is provided by primary and community care practitioners from GP surgeries, Norfolk Community Health and Care (NCH&C) and East Coast Community Healthcare (ECCH).

How is cancer care commissioned (paid for)?

NHS England Specialist Commissioning commission cancer services for children, young people and teenagers, for people effected by rarer cancers and for chemotherapy and radiotherapy. Public Health England commissions cancer screening services and smoking cessation. The remaining cancer services are commissioned by our five Norfolk and Waveney Clinical Commissioning Groups (CCGs).
Joining it all together

Our Norfolk and Waveney partnership is currently part of the East of England (EOE) Cancer Alliance but following a review by the National Cancer Team we will become part of a smaller North EOE Cancer Alliance together with our partners in Cambridge and Peterborough and Suffolk and North East Essex. We have a Norfolk and Waveney Cancer Locality Group which brings together the people who run cancer services, the commissioning organisations that pay for them and the people who use them – patients and carers.

Making improvements in cancer care

Working together, across Norfolk and Waveney means that we can make services fairer, more consistent, better quality and cost effective. Our cancer transformation programme is supported by national cancer funds, Macmillan Cancer Support and Cancer Research UK (CRUK).

Our local challenges and successes

As a local system we have seen good improvements in cancer care for our patients, whilst recognising we need to do more to improve outcomes and to meet with NHS national cancer ambitions. Prevention, personalisation, and population health lie at the heart of all the opportunities we have to better the care we provide in this area.

Our successes

We have introduced the Faecal Immunochemical Test (FIT) for use by primary care in lower risk patients who have gut symptoms. This identifies tiny amounts of human blood in stool which can be caused by a cancer. Patients with a positive FIT test will then go on to have an urgent referral.

Case study: A 58-year-old lady went to her GP because she had noticed a change in how her bowels had been working over the past few months. Her GP could not find anything on examination and so requested a FIT test. This came back positive and her GP referred her for urgent investigations at the hospital. She underwent a colonoscopy (camera test of the lower bowel) which showed an early cancer of the bowel. Following this she was able to have a curative operation to remove the cancer.

Our challenges

- To support our population to make lifestyle changes that will reduce their chance of developing cancer such as stopping smoking, reducing their weight and having a better diet.
- To increase the uptake of screening to pick up more cancers earlier. To do this we need to both address the falling trends for cervical and breast screening and increase further our bowel screening uptake. Current coverage and uptake varies across Norfolk and Waveney:
  - the national target for bowel screening is 60%, current local CCG performance ranges between 58.4%-60.9%
  - the national target for breast screening is 70%, current local CCG performance ranges between 60.7% to 66.7%
  - the national cervical screening target is 80%, current local CCG performance ranges from 71.3% to 77.7%
- To increase further the uptake of Human Papilloma Virus (HPV) vaccination to prevent cancers developing that are caused by this virus. The national HPV target is 80%, the current performance for Norfolk is 85.3% but the vaccination is due to be introduced for boys too¹.
- To make our population more aware of the signs of cancer so that they will go to their GP sooner, to have tests arranged to either confirm or rule out cancer.
- To reduce the variation in clinical outcomes by making sure that all our population have access to the best possible care. Related to this we must support our hospitals in achieving national cancer performance targets

¹ The Long-Term Plan: Five year planning for cancer Data Pack East of England North Cancer Alliance Aug 2019
including the new Faster Diagnosis Standard where from April 2020 patients referred with suspected cancer should have tests performed and informed of the results within 28 days.

- With our older population and the increasing number of cancers being diagnosed we must increase our cancer workforce so that patients can be tested and, if required, treated for cancer as soon as possible.\(^2\)

**What the public tell us**

There is an annual National Cancer Patient Survey\(^3\) in England to assess patient experience of cancer care. This survey generates hospital-based reports which our hospitals review with patients and carers to create a local action plan to improve patient experience. Key themes from the national survey include variation in:

- The quality of communication and care throughout cancer tests and treatment
- The time it takes for patients to be told if they have cancer or not
- Patient involvement in decision making
- The levels of information and support given to patients by both primary and secondary care (holistic needs assessments, cancer care reviews and personalised care plans)
- Access to a clinical nurse specialist.

In addition to the analysis of the national survey we have held two baselining patient and carer engagement events in King’s Lynn and Great Yarmouth, with a third planned.

Case study: Queen Elizabeth Hospital (QEH): One Hundred Voices in 100 Days\(^4\) Themes that emerged include communication, information and support, travelling for treatment and end of life care. These themes have set the priorities for the user group to bring to the attention of organisations designing and delivering cancer services. Approximately 50 patients and carers attended.

We have engaged with different communities and found that they may have particular difficulties accessing cancer care, for example; the Gypsy Roma Traveller community, the Portuguese speaking community in Great Yarmouth and Waveney, the West Norfolk Learning Difficulties (LD) Community and people affected by Mental Ill Health.

Case study: We are aware that there is variation in access to cancer screening and poor cancer outcomes for the learning difficulties (LD) community. Therefore, we are working with local LD nurses, voluntary sector advocates and the LD community in West Norfolk to explore the barriers and to co-produce how these can be overcome.

We have patient/carer representatives on our decision making group (our Cancer Locality Group) and project steering groups. We also have a partnership/system-wide cancer engagement group which brings together the patients and carers involved in our programme to inform all of our engagement work.

**What our stakeholders and our staff tell us**

Our Cancer Locality Group is our main decision making and stakeholder group. This meets bi-monthly and includes senior representation/involvement from local hospitals, commissioners, patient and carer representatives, the East of England Cancer Alliance, third sector partners and Healthwatch. We ensure that all programme decision making is open and transparent. Our group has reinforced how vital it is to plan for the increasing numbers of cancer patients

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\(^2\) The Long Term Plan: Five year planning for cancer Data Pack East of England North Cancer Alliance Aug 2019

\(^3\) http://www.ncpes.co.uk/

\(^4\) https://www.lynnnews.co.uk/news/appeal-to-hear-100-voices-in-100-days-to-shape-future-cancer-services-9043836/
particularly as it already very testing for clinical teams to meet the national cancer target of diagnosing and treating cancer patients within 62 days. We are developing robust system-wide workforce plans to ensure we have enough staff and the Norfolk Imaging Alliance (the three hospital radiology leads) are leading work to plan for the right amount of diagnostics.

The national priorities we must deliver

See our ‘plan on a page’ for cancer below which outlines the key national requirements we must deliver on.

How are we going to deliver?

Our local plan on a page

We need to make improvements across a number of areas in order to enable more people to be diagnosed faster and at an early stage and to improve five-year survival. At the same time, we want our patients to have a better experience of care. These improvements are described in our delivery plan (See Cancer appendix 1). We will set trajectories (targets over time) for our improvements which we will develop in conjunction with the Cancer Alliance. To do this we will use the most up to date cancer information we have for Norfolk and Waveney with the expected changes we will see due to our actions. Our planning has been informed by the “Long Term Plan Cancer Data Pack” produced by the EOE Cancer Alliance.

The major areas of work within our delivery plan are as follows;

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1. Reducing the risks of getting cancer:
We will work in partnership with Primary Care Networks, local cancer support groups, Norfolk and Suffolk Public Health, Active Norfolk, OneLife Suffolk and East Coast Community Healthcare Smokefree Norfolk to:

- Promote living healthily
- Protect against cancer by promoting the uptake and coverage of the HPV vaccination.
- Offer cancer patients tailored advice on healthy lifestyles to support their recovery and reduce the risk of their cancer coming back.

2. Increasing the number of patients diagnosed with an earlier stage cancer:
We will achieve this by:

- From Summer 2019, we are supporting public health (PH) to support the FIT test being used in the national bowel screening programme. And we are supporting PH to extend the HPV vaccination offer to all boys aged 12 and 13 years old.
- By 2020 HPV primary screening for cervical cancer will be implemented (led by Public Health). 2020-2025: Local plans will be in progress to improve uptake and coverage by addressing inequalities, improving access and reducing variation as agreed with PCNs and local actions following the national screening review. Local plans will include; developing new ways of inviting people for screening/follow up and working with different communities/advocacy groups.
- Increasing our population’s awareness of the signs and symptoms of cancer. We will continue to support the National “Be Clear on Cancer” campaigns but also will work with groups of patients e.g. the travelling community and Learning Disability patients and their carers to encourage them to seek advice at an earlier point.
- Increasing the number of people taking up screening for cervical, bowel and breast cancer in partnership with Public Health, Cancer Research UK and Macmillan Cancer Support. We will consider the recommendations and local implications of the “Report of the Independent review of adult screening programmes in England, October 2019” and work with Primary Care Networks to help them understand the variation in uptake of breast, bowel and cervical screening of their local patient populations and the evidence-based interventions that can improve this.
- Work with NHSE/PHE to address system capacity to ensure consistency in achieving performance standards in Breast Screening services across Norfolk and Waveney.
- Supporting clinical directors of Primary Care Networks to achieve the National earlier cancer diagnosis DES.
- Implementing Lung Health Checks as soon as possible when they are extended to our area by the National team. Until then we will explore piloting new innovations to screen our highest risk populations which has potential also to reduce health inequalities.

3. Making it quicker for patients to access to tests to either confirm or rule out cancer through:

- 2020/21 continued partnership working with local hospitals to support their implementation of the nationally defined best practice diagnostic pathways for people affected by lung, colorectal, prostate and oesophago-gastric cancers). This will also support their implementation of the new 28 day Faster Diagnostic Standard (FDS). This work will include implementing nurse led triage, straight to test, one stop cancer clinics, whole system multi-disciplinary teams (MDTs), a system-wide cancer dashboard, more efficient radiology and cellular pathology, and investment in diagnostic equipment.
• We will bid for national resource to support a Rapid Diagnostic Centre (RDC) service across our system. This will link to local Diagnostic and Assessment Centre planning. We will also pilot of use of lung cancer biomarker for at risk population.

2020/21: Implementation of RDC clinic service in Centre (NNUH) for vague symptoms and lung pathway (linked to local DAC planning). Roll out of use of lung cancer biomarker (depending on evaluation).

2022/23: Roll out of RDC clinic service at JPUH and QEH for vague symptoms and lung pathway (linked to local DAC planning). Roll out of use of lung cancer biomarker (depending on evaluation).

2023/24: Primary Care Networks (PCNs) working to national Direct Enhanced Service (DES) to support earlier diagnosis for their populations. Roll out of RDC across the partnership for other tumour type pathways (linked to local DAC planning). Plans for roll out of targeted lung health checks (linking to evaluation of lung cancer biomarker pilot).

2024/25: Roll out of RDC across the STP for other tumour type pathways. Implementation of targeted lung health checks in our STP (linking to evaluation of lung cancer biomarker pilot).

• We will pilot the use of capsule endoscopy.

• Achieving the new 28-Day “Faster Diagnosis Standard” (FDS) for suspected cancer referrals. We will do this by increasing:
  - Nurse-led triage of urgent referrals.
  - The number of patients that are booked direct for tests to determine if they have a cancer or not.
  - Better imaging techniques.
  - The number of One-stop Cancer Diagnostic Clinics to enable patients to have all the tests they need on the same day and by introducing:
    o Whole system multi-disciplinary teams.
    o A system-wide cancer dashboard.
    o More efficient radiology and cellular pathology.
    o Greater investment in cancer diagnostic equipment.

4. Improving treatment:

Once someone is diagnosed with cancer they should have access to the best possible and most innovative care available. This care is evolving all the time and often links into international trials of new treatments and technical innovations. We will work with clinical teams, NHSE Specialised Commissioning and the Eastern Academic Health Science Network to:

• Improve patient access to clinical trials and introduce innovations as soon as possible.

• Extend the use of molecular diagnostics and genomic testing and introduce innovations in chemotherapy, radiotherapy and immune-therapies.

• Work with the East of England Radiotherapy Network to support the implementation of the new specification for radiotherapy and with Specialist Commissioning and local hospitals to implement the new children’s specification and to improve uptake of clinical trials for teenagers and young adults.
  - 2020/21: Radiotherapy network in place. National radiotherapy specification implemented. Children and young people’s national specification implemented. Local plans to achieve clinical trials participation rate of 50% for children and young people. Whole genome sequencing beginning to be offered to all children with cancer.
2021/22: Local plans to achieve clinical trials participation rate of 50% for children and young people.

2022/23: Local plans to achieve clinical trials participation rate of 50% for children and young people.

2023/24: Local plans to achieve clinical trials participation rate of 50% for children and young people. Whole genome sequencing offered to all children with cancer.

2024/25: Clinical trials participation rate of 50% for children and young people.

- Work collaboratively regarding cancer genomic testing, pathways and local testing providers in line with the National Genomic Test Directory, Medicine Service and Genomic Laboratory Hubs in order to offer more extensive genomic testing to patients who are newly diagnosed with cancers.

5. Providing increasingly personalised care:

We want everyone to have the right support to live as well as possible while they have cancer treatment, and after treatment has finished. This support has to meet individual patient needs, to help patients plan their care, to provide advice about the care and support that is available to meet their individual needs, and how to maintain their health and well-being. We will offer cancer patients personalised care to include the following:

- 2020/21:
  - Everyone diagnosed with cancer has access to personalised care (recovery package: holistic needs assessment, care plan, health and well-being information and support).
  - Site specific protocols for personalised follow up/IT remote monitoring for breast, colorectal and prostate pathways.
  - Partnership working with PCNs to improve quality of cancer care reviews. Implementation of quality of life measure.
  - Pilot of community cancer nursing services providing treatment and supportive care closer to home.
  - Baseline access to psychological support, healthy lifestyles choices and preventing/managing consequences of treatment.

- 2021/22-25:
  - Introduction of further site specific protocols for personalised follow up/IT remote monitoring for additional tumour site pathways.
  - Ongoing partnership working with PCNs to improve quality of cancer care reviews.
  - Local plans to improve access to psychological support, healthy lifestyles choices and preventing/managing consequences of treatment.
  - Roll out of community cancer nursing services.
  - Introducing the new national quality of life measure.
  - Supporting cancer patients who experience long term effects of cancer treatment Improving local lymphoedema services.

6. Ensuring we have a sustainable workforce:

We have a local workforce project with the EOE Cancer Alliance to identify our current cancer workforce in our STP and what we will need in future years.
• 2020/21:
  o Local project with GE/Alliance to identify current and future view of cancer workforce in our STP. This includes reviewing how different types of clinician could provide cancer care for our patients – future models of care.
  o Our workforce leads will develop a local plan to implement the recommendations from the Alliance project in partnership with providers and commissioners.
  o National initiatives to recruit an additional 1,500 new clinical and diagnostic staff across seven priority specialisms between 2018 and 2021. All patients have access to a CNS/Support worker.

• 2021/22-2024/25: Implementation of recommendations from GE/Alliance project in partnership with providers and commissioners.

7. Improving patient experience:

• 2020/21:
  o Hold patient engagement event in each locality and agree shared methodology for analysis of National Cancer Patient Survey.
  o Support cancer service user group in each locality. Maintain STP patient engagement group to coordinate health inequalities projects (above).

• 2021/22-2024/25: Work with providers, cancer service user groups, STP engagement group, and voluntary sector to improve patient experience.

8. Reducing inequalities:

• 2020/21: Baseline inequalities in access to cancer screening treatment and care.

• 2021/22-2024/25:
  o Implement local plans to address inequalities and reduce variation in partnership with PCNs for people from the LD and GRT communities, people whose first language is not English, people affected by mental health issues and the homeless.
  o Working across our three hospitals to ensure that as far as possible patients have equity of access for care and quality of care.

• We will work with Public Health to focus on reducing lifestyle risks for our patients, particularly those in our most deprived communities. We will actively seek funding support to allow introduction of innovations such as Early Detection Tests for lung cancer to target our most at risk patients ahead of the National Lung Screening Pilot.

9. Evaluating impact

• 2020/21: Agree approach to evaluation and commission dedicated support to ensure that the actions we are taking will help us achieve our priorities and those within the Long Term Plan.

• 2021/22-2024/25: Data sharing and IG process to support STP evaluation of implementation of LTP ambitions.

We have an agreed approach to evaluating our cancer plan and have commissioned dedicated support from our Primary care research team for the evaluation.

Our senior leaders and our system cancer locality group will monitor and oversee our progress.
How will this be clinically led?

Our overall system-wide cancer programme has a dedicated Clinical Lead who is a senior doctor. Each separate cancer workstream within the programme has named clinical leads from each hospital and we have working groups with consultants, specialist cancer nurses, radiographers, our Macmillan GPs and the Local Medical Committee. We have support from our local Public Health consultants. We will work with the clinical directors of the new Primary Care Networks (groups of GP surgeries working with other community services, including mental health) to help them in their work to support earlier diagnosis of cancer.

What is the impact on the wider determinants of health?

Poor outcomes for cancer are often linked to areas of socio-economic deprivation. These communities may also encounter challenges with poor housing, being able to afford a healthy diet, gaining employment and zero hours working – which can make attending health appointments such as screening a challenge. We are using the cancer information we have with the information from our Public Health team to make sure that we try and reduce the gap in health outcomes (how long people live and how long they live in good health) for people in our areas of socio-economic deprivation.

How will we engage going forward?

We want to be sure that patients experience the best possible cancer care in Norfolk and Waveney. We already work with Healthwatch, local and national cancer charities, and local patient groups in our work but we want patients and carers and local communities to be more involved in making changes for the better. This will involve:

- Leading transformation: patients and carers participating in clinical groups that drive our transformation work.
- Decision making: patients and Healthwatch being members of STP Cancer Locality Group.
- Collecting patient stories and holding engagement events: to learn from patient and carer experiences and how working together can help to make things better.
- Working with different communities: to work out how we can adapt our cancer screening, diagnostic, treatment and supportive services to make them more accessible and suited to individual needs.
- A shared approach to analysing patient experience (via the National Cancer Patient Survey): to work with our patient groups across the STP in a consistent way to use this information to improve our care.

What does this mean for our workforce?

We need to adapt our approach to cancer workforce design and planning to make sure our patients receive the care they need and our wider clinical workforce can be supported to extend and diversify their skills. This includes the development of a range of new nursing and allied health professional roles for example nurse practitioner roles, associate clinical nurse specialists, consultant nurses and radiographers, community cancer nurses, pathway navigator and co-ordinator roles. We will work with Health Education England and the EOE Cancer Alliance to do this. We are currently analysing our local cancer workforce data to develop a five-year cancer workforce strategy; this work will include consideration of a range of options to support more robust operational delivery of cancer care across the area and the new care models and technologies which are emerging. We will work across the STP on shared recruitment and retention initiatives.

What does this mean for our technology?

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6 The Long-Term Plan: Five year planning for cancer Data Pack East of England North Cancer Alliance Aug 2019
Our digital infrastructure is poor and this needs to be developed to support safe and effective cancer care as well as allowing new innovations such as Artificial Intelligence (AI) to be introduced. At a patient care level, we must invest in digital solutions to support clinical decision making, electronic health and social care records and image transfer between our hospitals. AI has enormous potential to support the analysis and more effective deployment of diagnostic and treatment capacity for the demand and patient flow across our system-wide cancer pathways.

We have been able to access some national transformation money through the East of England Cancer Alliance to start the partial establishment of a digital histopathology service at the Norfolk and Norwich Hospital. We will seek further investment to fully establish this which will also support a more sustainable histopathology workforce.

**What does this mean for our buildings?**

In order to realise our priorities as outlined we will need to consider how our current building stock can support the roll out of both the rapid diagnostic assessment centres and cancer “one stop shop” clinics.
Children and young people

Our local priorities for children and young people

Norfolk and Waveney’s vision is that every child and young person will FLOURISH (Family, Learning, Opportunity, Understood, Resilience, Individual, Safe and secure, Health).

This is the vision of the collective system in Norfolk for children and young people (CYP) through the CYP strategic partnership board. In every decision we undertake we will ask ourselves where the FLOURISH opportunities lie.

Norfolk County Council’s (NCC) ‘vital signs’ priorities and Suffolk County Council’s (SCC) ‘every child will the best start in life’ priority align and support FLOURISH. No child or young person will be excluded and we will strive proactively to reach out to groups that may have previously been unseen or recognised.

In line with the Royal College of Paediatrics, our long term priorities for children in Norfolk and Waveney include:

- Care will be integrated allowing children and their families to access physical and mental health support seamlessly through primary, community and acute services and into adulthood. This directly impacts on our system goal: ‘to make sure you only have to tell your story once’.
- Mental health services will grow and will be underpinned by better partnership working between providers, social care, education and health. This directly impacts on our system goals: ‘To make sure you only have to tell your story once’, and ‘To make Norfolk and Waveney the best place to work in health and care’.
- Care for children with long term and complex conditions will be more accessible. This directly impacts on our system goal: ‘To make sure that people can live as healthy a life as possible’.
- Our data will be able to tell us more about how accessible our services are and what services are needed most. This includes knowing when a service isn’t working as it should be. This directly impacts on our system goal: ‘To make sure you only have to tell your story once’.
- Access to preventative support for children and families who need support with healthy eating will improve to reduce the number of children needing tier 4 support with their weight. This directly impacts on our system goal: ‘To make sure that people can live as healthy a life as possible’.
- Our collective support offer for children will be consistent across Norfolk and Waveney so that regardless of postcode, families can expect to have equal access to services to achieve similar outcomes. This directly impacts on our system goal: ‘To make sure that people can live as healthy a life as possible’.

Our local system

We estimate that 7.3% of children (age 0-18) have a disability, which equates to 14,980 people in Norfolk and Waveney. 14% of Norfolk school children have special educational needs (SEN) compared to 12.3% in Suffolk; or some 17,000 children (3,080 in Waveney). Both disability and Special Educational Needs (SEN) are more common in boys than girls. We have a wide range of universal and specialist services supporting this group, including: health, education (mainstream, special, virtual school sensory support), portage, social services, short breaks, communication technology aids and speech and language therapy (SaLT).

In 2016 there were 1,012 children in Norfolk who were the subject of a child protection plan (and therefore were ‘Children in Need’ or CiN) who were disabled. This equates to 21.1% of CiN; higher than the national average of 12.9%. 2.3% of children in Waveney are also likely to have a CiN plan.

Using Norfolk only data as an example, of those supported as CiN, 46% had a learning disability (LD) and 39% a behaviour disability and overall 17,185 school pupils in Norfolk (primary, secondary and special schools, including academies) have an identified special educational need (15,900 in state funded schools). This is 14.7% of children in primary state-funded schools children and 13.5% of children in secondary state-funded schools.

We aim to provide strong leadership around the development of primary care networks (PCN) and integrated care across our secondary care services. Using our shared understanding of the challenges facing our children and young people and recognising where they live will influence their opportunities access to services and life experiences, we
will collectively direct resources based on local need, to ensure all are afforded the same opportunities and support to Flourish.

Our local designated safeguarding and looked after children (LAC) team influence, advise and support this system plan to ensure it is accords with the principles of the Children Act 1989 and is aligned to the Norfolk and Suffolk Safeguarding Children Partnerships and priorities. Working as a system to ensure health and care services meet the statutory requirements of section 11 of the Children Act 2004 and ensure safeguarding is everybody’s business remains at the heart of service delivery.

Our children and young people and the wider determinants of health

Children with SEN are less likely to experience a fulfilling education, more likely to be bullied at school and less likely to leave school with outcomes that reduce their chances of living in poverty as adults. In Norfolk fewer pupils with SEN achieve five GCSE A*-C; 22% of children with identified SEN achieved this educational standard in 2014/15, compared to 62.5% of children with no identified SEN.

Research shows that children with SEN are more likely to experience poverty than others. There is a link between disability and deprivation as children from less advantaged socioeconomic backgrounds tend to be disproportionately represented amongst those with disabilities. Disabled children and their families are worse off financially and have markedly poorer standards of living than those families who do not live with disability.

Children from deprived households may be more exposed to risk factors that influence their chance of experiencing disability such as substance misuse. As such, SEN can be a result of poverty as well as a cause of poverty, and experiencing deprivation has significant impacts on physical, mental health (MH) and wellbeing. Poor access to early intervention services may impact on a child’s ability to access education and support to progress alongside their peers. This can have an adverse impact on mental health and wellbeing, and cause disruption to studies later on.

Children and young people with unmet needs are more likely to enter the criminal justice system which in turn affects future employment and housing opportunities.

Families tell us once they are in services the offer is good, however the journey to getting into services can be difficult.

Our local successes

Our local system recognises the importance of children and young people and this is reflected both in the seniority of leadership and the priority given to collaboration as a key measure of excellent care.

The partnership workstream for children and young people is chaired by the Executive Director of Children Services from Norfolk County Council, supported by the joint appointment of an Associate Director for Children and Young People across the Clinical Commissioning Groups and Norfolk County Council, to embed and oversee the integration agenda.

Our system and its leaders are passionate about children and young people services and committed through joint forums to work together and support each other delivering high quality safe services for to support them to flourish.

The Norfolk and Waveney Children, Young People and Maternity (CYPM) team has been in operation since 2017. This has helped to identify gaps and inconsistencies in services and subsequent opportunities to address them. Recent successes include commissioning talking therapies for children aged 0-11 who have experienced sexual abuse, enabling children older than 9 years to be referred for assessment for development coordination difficulties and working systematically through individual provider contracts to implement new ways of measuring the impact of our services for children with SEND.

Joint pieces of work in progress, include:

- Speech and language services commissioned services and subsequent review (CYP appendix 1).
- Joint strategies across health and care to improve services for children and young people with autistic spectrum disorder (ASD) (See CYP Appendices), SEND (See CYP Appendices).
• Additional joint investment to meet service need and create consistency across Norfolk and Waveney.
• A joint review with our local authorities into occupational therapy (OT).

Our challenges
The opportunities that now need to be explored include understanding the scale of work required to deliver alongside competing priorities. Coupled with this, waiting times for treatment are too long and we must build our workforce to ensure children and young people have access to services appropriate to their needs in a timescale that does not delay development and affect wellbeing.

Working across the system we will develop shared ownership and understanding of what matters to children and young people. This will support improved outcomes, quality and safety.

What the public tell us
The experience of our children and young people and their families is pivotal in driving forward transformation and we have many examples of where we have listened to and acted upon feedback given which have been provided as appendices.

We have heard the following:
• Accessing support is confusing across our community health services
• We need to be able to build on what’s working well quickly
• Families want access to a named individual to help them navigate the system
• Our services focus too much on process and not outcomes
• Local decision making has created differences in localities in how to access services and what services are available
• Making decisions that impact on front line services can take too long

In 2017 school children were consulted as part of the secondary health-related behaviour questionnaire from Schools Health Education Unit (SHEU) to inform how providers could develop their services (See CYP Appendices).

Engagement has been undertaken during 2019 in child and adolescent mental health services (CAMHS) (See CYP Appendices) and in relation to neurodevelopmental disorders (NDD). The feedback from these reports are supporting the transformation that is currently being undertaken. This includes hearing from young people who might otherwise have become lost in the system.

Family Voice (See CYP Appendices) and Suffolk Parent Carer Network (SPCN) (See CYP Appendices) are our parent carer forums for Norfolk and Waveney with Healthwatch Norfolk (See CYP Appendices) and Healthwatch Suffolk (See CYP Appendices) actively engaging with the public. All undertake surveys and results are shared to inform decision making and service developments.

What our stakeholders and our staff tell us
Our stakeholders tell us that we can do much more to improve access to assessment and treatment and in how we support families to build resilience and prevent family crisis.

Despite good engagement thus far we need to do more to listen to families and create further opportunities for feedback to inform service improvement. This includes making reasonable adjustments to give all children who want to influence change the chance to do so.

Our staff want change and we will collectively achieve it. However we must have a sustainable workforce that can manage the demand to improve system resilience and wellbeing in our skilled workforce. Working together has already improved our workforce experience and we are committed to embedding this at all levels and making Norfolk and Waveney a destination of choice for the CYP workforce.
The national and local priorities we must deliver

Special Education Needs and/or Disabilities (SEND)

Norfolk and Suffolk counties each have a SEND area strategy (See CYP appendix) that has been co-produced and published with a process to monitor, review progress and develop a self-evaluation framework (SEF).

Four priority areas have been identified:

1) SEND Journey - Children and young people with SEND have a changing presentation throughout their life journey. Simplifying pathways will support children, young people, their families and those working with them to know what to do throughout their changing needs and presentation throughout the ages and stages of their life.

2) Local Offer - Improving confidence in the Local Offer by responding to identified need and ensuring it is communicated effectively and kept under review. The Local Offer will be responsive to the needs and aspirations of children and young people, their families and professionals who support them.

3) SEND provision - Co-produce jointly commissioned, integrated, SEND services and provision and ensure sufficiency of specialist placements and services to meet the identified needs across the system.

4) Preparing for adult life - Ensure seamless transition for young people and their families into further education and employment, including support for housing, health and social inclusion. Adult Social Services and Children’s Services leadership teams have agreed to establish a 14-25 Preparation for Adult Life Service, currently being recruited to.

A transformation programme is in place in Norfolk with a £120 million investment over five years to develop at least three new special schools. This includes workstreams that will support the delivery of the four priority areas within the SEND area strategy:

- Workstream 1. SEND support and inclusion
- Workstream 2. Education health and care (EHC) plan performance improvement
- Workstream 3. Infrastructure and new provision
- Workstream 4. Alternative provision and inclusion
- Workstream 5. SEND finance recovery plan high needs block and SEND transport

There is a similar programme in Suffolk and we want to work together to ensure that children’s needs are identified and met as early as possible, where possible preventing issues from escalating.

How are we going to deliver?

To support delivery of the four priority areas and the resulting transformation programme the following has been delivered:

- NCC have increased their workforce within both the Virtual School for SEND and educational psychology services to support greater inclusion at SEN Support and to improve EHC needs assessment 20 week process, whilst making use of digital systems will improve sharing and access to information.

- Training programmes have been produced across Norfolk and Suffolk that include: writing outcome focused advice for EHC needs assessment, preparing for adult life (transition), early year’s identification and notification, Learning Disability (LD) yearly health checks and EHC appeals and tribunals. There is a rolling programme through the health system on writing good outcome focused health advice for EHC needs assessments and in contracts to complete the eLearning programme that is available to all on the Norfolk SEND Local Offer website. These are delivered and reviewed across the area to ensure that the workforce has the right skills, knowledge and competencies when working with children and young people with SEND.
A quality assurance framework has been developed to identify and deliver areas of improvement throughout the EHC needs assessment process and subsequent reviews.

We are working with our special schools to increase uptake of health checks for children and young people with LD. Our focus is on improving the awareness and identification of children and young people with a LD to then invite them for their annual LD health check at 14+. We have set-up a group and will work with young people who will be directly affected by this work.

Aligning reviews and new assessments for CYP with an EHC plans and continuing care (CC) is developing further following a successful pilot. CC patients are those who have needs arising from a disability, accident or illness that cannot be met by an existing universal or specialist service alone.

A multi-agency dashboard is being developed to assist with a shared understanding of the needs for children and young people with SEND to influence future commissioning of services and tracking of children’s outcomes.

A joint project ‘Valuing SEND’ has been commissioned by Norfolk, Hertfordshire and Oxfordshire LA’s to explore a new approach to track needs, provision and outcomes for children and young people with SEND across agencies.

Child Adolescent Mental Health Services (CAMHS)
The NHS Long Term Plan (LTP) sets out specific aspirations in relation to CAMHS:

- 345,000 additional children and young people aged 0-25 will have access to support via NHS-funded mental health services and school or college-based Mental Health Support Teams (in addition to the Five Year Forward View for Mental Health commitment to have 70,000 additional children and young people accessing NHS services by 2020/21).
- There will be a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults.
- There will be 100% coverage of 24/7 mental health crisis care provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions.
- CYP mental health plans will align with those for LD, autism, SEND, CYPs services, and health and justice.
- The NHS LTP outlines the need to develop a new approach to young adult mental health services, supporting the transition to adulthood, which creates a comprehensive offer for 0-25 year olds and delivers an integrated and evidenced-based model.

How are we going to deliver?
In response to the LTP aspirations, local need and feedback an innovative and transformational model of working is being developed based on the iTHRIVE framework and building on the commitments identified in the system local transformation plan. Instead of a tiered system that creates gaps and exacerbates waiting times, it will focus on the needs of individual children, young people and young adults.

Instead of moving a children or young person around the system, we will move the system around them. Our new approach will build on the system experience of working 0-25years. We will embrace some core principles:

- **0—25 years**: any child, young person or young adult up to their 26th birthday will be served by this approach in all settings and in all areas of Thrive methodology.
- **A focus on Thriving**: investing in early prevention and aiming to return those with difficulties to a Thriving state.
• **Working as a single system**, with shared case management, agreed goals, performance management and assessments across providers. This will enable families and young people to tell their story once.

• **Clear access routes** for children, young people, young adults and professionals working across systems removing the need to re-refer (so CYP are not moved to the end of another waiting list), if a system partner is better placed to meet the need.

• **Community Based**: serving local communities and building community capacity. We are mindful that CYP communities may not reflect a geographical location.

• **Relationship focused**: reducing ‘hand-offs’ and reducing the amount of times children and young people need to tell their story.

• **Multi-agency multi-disciplinary teams** that provide support to families, professionals, and universal settings (especially schools).

• **Goal-focused and episodic interventions**: involving children, young people and young adults in setting goals and making choices.

We have had, and will continue to have, significant engagement with stakeholders across the system, including children and young people and their families. This engagement has enabled us to progress service design to the point of preparing for implementation and testing, for what will be an iterative and developmental transformation process. The model allows for additional capacity, and considers all everyone from 0–25 as being ‘in’, with a demonstrable shift in provision to prevention, personalisation and early intervention (See CYP Appendices), including school and college-based support.

To facilitate the move towards iTHRIVE we have recently had national ‘trailblazer’ funding approved for two Mental Health Support Teams (MHST), and locally we have prioritised funding for an additional four CYP Wellbeing Practitioner (CWP) posts.

To enable the iTHRIVE approach, a new integrated governance body, the Alliance Board, will hold decision making responsibility for the CYP mental health system. The Board will be chaired by the Director of Children Services for Norfolk and in keeping with the ‘one system’ approach to the transformation of CYPMH and the wider development of Norfolk and Waveney as an Integrated Care System (ICS). Membership will include commissioners, provider organisations, education, the third sector, family networks and young person representation.

The remit of the Board is wide ranging, it is not a sub-committee of the statutory bodies, but has authority to act on behalf of the relevant bodies through the delegated authority of the Board’s members and the Section 75 Agreement between the CCGs and NCC. The Board will be supported by an Alliance agreement which will enable all members to collectively; share responsibility and accountability for strategic direction, ensure delivery, lead service transformation and assess and improve operational delivery of support to CYP MH. The Alliance will provide leadership to enable those in direct contact with CYP in their roles, to work to a jointly owned outcome framework which focusses on improving the lived experience of children and young people and supports them to reach their potential.

We routinely liaise with colleagues responsible for adult mental health transformation to not only reduce duplication but also to manage the ‘transition’ phase from 26 onwards into adult services. Where appropriate we collaborate, developing new all-age crisis pathways, for example, whilst also liaising closely with other system partnership workstream leads to ensure wider alignment. This will include our acute providers and the system collectively working on new models of care with acute crisis wrap around care as required.

Our system, including mental health, maternity, early year’s provision and the CCGs, are fortunate to currently be working with the Early Years Transformation Academy. Within this piece of work we are focusing on perinatal mental health and attachment. This work encompasses a review of current provision and what the future may look like.

There are currently a number of CYPF transformation initiatives across Norfolk and Waveney, including Children’s Services delivery model, a new Early Childhood and Family Service (ECFS), children with disabilities (CWD) and SEND transformation programme. At the same time, an NDD report has been produced with clear recommendations for change. The Director of Children’s Services is the Senior Responsible Officer (SRO) for a sixth system partnership workstream focused on CYP, and will chair the new integrated aforementioned Alliance Board governance body.
recognise the need to align collectively all transformation in order to deliver the best outcomes, making the best of the available resource.

Eating disorders (ED)
The NHS LTP sets-out that the 95% access and waiting time standards for children and young people’s eating disorder services will continue beyond 2020/21. Current performance across our system:

- Consistently meet the 95% standard for urgent referrals
- Performance against the standard for routine referrals has been improving through 2018/19 and into 2019/20 – the system combined performance for Q1 2019/20 was 92%

How will we deliver?
We will continue to work with partners to fully understand capacity and demand requirements; to ensure that there is sufficient resource to deliver evidence based support to CYP and families; to maintain ongoing achievement of the 95% standard and to develop opportunities for improving early intervention and prevention.

We recognise that in order to support CYP to have the best start in life and realise their potential it is essential that we adopt and maintain an integrated, system approach. All those who have contact with 0-25s in their daily lives have a role to play in supporting healthy development and progression to adulthood. We are committed to further developing our system approach to releasing and aligning resource to meet the needs of all our Norfolk and Waveney 0 to 25s.

Autistic Spectrum Disorder (ASD)/Learning Disability (LD)
We are committed to tackling the causes of morbidity and preventable deaths in people with a LD and for autistic people.

How will we deliver?
We will:

- Improve the uptake of the existing annual health checks in primary care for people aged over 14 years with a LD, so that at least 75% of those eligible have a health check each year.
- Pilot the introduction of a specific health check for people with autism, and if successful, extend it more widely.
- Expand the stopping over medication of people with a LD, autism or both and Supporting Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes to stop the overmedication of people with a learning disability, autism or both.
- Continue to fund the Learning Disabilities Mortality Review Programme (LeDeR), the first national programme aiming to make improvements to the lives of people with learning disabilities.
- Over the next three years, autism diagnosis will be included alongside work we are doing regarding children and young people’s mental health services to test and implement the most effective ways to reduce waiting times for specialist services. This will be a step towards achieving timely diagnostic assessments in line with best practice guidelines.
- Together with the local authority’s children’s social care and education services, as well as expert charities, jointly develop packages to support children with autism or other neurodevelopmental disorders, including attention deficit hyperactivity disorder (ADHD) and their families, throughout the diagnostic process.
- By 2023-24 children and young people with a LD, autism or both with the most complex needs will have a designated keyworker.

Initially, keyworker support will be provided to CYP who are inpatients or at risk of being admitted to hospital. Keyworker support will also be extended to the most vulnerable children with a LD and/or autism, including those who face multiple vulnerabilities, such as looked after and adopted children, and those in transition between services.
Due to increasing concerns and feedback, a review of NDD was commissioned in the spring of 2019. This review involved providers, expert charities, stakeholders, children, young people and their families. The resulting action plan and the development of a business case will not only address the workforce challenges but will include a new model of post diagnosis support.

Other key pieces of work demonstrate our commitment to the ASD and LD agenda:

- Our CYP teams remain committed to prevention and personalisation as key priorities in how we deliver care for CYP. Improving the quality, accessibility and uptake of LD health checks is pivotal in this. We are currently engaging with special school head teachers to better understand how we can better work together to achieve this goal. A task and finish group has commenced to support this, which includes education and health colleagues.

- A multi professional transforming care (TC) operational group meets regularly to discuss CYP on the risk of admission register (RoAR), as well as CYP with low level concerns (See CYP Appendices). Actions are delegated to the most appropriate attendee (usually the person who has greatest knowledge and contact with the CYP). The vision is to continue with this model as either key workers or otherwise.

**Long term conditions (LTC)**

The NHS LTP sets out its ambition for CYP and LTC:

- By 2028 the NHS will move to a 0-25 years’ service and towards service models for young people that offer person-centred and age appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.

- Local areas will design and implement models of care that are age appropriate, closer to home and bring together physical and mental health services. These models will support health development by providing holistic care across local authority and NHS services, including primary care, community services, SaLT, school nursing, oral health, acute and specialised services.

- From 2019-20 clinical networks will be rolled out to ensure the NHS improves the quality of care for children with long-term conditions such as asthma, epilepsy and diabetes. This will be achieved though sharing best clinical practice, supporting the integration of paediatric skills across services and bespoke quality improvement projects.

Across our system both CAMHS and SEND respectively cover 0-25 years of age. We recognise that adopting person centred services for CYP up to 25 across mental and physical health would be beneficial and we embrace this significant change. We recognise that support with transition (moving from children’s to adult services) is variable, at a time when wellbeing is at risk. There is an additional focus required here.

**How will we deliver?**

- We are developing integrated models of care for the CYP population as a system. Work has already commenced in this area:
  - Joint commissioning of Speech and Language Therapy has been in place for three years. This not only allows for a service model that is consistent across typical health and education boundaries, but it ensures that service changes can be implemented across the whole system using the ‘whole’ resource available. We are sighted on where resource in the system is particularly stretched and we can access expertise within the local authority to help address these challenges, including working together to resolve workforce gaps.
  - We intend to build on this model of practice with a system wide, education, social care and health review of occupational therapy, to remove the barriers that have been created through silo commissioning. Children and families should be able to access the right therapeutic support regardless of whether the referral is from a school or a GP.

- Clinical networks for particular LTCs, such as asthma diabetes and epilepsy are established and attended by providers and commissioners. These networks set benchmarks for Norfolk and Waveney and share best practice from other regions.
Cancer
The NHS LTP requires us to develop and implement networked care to improve outcomes for children and young people with cancer, simplifying pathways and transitions between services and ensuring every patient has access to specialist expertise.

How will we deliver?
Cancer services for children and young people are provided by tertiary centers in Norwich, Cambridgeshire and London, as a hub and spoke model. Locally this has, in some instances, led to a poor patient experience and we are working in partnership on simplifying of pathways and seamless movement through the region. This includes how we can ensure sharing information regarding medical interventions with providers in Norfolk and Waveney is timely.

Palliative care
Over the next five years the NHS nationally must increase its contribution by match-funding CCGs that commit to increase their investment in local children’s palliative and end of life (EoL) care services, including children’s hospices. This should more than double the NHS support, from £11 million up to a combined total of £25 million a year by 2023-24.

How will we deliver?
The Norfolk and Waveney CYP palliative care network (See CYP Appendices) works across the system to implement change and prioritise CYP palliative care. An example of the excellent work undertaken via the network has been a new hospice for children and young people, funded by charitable income, due to open in Norwich in autumn 2019 to provide much better care. Opportunities for external match-funding will be explored as part of our five year plan for children and young people.

Eyesight, hearing and dental services
Via the LTP, the Starting Well Core initiative is supporting 24,000 dentists across England to see more children from a young age to form good oral health habits, preventing tooth decay in five year olds.

How will we deliver?
System partners, particularly those who support early years, have started to implement a local strategy for the Starting Well Core initiative through the Just One Norfolk website.

The input of the Designated Clinical Officer (DCO) and deputy will be instrumental in seeking to understand how we can support this programme, using our local soft intelligence and data platforms to increase reach into special schools and community paediatric provision.

Obesity
By 2022-23, the NHS nationally expects to treat up to a further 1,000 children a year for severe complications related to their obesity, such as diabetes, cardiovascular conditions, sleep apnoea and poor mental health. The LTP is very clear in its ambition in relation to childhood obesity and its impact on physical health and the wider determinants of ill-health.

The NHS must provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a body mass index (BMI) of 30+ (adjusted for ethnicity), where the NHS can have a significant impact on improving health, reducing health inequalities and reducing costs.

How will we deliver?
Here are the actions we are taking:
The University of East Anglia Health and Social Care Partnership (UEAHSCP) Parental and Early Childhood Obesity Group focuses on pregnancy as a critical and appropriate period to target health-related behavioural changes in diet and physical activity with positive impacts across the next generations.

The Norfolk 0-19 years Healthy Child Programme (HCP) delivers a new healthy weight pathway #NorfolkCan. The universal, preventative programme focused on earlier identification and primary and secondary prevention of unhealthy weight, employing a whole family approach. The Universal Plus and Partnership Plus, target additional support and recruits a new skill mix ‘healthy lifestyle practitioner’ to work within the integrated 0-19 teams. This approach recognises parents and carers as champions of change when it comes to healthy lifestyles and wellbeing for children and young people.

Waveney is working towards a place-based pilot in Lowestoft using the Amsterdam model, working with a wide range of partners and One Life Suffolk.

This Mum Moves is a Sports England initiative aimed at supporting expectant mothers to be active during and after pregnancy. We have submitted a bid to be a pilot site with the focus on upskilling our workforce.

Our Norfolk and Waveney Healthy Pregnancy Plan is a key influencer, supporting children to have the best start in life by focusing on a preventative approach to tackle causes of poor health. The plan promotes equality targeting disadvantaged and vulnerable groups.

Work has commenced to address equality of access to tier 3 weight management services across Norfolk and Waveney. A scoping exercise has been undertaken to map the differences in pathways to tier 3 services. This work has been aligned to an STP wide work-stream to review adult pathways.

Healthy Start is a national government scheme where eligible families (pregnant women or those with a child under four years old and receive benefits or are on a low income) receive health promotion information about health eating and food coupons to exchange for cow’s milk free/frozen fruit and veg and vitamin vouches.

Immunisations

The LTP requires us to prioritise improvements in childhood immunisation and to work closely with other areas of government and key programmes such as the HCP.

Children and young people need several different vaccines to be fully protected from some diseases so it’s important that they complete their childhood immunisation programme: https://www.nhs.uk/conditions/vaccinations/

Our coverage estimates for most vaccines remain the same as in the previous four years benchmarking. They are between 90% to 95%, against England87.2% to 88.6% (See CYP Appendices).

How will we deliver?

- Coverage for MMR is 91.7%. Herd immunity, a form of indirect protection from infectious disease that occurs when a large percentage of population has become immune to an infection, requires coverage to be at 95%. Work is in progress to develop an action plan to improve up-take and this will and was expected to be in final draft form by November 2019.

- The universal human papillomavirus (HPV) programme has been introduced as of September 2019; boys in year 8 will now be offered a vaccination.

Integrated commissioning

For us to deliver services in a more sustainable way we know we need to work more collaboratively to jointly commission early help services. This will extend to joint quality improvement and assurance programme, joint training and development, joint learning and supervision.
Norfolk and Waveney’s ambition for joint commissioning is for children and young people with SEND to be supported to be safe from harm, have learning opportunities and have the skills for life leading to meaningful paid employment and fulfilment in their lives.

How will we deliver?

To achieve this for young people with SEND 0-25 we must:

- Assess, plan and deliver services that are co-produced with children and young people with SEND and their parent carers.
- Services must collaborate to deliver personalised services centred on the young person needs and the outcomes that they want to achieve.
- Norfolk and Suffolk Children’s Services and its commissioning partners must integrate service provision where it is needed to meet the identified SEND needs.
- Families and professionals need to be ambitious and focus on positive outcomes for disabled children.
- We need to measure that interventions are having the impact required.

The Children’s Health Integrated Commissioning group (CHiCG) is attended by local authority education, social care, and SEND commissioners and Family Voice. The group is chaired by a GP. The role of the group is to drive forward integrated commissioning and identify new opportunities for joint working across Norfolk. Work has commenced to agree the principles and framework which will directly impact the transformation programmes for CAMHS and SEND. This is an ongoing programme of integration and we expect to start realising the benefits of this during 2020.

Our integration work programme with Suffolk, which includes areas such as SEND and CAMHS is developed through both strategic and operational groups. Where pathways in Suffolk and Norfolk differ, the CYPM team work to ensure services are aligned so that children, young people and families have equal access to appropriate assessment and support.
Our children and young people five year plan

Our plan is a working document with elements still in development. Further detail in relation to our delivery milestones are set out in the Norfolk and Waveney CYP high level five year plan (See CYP Appendices)

<table>
<thead>
<tr>
<th>Year 1 2019/20</th>
<th>Outcome</th>
<th>Deliverables/Enablers</th>
<th>Success measure (proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increase engagement with children and young people to design paediatric services</td>
<td>Engagement with expert charities and local authority. Establish mechanisms for feedback through commissioned services. Utilise outcomes of independent reviews across SLT, CAMHS, SEND services. Review of Occupational Therapy services across the system.</td>
<td>Increase in access to services.</td>
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<tr>
<td></td>
<td>Boys aged 12 and 13yrs have access to HPV vaccinations</td>
<td>Development of communication and engagement strategy. Collaboration with education, public health, primary care networks, Community health providers.</td>
<td>Marked increase in uptake.</td>
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<tr>
<td></td>
<td>Children and young people with LD/Autism or both have access to person centred, age-appropriate mental and physical healthcare</td>
<td>Multi agency dashboard to track progress of children and young people with SEND LA strategy.</td>
<td>Children and young people have access to improved 7 day crisis support. New inpatient model and new specialist community model in place by 2021/22. Re-design programme for specialist community LD team has commenced for completion by 2021/22. Learning from LeDeR reviews is implemented in service re-design (over five year period)</td>
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<tr>
<td></td>
<td>Established clinical networks for asthma, epilepsy and diabetes</td>
<td>Support acute and specialist commissioning and provider teams. Identify programme lead.</td>
<td>Identified programme leads and terms of reference agreed. To be confirmed.</td>
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<tr>
<td>Year 2 2020/21</td>
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<tr>
<td><strong>Outcome</strong></td>
<td><strong>Deliverables/Enablers</strong></td>
<td><strong>Success measure (proposed)</strong></td>
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</tbody>
</table>
| Creation of integrated children and young people services | *Phased funding from April 2020 – 2023/24*  
Joint associate director post between CCG’s and local authority  
Development of a joint commissioning framework  
Development and implementation of online tools for determining health and social care budgets  
Development of multi-disciplinary NDD pathways using expert charities and provider organisations | Full roll-out by March 2021  
Increase in jointly commissioned services  
Implementation of shared tool  
Higher numbers of families are accessing pre and post diagnostic support. VCS agency supporting roll-out |
| Children and young adults with LD have improved health outcomes as a result of health checks | Engagement by special and complex needs schools across Norfolk and Waveney  
Development of communication strategy to engage with young people and their families  
Engagement with adult LD teams at NCC and SCC | Increase in uptake and quality of LD health checks |
| Swifter access to assessment and diagnosis for adults with ASD (18—25) | Scoping exercise to be completed in year one in collaboration with NCC | Scoping exercise completed. Implementation plan co-produced for 2021/22 |
| Improve clinical care for children and young people across Norfolk – introduction of proton beam and genome sequencing | Collaborative support for acute and specialist commissioning and provider teams | To be confirmed |
| Implementation of integrated and digital child protection systems across provider network | Establishment of digital IT team | To be confirmed |

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<tr>
<th>Year 3 2021/22</th>
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<tbody>
<tr>
<td><strong>Outcome</strong></td>
<td><strong>Deliverables/Enablers</strong></td>
<td><strong>Success measure (proposed)</strong></td>
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</tbody>
</table>
| Increase in support for children and young people with severe complications relating to obesity | Tier 4 pathways commissioned by NHSE  
Programme to review Tier 1-3 (CYP complete) | National increase of 1,000 patients accessing support |
<p>| Better access to diagnosis for women with perinatal / personality disorders | Additional support for midwives and health visitors to screen for mental health concerns | Increase in number of women diagnosed and accessing support services postnataally |</p>
<table>
<thead>
<tr>
<th><strong>Outcome</strong></th>
<th><strong>Deliverables/Enablers</strong></th>
<th><strong>Success measure (proposed)</strong></th>
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<tbody>
<tr>
<td>Children and young people with Neuro-diversity are diagnosed sooner</td>
<td>NDS business case across Norfolk&lt;br&gt;Norfolk wide review into sustainability of existing provision&lt;br&gt;Trauma informed services for CYP</td>
<td>Reduction in waiting time for children and young people with ASD / ADHD / NDD</td>
</tr>
<tr>
<td>Providers of Eating Disorder services across Norfolk and Waveney are able to achieve 95% standard</td>
<td>Review of existing provision undertaken&lt;br&gt;RETHINK mental health review</td>
<td>Compliance with contractual requirements&lt;br&gt;To be agreed</td>
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<td><strong>Year 4 2022/23</strong></td>
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<tr>
<td><strong>Outcome</strong></td>
<td><strong>Deliverables/Enablers</strong></td>
<td><strong>Success measure (proposed)</strong></td>
</tr>
<tr>
<td>More children and young people aged up to 25 years will be able to access community mental health services</td>
<td>Health reorganisation enables commissioned services beyond 18 years (0-25)&lt;br&gt;Identified budgetary spend with adult services envelope</td>
<td>Additional 35% across Norfolk and Waveney</td>
</tr>
<tr>
<td>Children and young people with LD / Autism will have a designated key worker</td>
<td>Local authority SEND transformation programme</td>
<td>To be agreed</td>
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<tr>
<td>Children and young people with LD and/or autism can be supported in their own community</td>
<td>Additional investment into SEND sufficiency&lt;br&gt;Roll-out of training programme</td>
<td>Reduction in inpatient provision</td>
</tr>
<tr>
<td>Children and young people and families can choose how they want their care delivered</td>
<td>Personal health budgets&lt;br&gt;Stronger market resilience in care provider services</td>
<td>Increase in uptake of PHB’s for people 0-25</td>
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<td><strong>Year 5 2023/24</strong></td>
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<tr>
<td><strong>Outcome</strong></td>
<td><strong>Deliverables/Enablers</strong></td>
<td><strong>Success measure (proposed only)</strong></td>
</tr>
<tr>
<td>Reduction in stillbirths, neonatal and maternal deaths or children born with brain injuries</td>
<td>Local maternity system leadership and collaboration&lt;br&gt;Implementation of Better Births programme</td>
<td>National target of 50% is achieved</td>
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<tr>
<td>iTHRIVE is embedded across integrated children and young people services</td>
<td>Workforce training programme&lt;br&gt;Workforce strategy in development</td>
<td>System change achieved in Mental as a result of iTHRIVE</td>
</tr>
<tr>
<td>Electronic care records enable a digital flag to ensure staff know when a patient has a learning disability or autism</td>
<td>Digital development workstream&lt;br&gt;LD health checks scheme to raise awareness in primary networks</td>
<td>Functionality across digital systems is in place</td>
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<tr>
<td>Monitoring mechanisms able to 'map' flags across Norfolk and Waveney is active</td>
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<tr>
<td>More children are supported to die in a place of their choice</td>
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<tr>
<td>Increased investment to local areas</td>
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<tr>
<td>Palliative Care Network</td>
<td></td>
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<tr>
<td>Successful roll-out of enhanced EOL plans</td>
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<tr>
<td>Reduced hospital stays for EOL patients</td>
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<tr>
<td>Family feedback</td>
<td></td>
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<tr>
<td>Established Paediatric networks to enable acute care closer to home</td>
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<tr>
<td>Collaborative support for acute and specialist commissioning and provider teams</td>
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<tr>
<td>To be agreed</td>
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<tr>
<td>Roll out of digital maternity care record to enable mothers to access their personal care record</td>
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<tr>
<td>Establishment of digital IT team</td>
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<tr>
<td>% increase in pregnant women accessing health records pre-birth</td>
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<tr>
<td>To be agreed</td>
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### 2028

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Deliverables/Enablers</th>
<th>Success measure (proposed only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved access to high quality physical and mental health services</td>
<td>Established Integrated Care System across Norfolk and Waveney</td>
<td>To be agreed</td>
</tr>
<tr>
<td>Integrated 0-25 children and young people health and care system</td>
<td>Established Integrated Care System across Norfolk and Waveney</td>
<td>To be agreed</td>
</tr>
<tr>
<td>Skilled workforce</td>
<td>Established Integrated Care System across Norfolk and Waveney</td>
<td>To be agreed</td>
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</tbody>
</table>

**How will we ensure this is clinically led?**

Across our system we recognise that quality high value responsive services need to be clinically led. As we further develop our CYP plan and transform services we will build on the arrangements already in place; namely:

- Our CYP health network, where members include all NHS providers, Healthwatch Norfolk, SCC and NCC meet quarterly where topics are discussed and updated from across the system (See CYP Appendices).
- Our Norfolk Strategic Partnership Board (See CYP Appendices), chaired by the Director of Children’s Services at NCC, with senior health and care colleagues as part of the membership reporting directly to both the system partnership and our health and wellbeing boards.
- We value the importance of clinical leadership with social care and education colleagues.
- Our Norfolk and Waveney Safeguarding Children Healthy Advisory Group (See CYP Appendices) brings clinicians together from providers and commissioners for CYP safeguarding discussions ensuring everyone is aware of safeguarding changes as well as ensure safeguarding is considered in all work undertaken.
- Our Norfolk and Waveney Safeguarding Children Operational Group (See CYP Appendices) includes named nurses from provider organisations sharing best practice learning and influencing the safeguarding agenda.
- Our Norfolk and Waveney LAC Joint Health and Children’s Services Operational Group (See CYP Appendices) provide input and oversight of services for LAC.

Additional forums that have providers and clinical commissioners working together to achieve best outcomes for children and young people include palliative care networks, our CAMHS delivery group, our SEND Clinical Network (See CYP Appendices) and our transforming care operational group.

How will we engage going forward?

We are committed to building on our continued engagement with families, children and young people and advocacy groups to ensure that all planned and future work programmes will be coproduced.

Our engagement with parent advocacy groups is established and developing and we actively seek opportunities to engage with the wider system through networking forums, educational boards, operational and strategic groups. We will continue to build on good practice that we have already commenced, such as attendance at informal parent led coffee mornings, chat sessions, attendance at the Norfolk Head Teachers Association for primary and secondary schools and SEND forums. We intend to make greater use of social media to share resources, promote system wide campaigns and invite feedback from service users to decision makers.

Our CYP network provides a necessary and valuable foundation for sharing and collaborating on key pieces of work across the Norfolk and Waveney system. The membership of this group are system leaders who are responsible for ensuring that input into shared strategies reflect the experiences and wishes of the patients, staff and stakeholders they represent.

What does this mean for our workforce?

It is recognised that in order to achieve our ambitions for children and young people we need a resilient and sustainable skilled workforce. We will need to do things differently, including by providing different career opportunities and progression.

We have been successful in securing additional resource for the workforce and continue to submit national bids for such posts and career development. Examples of these include:

- Four new CWPs, to add to the existing two cohorts of CWPs in our system.
- Funding for two MHSTs to provide an enhanced Targeted service to children and young people in education settings as part of the Trailblazer initiative mentioned above.
- The UEA was awarded a bid to deliver accredited training for the eight new Emotional Mental Health Practitioners who will be recruited to the two MHSTs.
- Development funding was awarded by the Big Lottery Fund to work up a larger bid to embed trauma informed practice across Norfolk and Waveney.
- NHSE Recruit to Train programme: We have submitted a bid for 25 full time posts that will be new to our system, with staff trained to deliver one or more of three therapeutic modalities (cognitive behavioural therapy, autism and learning disabilities, and / or working with 0 – 5 year olds).
- Early year’s transformation academy (EYTA) support programme for senior leaders across health education and social care has commenced in spring 2019.
What does this mean for our technology?
There is compelling evidence that children and young people have greatest opportunity to thrive when those who care for them are confident and well informed about their child’s health and know how and when to seek information and support. As parents/carers increasingly turn to the digital world we understand that information and resources must therefore be designed and delivered to be relevant, validated and easily accessible.

The Norfolk HCP have developed an innovative digital platform aiming to provide a single digital point of access to validated information, support and resources that will support our ambition to improve parents and carers confidence and ability to care for their own children. This can be seen at www.justonenorfolk.nhs.uk.

Initially supported by the Eastern Academic Health Science Network (EAHSN), we based the first version of the site on the themes identified from data gathered through our single point of access, our current service delivery and data from partner agencies – our hospitals, our GPs, County Council, Public Health.

As well as aiming to inspire self-care and behaviour change the platform can also provide clinical intervention using digitalised assessment tools linked to clinical records, providing opportunity for very early identification and preventative care from the antenatal stage onwards, with supported tailored to individual needs and abilities.

More information is available in the CYP Appendices.

What does this mean for our buildings?
We acknowledge that the estate for CYP services needs to be children and young people friendly, flexible and accessible to meet the 0-25 year age range. This will underpin all service development.

Plans for CAMHS transformation will more probably require a significant reconfiguration when it comes to the use of our buildings. The central feature of the new iTHRIVE model is the deployment of community bases for multi-agency multi-disciplinary teams, who will serve defined geographical footprints.

There will be a minimum of five bases, each covering one of Norfolk and Waveney’s local delivery group areas. However, some areas may need multiple base sites, according to local need and population size. A key feature of the implementation phase will be a mapping of current estate use, not just by CAMHS, but also by the wider children’s workforce, education and health, in order to determine the best and most practicable way to mobilise the workforce to deliver the new service model.

What will be different for our children and young people?
Child and adolescent mental health services

Now:
Meg had in her short life has already experienced significant trauma. In her pre-school years she had suffered physical abuse and trauma relating to close family, with intermittent contact with close family, which then stopped. The school were supporting emotionally, however they have become increasingly distressed.

The remaining close family are struggling to support her at home. Without support it is likely that Meg will develop significant mental health difficulties, be permanently excluded from school, be vulnerable to child sexual exploitation and/or criminal exploitation, enter the criminal justice system or become a looked after child.

Current services are commissioned with a gap, which has meant for a number of months she has slipped between two services. Now her needs have become severe, she will receive an assessment and despite professionals anticipating the potential poor outcomes, she will have a wait for treatment.

In future:
By operating as 'one team' under the iTHRIVE principles, we will undertake a joint assessment (by specialist and targeted services), which will clearly identify the needs and what intervention is likely to help. As 'one team' we will identify the skills required to deliver the intervention and as 'one team' we will consider the wider workforce
available who could deliver the intervention needed. Meg will not have to wait, treatment will be timelier. As 'one team' we will ensure Meg has a better future.

| How a child at school with long term health condition does well at school as a result of inter-agency planning and working |
| Shi-na was four years old and living with his mother and maternal grandmother; his parents were divorced and his father lived overseas. He was small for his age, pale and looked unwell. He only ate packet baby food designed for nine-month olds and his speech and language skills were delayed. A variety of health professionals had been working with Shi-na and his mother for several years due to the concerns she raised about his inability to eat solid food. He had been investigated at the hospital many times with no cause found. The School Nurse became involved as he prepared to transition to school, to liaise between the family, health professionals and school staff about supporting his wellbeing. Communication between the health professionals increased and it became clear that there were significant concerns about him. Shi-na started school and it quickly became apparent that his reported ‘symptoms’ were not real. A multi-agency safeguarding approach enabled Shi-na to be seen as an individual and his actual needs identified and addressed.

And the consequence was....

Shi-na was removed from his mother’s care and his father moved back to the UK to look after him. His development has caught up with his peers and developed a healthy appetite for all kinds of food.

| Mental wellbeing |
| Steven is 17 years old. He has dropped out of college because he was feeling overwhelmed by everything. Steven had been struggling with self-harming and thoughts of suicide. His friend told him about ChatHealth, the confidential texting service for young people. The texts are responded to by a School Nurse. Having established Steven’s safety, the School Nurse then spent six weeks building a relationship with Steven by text and supporting him to share what was going on in his life. Steven had experienced physical and verbal abuse at home. Steven welcomed the support via ChatHealth and consented to the School Nurse making contact with a local support project to provide face-to-face help around housing, rights and accessing other services. The School Nurse also made him an emergency appointment with his GP when it was clear that his feelings of self-harming were becoming stronger.

And the consequence was....

Conversation with Steven is ongoing and he is now accessing a course provided by MIND, which the nurse referred him to and also supported him through the process of meeting the MIND worker. |
Diabetes

Our local priorities for diabetes care

- To develop and promote high quality person-centred care which focuses on individual needs
- To promote equity of access to care for all people living with diabetes regardless of their personal circumstances or background
- To help people to live as well as they are able
- To eradicate variation by promoting best practice in diabetes care and strive to achieve all NICE quality standards

The above priorities contribute to our system goals in the following ways:

To deliver our goal to ensure patients only have to tell their story once, we are integrating services with a focus on individual patient need. We are working to develop care pathways within primary and community care which can meet the needs of the majority of patients without requiring onward referral. This work is already underway; we are improving education levels of primary care staff, developing more efficient ways of working to ensure patients are seen by the healthcare practitioner most appropriate for their needs, establishing one-stop-shops and extended access models and implementing outreach for people who need it, for example people living in care homes or who are housebound.

In addition, we are developing links between health and physical activity provision with an ambition to move away from the historic medicalised model of care. We have recently started pilots with local walking football and rugby teams to identify people who can act as ambassadors and encourage people referred from their GP surgery, many of whom may not feel confident joining an exercise programme, to participate in low-cost exercise provision and we have plans to expand further.

There is significant unwarranted variation in diabetes metrics across Norfolk and Waveney in both primary and secondary care services. Locally, we are fortunate to have clinicians with national and international expertise in diabetes and we also have the highest performing primary care provider in the country. In line with our system goal of prevention and a reduction in health inequalities we have started to develop pilot projects which will demonstrate opportunities to scale-up best practice models. Furthermore, we are reviewing how we can make better use of the clinical expertise available. By supporting our staff to learn from diabetes experts, we will directly contribute to our third and final system goal by helping make Norfolk and Waveney the best place for health and care professionals to work.

Our local system

There are more than 60,000 people in Norfolk and Waveney living with diabetes. Anyone diagnosed with diabetes receives their care from a large number of organisations:

- 105 GP surgeries where most people will receive their standard care.
- Our three local hospitals caring for people with diabetes. In addition people living in East, West and South Norfolk may also receive care from hospitals outside the local area, including Addenbrookes, Papworth, Ipswich and the West Suffolk hospitals.
- Community diabetes services provided by two community trusts: the Norfolk Community Health and Care Trust (NCH&C) and East Coast Community Healthcare (ECCH), whilst the diabetes community nursing team service for Norwich, North Norfolk and South Norfolk is managed by NNUH.
- In addition, there are many other services who will come into contact with people with diabetes for example, the voluntary sector, domiciliary care and care home providers.

Our local challenges
We know that there are challenges in the current system and diabetes has been identified as a key priority for our local health and care partnership. These include:

- The system is struggling to meet both the demand and the cost of diabetes-related complications.
- Prompt access to data which allows us to understand our activity and the financial impacts across the system has not been available.
- Staffing changes and capacity limitations are having a significant impact on service delivery.
- Rurality and the lack of transport infrastructure can mean people face challenges accessing care.
- There is significant variation between GP surgeries, and across Norfolk and Waveney which impacts on the care people with diabetes receive.
- The lack of joined up care and an inability to consistently share information across the system remains a concern. This is a particular issue for people with additional challenges such as those with learning disabilities.
- Services are not taking account of the specific needs of vulnerable people potentially resulting in poor outcomes when accessing care.

Our local diabetes system strategy was signed off in October 2018. It sets out our commitments to address these challenges. The strategy can be found at https://www.westnorfolkccg.nhs.uk/about-us/publications

Our local successes

Notwithstanding the opportunities to improve diabetes care, there are some good examples of excellent provision and collaboration across our system:

- Implementation of clinical guidelines and standards of care for care home residents and people who are housebound have been well received and shared widely throughout the UK.
- Providing diabetes testing in foodbanks; demonstrating effective collaboration between multiple agencies and partners.
- Our frontline staff are engaged and have good ideas for how services can be provided more efficiently in the future.
- The rollout of innovative technology such as ‘InSight’ foot cameras and the establishment of a foot care collaborative are making a real difference to the care people receive.
- Our local health and care diabetes strategy was highlighted as an example of best practice by NHS England and has been adopted by other systems.

What the public tell us

In November 2018, Healthwatch produced a snapshot of diabetes care in Norfolk which was developed based on service user feedback.

Key themes from the report were:

- In general, people spoke positively about their care and the ability to have questions answered if needed.
- People with Type 1 diabetes appeared more confident about managing their blood sugar than people with Type 2 diabetes who were less clear about the meaning of blood sugar levels.
- Patients recognised and had experienced the increasing pressure services are under.
- People with diabetes suggest peer support could really benefit people to manage their condition.
- Support for lifestyle change and motivational support was lacking.
- Many people felt they would benefit from support for their psychological and emotional wellbeing which was not always offered.

What our stakeholders and our staff tell us
Staff and stakeholder engagement events have been held within the STP in Sept 2018 and June 2019, the feedback has been:

- GPs, practice nurses and other primary care staff are really supportive of plans for change.
- Pharmacy staff feel they can better support treatment provision.
- Optometry staff are not currently integrated into the care pathway.
- Specialist support, e.g. mental health teams and the learning disability teams, have highlighted gaps in joined up care.
- Some staff do not understand why diabetes is a priority for our health and care partnership.
- Addressing the factors which put people at high risk of diabetes is essential to stem the rising demand.

Our national priorities for diabetes

The national priorities we must deliver against are in keeping with work already underway across our system:

- To address inequality of access in secondary care to multidisciplinary foot care teams and specialist nursing support for people who have diabetes. Locally we have a number of initiatives in train already with their impact currently being reviewed for effectiveness.
- To take action on food standards in hospitals. Our review of inpatient care is due to start in 2020.
- To support people who are newly diagnosed to manage their own health by further expanding provision of SE and digital self-management support tools, including expanding access to HeLP Diabetes, an online self-management tool for those with Type 2 diabetes. Our digital structured education for type 2 diabetes is already being mobilised across our partnership. Other digital tools to help people manage their condition are expected to commence within the current financial year.
- To enable more people to achieve the recommended diabetes treatment targets and drive down variation between CCGs and practices to minimise their risk of future complications. Pilot projects are already being established across our system making a significant change to the diabetes care pathway and helping keep people well.
- We must offer targeted support offer and access to weight management services in primary care for people with a diagnosis of Type 2 diabetes with a BMI of 30+; and we must test an NHS programme supporting very low calorie diets for obese people with Type 2 diabetes. As a system we are awaiting the learning from the DiRECT pilot schemes and will seek to implement plans for improving weight management services for people with diabetes based on the pilot outcomes.

How are we going to deliver?

The diabetes transformation for Norfolk and Waveney is detailed in a mobilisation plan named Diabetes Programme Blueprint (See Diabetes Appendix). The work is currently split into 10 projects and there are another 20 projects which are yet to be developed. The 10 projects are:

1. Prevention
2. Primary care integration
3. Structured education
4. Workforce education
5. Vulnerable groups
6. Older people
7. Foot care
8. Mental health
9. Weight management
10. Pregnancy

Our priorities for year 1 are:

- To focus efforts on developing a sustainable system in primary care which makes efficient use of all the staff resources available. A pilot project in West Norfolk has been established to review how data can be used to make the provision of care more efficient. The pilot will also include reviewing the staff needed to deliver care and how supporting services e.g. pharmacy can be integrated into the care pathway. Learning from the pilot will inform further rollout in 2020/21.

- Establish the NHS Diabetes Prevention Programme (NDPP) across our whole partnership. The NDPP is mobilised and a referral generation service has recently been commissioned. Support will be provided to the referral generation service in order to maximise referrals to the NDPP, particularly from groups who have traditionally proven hard to engage. We are implementing a new incentive scheme for the NDPP to ensure GP surgeries are financially rewarded for pro-actively identifying people at risk.

- In addition to the NDPP, we have developed service directories detailing local prevention services which may also be appropriate for people at risk of diabetes. Directories have been distributed to all GP surgeries across Norfolk and Waveney and were well received. The directories are currently being updated and will be included on the diabetes section of the STP website to improve access for both healthcare professionals and patients.

- We are also starting to consider potential projects with dentistry and optometry providers. Neither specialism is currently effectively integrated into the care pathway but offers significant opportunities to detect early signs of diabetes and therefore help us target our prevention offer more effectively.

- Develop a primary care incentive scheme for Norfolk and Waveney which will encourage practices to work as a Primary Care Network to improve the standard of care for their patients. The incentive scheme will help us improve the quality of diabetes care experienced by most people and will also help us to address unwarranted variation many people experience.

- Improve our offer for structured education. In addition to the rollout of digital structured education across the system, a review of face-to-face provision is underway. A standardised specification has been developed for type 2 diabetes which will help drive out variation in the quality of care between our localities. A standard specification is now being developed for type 1 structured education.

- Understand our most vulnerable groups and start to develop a service offer to meet their needs. A 1 year pilot project in Great Yarmouth and Waveney is commencing aimed at providing care to people who are the most vulnerable. This pilot will bring together resources from primary and community care, private organisations and the local voluntary sector working towards health improvements for people with diabetes. Learning from this pilot will inform the provision of care across our system.

- Identifying technology which will allow people to self-care or access services in a more flexible way.

The recently published National Diabetes Inpatient Audit has identified significant reporting variation of patient harms data between our three hospital Trusts which is currently being investigated. We will work closely with Quality Improvement colleagues in order to review the data reporting processes and standardise across the Trusts. This work will be undertaken as a priority ahead of the secondary care work already planned for 2020. Moving into year 2, the focus of the work will start to include a review of treatment in hospital, helping people to manage their diabetes when admitted (this will include options to support carb-counting) and how we look after children and people with type 1 diabetes. Scoping work is to be carried out, reporting back in 2020, to identify and prioritise the key areas to be addressed.

Starting in 2020, we intend to review the diabetes community nursing team offer in each of our localities to ensure consistency and improve the way services support the care provided in GP surgeries.
Next year, we will also build on the work being done now to become more ambitious in our rollout of the NDPP, working with NHS England and the NDPP provider to further increase referrals into the programme, particularly from groups we know will derive the most clinical benefit. In August 2020, NHS England will be leading a re-procurement process for the NDPP and work is already underway within our partnership to identify local needs to inform this process. The new wave of NDPP will include a digital offer which, in a rural geography such as Norfolk and Waveney, is likely to have a real impact in increasing referral rates.

Implementation during years 3-5 will be spent rolling out the learning form earlier years and refining the care pathway to ensure we have a model of care which meets local needs and addresses unwarranted variation. Ultimately we seek to offer holistic care from a workforce skilled to manage the care of people with diabetes in the community and better support people with diabetes to self-care where clinically appropriate to do so.

How will this be clinically led?

Our diabetes strategy was developed in collaboration with clinicians with an identified local GP champion, also Chair of the Primary Care Diabetes Society, to provide clinical leadership. We are also identifying additional specialist clinical input to oversee the operational implementation of each of the 10 projects and related workstreams.

Our Diabetes strategy is overseen by the Diabetes Programme Board, which is attended by clinicians and managers from all partner organisations, along with service user representation provided by Diabetes UK. The attendees include; Consultant Diabetologists, community nurses, mental health nurses, public health, Active Norfolk and local GPs. The Diabetes Programme Board also oversees the utilisation of the diabetes transformation funding, ensuring clinicians are involved in all key decisions taken around the operational and financial elements of the diabetes transformation.

In line with the foundational commitments described in the Long Term Plan, we have reached out to support GP provider organisations to develop diabetes projects. Where projects are being delivered at a local level (e.g. by a Primary Care Network), we have engaged with the GP provider organisations in each locality and will work alongside them to develop and implement service transformation which meets their long-term needs.

What is the impact on our wider determinants of health?

Risk and prevalence of type 2 diabetes is influenced by a range of factors; for example:

- Although Norfolk and Waveney is generally considered to be of average or above average affluence, there are inequalities. It is estimated that as many as 120,000 people living in locally are amongst the most deprived 20% of people living in England. Deprivation is a significant risk factor for type 2 diabetes.
- Linked to deprivation, being overweight or obese also contributes to the risk of type 2 diabetes. The prevalence of people who are overweight or obese varies across Norfolk and Waveney, but in some areas is estimated to affect about 70% of the adult population, which is higher than the England average which is 61%.
- Although ethnicity is a risk factor for diabetes, there is no large BAME community within our partnership. ONS data indicates that 96.7% of the population identify themselves as ‘White’ however, there are some groups whose ethnicities make accessing care a challenge for example, traveller communities or people who do not speak English.

To address these, we have a workstream dedicated to reviewing our service offer for people who are harder to engage or are from deprived or vulnerable groups. Examples of their work to date include:

- For some people, providing services away from GP surgeries may mean they are easier to access. We recently held a successful pilot providing education, risk assessment, mental health support and diabetes testing at foodbank in Norwich; and
To develop this idea further, a further pilot project is starting in Great Yarmouth and Waveney which will look at how we find and care for people who do not engage with GPs.

Pilots are also starting between Active Norfolk, Norfolk Football Association (FA) and the Rugby Football Union (RFU) to trial a buddying system at established walking football / rugby centres. The purpose of the pilot is to identify volunteers who can support people back into exercise using low-cost activities.

Longer-term work is also planned to more effectively link housing associations and the JobCentres into the care pathway.

We are developing projects in collaboration with our Mental Health Trust to ensure people who are prescribed medication known to increase their risk of diabetes are supported to receive diabetes tests.

We have successfully implemented a project in West Norfolk to provide annual diabetes reviews to people resident in care homes or housebound. This pilot identified an unmet need and so we are in the process of rolling out across Norfolk and Waveney. People who are resident in LD homes are now also being included in the expanded project to ensure their needs are being met.

One of our PNCs is trialling a model of care delivered by healthcare practitioners. These staff have more capacity to allow them to understand individual needs and deliver personalised care as described in the LTP foundational commitments.

How will we engage going forward?

We have good working relationships with service user groups such as Diabetes UK and Healthwatch, but we know we need to do more. There are plans to improve service user engagement and our peer-support offer, as well as to raise awareness of diabetes amongst the public. Some ways in which we intend to do this are:

• Partnering with Active Norfolk to ensure a prominent presence at the Royal Norfolk Show.
• Developing a virtual service user group to allow people with diabetes to provide their views without needing to attend meetings.
• Developing a diabetes section on our partnership’s website.
• Ongoing engagement with our Local Delivery Groups and the GP Provider Organisations to understand the issues facing primary care in each of our localities.
• Providing additional information about diabetes in the GP newsletter and to primary care.

In addition, we are working to improve our collaboration with social care. In particular we will need to work together effectively in order to review the diabetes care provision for Looked After Children (LAC), a project we expect to commence in 2020. We will also need to work closely with local authority colleagues to facilitate access to the Traveller Community sites, a vulnerable group whom we know we do not currently provide care to in a consistent way.

What does this mean for our workforce?

We have identified workforce development as a priority to implement long-term sustainable change and a project to coordinate provision of education opportunities is already underway. We know that the future provision of treatment will need staff at a range of grades and so we need to develop a training and development offer which meets this need. Places are available on the courses with the University of Essex and University of Warwick for clinical development and we have recently secured funding to provide training for Healthcare Assistants (HCAs).

We are developing a pilot project to look at how Health Care Assistants (HCAs) can be more effectively utilised. A local GP has successfully developed a model whereby the HCAs provide all routine diabetes care. The pilot will evaluate whether this is a model which can be rolled out at scale. The pilot will end and be evaluated in 2020.

What does this mean for our technology?
The NHS Diabetes Prevention Programme (NDPP) is being refreshed in August 2020 to include digital access which will help improve how we support people to manage their health to mitigate the risk of developing diabetes. We believe there are significant numbers of people who have not engaged with the NDPP due to the time commitment required and the availability of local courses. This development is therefore likely to have a really significant impact on our ability to help people avoid developing a diagnosis of diabetes.

Given the local rurality, digital technology offers really exciting opportunities to improve the accessibility of services available to people with diabetes. We have already started to rollout MapMyDiabetes which provides structured education for people with Type 2 diabetes, meaning people who previously couldn’t attend the face to face sessions will now have access to high quality education. Early in 2020, we have plans to implement digital offers for Type 1 diabetes and children and young people and, at the time of writing, may well be the first system to have this provision in the UK.

Digital technology also offers opportunities to support people to manage their condition better once diagnosed. We are progressing plans to implement OurPath and The Low Carb Programme and are looking at other digital options, such as Changing Health and Oviva which support people to become more physically active, eat a healthier diet and reduce their risk of complications from their diabetes.

Across Norfolk and Waveney, people with type 1 diabetes meeting the clinical criteria set out by NHS England, now have access to Freestyle Libre. This technology allows for continuous monitoring of blood glucose levels without needing finger prick testing, and we are developing plans to ensure we offer continuous glucose monitoring to all pregnant women with type 1 diabetes by 2020/21. Provision of this technology aims to help patients’ better self-care and reduce hospital attendances.

What does this meaning for our buildings?

For those diabetes services currently delivered in the community the expectation is that these will continue to be delivered from existing premises, such as GP surgeries and community hospitals. For patients requiring more intensive support the Elsie Bartrum Centre in Norwich will continue as a specialist diabetes centre. In Great Yarmouth and Waveney, the podiatry team are considering options for a larger clinical room and we would expect this move to happen before the end of the year.

Where there are opportunities to improve our buildings and treatment areas we are seeking investment to remedy this. For example, we are working with the Norfolk Diabetes Trust, Queen Elizabeth Hospital and West Norfolk CCG to improve the treatment area at the hospital. We expect to develop and submit a proposal to the Norfolk Diabetes Trust within the current financial year.
What will be different?

Mark’s story

Mark is a working age man who is self-employed. Mark has been feeling unwell for some time but doesn’t want to go to see the GP because it means taking time off work. He knows he’s overweight, he’s been meaning to do something about it for a while but never has time.

Mark finally visited his GP to discuss a cut which isn’t healing. The doctor carried out a blood test and asked him to come back for the results. At the second appointment, Mark is diagnosed with Type 2 diabetes by his GP. This diagnosis takes place during a 10 minute appointment during which Mark received a lot of information about diabetes which he struggled to take in. The GP prescribed medication and recommended Mark goes to an education course.

Mark found school a challenge and education doesn’t appeal, especially as it will mean missing work and losing money so, he reads about his condition on the internet where the information is conflicting and frightening. Scared by the prospect of what diabetes might mean, Mark tries to forget his diagnosis and gets on with life as normal.

How will diabetes services be different for Mark in the future?

Mark receives his diagnosis from his GP during a 10 minute appointment. The GP prescribes medication for Mark and refers him to the local pharmacist. The doctor also books an appointment for Mark with one of the practice Healthcare Assistants (HCA) and discusses an offer of psychological support.

When collecting his medication, the pharmacist takes time to explain what diabetes means, the medication which has been prescribed and the importance of looking at making lifestyle changes.

Mark finds that the practice offers diabetes care in the evenings and at weekends so, he can get to his appointment with the HCA without missing work. During this appointment, she takes time to talk to Mark about his lifestyle, how he might make changes to help improve his health and together they develop a plan.

Mark is given access to a digital programme which he can complete at his own pace. He finds it contains lots of useful advice and tips to help him live a healthier lifestyle. The HCA also talks to Mark about support to get him exercising. Mark is offered contact details for someone at a local walking football or walking rugby team but, because of his weight, he doesn’t feel comfortable joining a team sport. The HCA explains there is no pressure and convinces Mark to give the team ambassador a call.
Edith lives in a residential care home and has a diagnosis of type 2 diabetes. Edith’s GP prescribed her medication a while ago which she has taken every day but she’s not sure if she needs to go back. She’s recently been waking up in the night and feeling confused when she wakes up, but doesn’t want to cause a fuss because the staff are very busy. One morning Edith collapses fracturing her hip and is admitted to A&E. Blood tests show that Edith’s fall was caused by her blood sugars dropping too low and her medication is immediately stopped.

How will diabetes services be different for Edith in the future?

Edith is identified by the community nursing team as being a care home resident who hasn’t had an annual review for her diabetes. A Healthcare Assistant visits the home and conducts all the required tests, two weeks later a diabetes specialist nurse visits the home with Edith’s test results and stops the medication Edith has been prescribed as her blood sugar is no longer raised.
Maternity

Our local priorities for maternity services

Key priorities for our Maternity Transformation Programme are delivering continuity of carer for most women by March 2021 and halving the rates of stillbirth and neonatal and maternal deaths by 2025. Board level safety champions are working alongside the midwifery, obstetric and neonatal safety champions, to provide clinical leadership and oversight of safety projects into trust boards.

There are also a number of important new priorities for maternity, such as:

- Ensuring continuity of carer for women from BAME backgrounds and other vulnerable groups
- Increasing access to perinatal mental health services
- Exploring new smoking cessation pathways for mothers and their partners or other household smokers who need support during this significant period of their family life
- Providing more personalised care to improve child and maternal health
- Ensuring a greater focus on population health across the system, to tackle health inequalities and ensure equitable access to care for all our population.
- Having a greater focus on digital solutions, with the aim of enabling women to access their maternity record digitally from 2019/20, with expansion to the whole of England by 2023/24.

The above priorities contribute to our system goals in the following ways:

Ensuring an increased focus on tackling the wider determinants of health such as smoking, alongside targeted work with women from BAME backgrounds and other vulnerable groups directly contributes to our system goal focused on preventing and reducing health inequalities; namely ‘to make sure people can live as healthy a life as possible’.

Looking to digital solutions to improve both provision and choice of care supports our system goal of integration; namely ‘you should only have to tell your story once’.

Our local system

The Norfolk and Waveney Local Maternity System (LMS) operates across our three main hospitals, the Queen Elizabeth King’s Lynn Hospital, James Paget University Hospital and Norfolk and Norwich University Hospital. They are beginning to work as a single system, with the aim of ensuring that all women, babies and families are able to choose and access services they need as close to home as possible. There are clear opportunities for women to choose which of the three hospitals they would like to manage their care – regardless of where they live.

Our local challenges

The geography of Norfolk and Waveney is particularly challenging. Key issues in delivering maternity services to women and families in rural areas are around location and accessibility, the range of services provided and staff able to provide the care.

Distance from parents’ homes to services may be considerable, and travel time to the obstetric units significant. Travel difficulties are exacerbated by the road network, transportation services and weather. Poor accessibility impacts most on those with high risk pregnancies, young parents and low income families. Long distances from the tertiary centre at NNUH and the distress experienced in transferring women to larger regional centres to give birth can result in difficulties for families.

The National Maternity Review, Better Births, recommended that most of a woman’s maternity care, including during labour and birth, should be provided by the same midwife, regardless of whether it is in the community or hospital.
The ambition to deliver maternity services through continuity of carer models is to ensure safe care based on a relationship of mutual trust and respect in line with the woman’s decisions. The ambition set out by the National Maternity Review is to ensure:

1. Every woman has a midwife, who is part of a small team of four to eight midwives, based in the community setting, who knows the women and family, and can provide continuity throughout the pregnancy, birth and postnatally.
2. Each team of midwives will have an identified obstetrician who can get to know and understand their service and can advise on issues as appropriate.
3. The woman’s midwife should liaise closely with obstetric, neonatal and other services ensuring that she gets the care she needs and that it is joined up with the care she is receiving in the community.

We are not on track to deliver the trajectories for providing continuity of carer. However, we are learning from other systems and trusts who are further ahead and plan is to utilise this learning and proceed to a large scale change of how services are delivered. This will have significant impact on the current workforce and will take some time to embed. We are currently not on track to achieve the 35% target for March 2020, but if we achieve buy in from all three trusts, we should exceed our 51% target for March 2021.

<table>
<thead>
<tr>
<th>Barriers to changing the way midwives work</th>
<th>What would help midwives to work differently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practical barriers</td>
<td>Concessions in how midwife roles are organised</td>
</tr>
<tr>
<td>- Caring responsibilities (64% had caring responsibilities, 46% for children)</td>
<td>Adequate staffing to cover the work</td>
</tr>
<tr>
<td>- Transport issues</td>
<td>Financial/practical incentives: enhanced pay, assistance with travel</td>
</tr>
<tr>
<td>- Responsibilities elsewhere (eg. other midwifery roles, volunteering)</td>
<td>Induction, support, training, and development</td>
</tr>
<tr>
<td>- Health conditions</td>
<td>Good leadership, management and organisation</td>
</tr>
<tr>
<td>Wellbeing and work-life balance concerns</td>
<td>Continuity and quality as an incentive</td>
</tr>
<tr>
<td>Personal preference for particular ways of working</td>
<td>A change in midwifery culture</td>
</tr>
<tr>
<td>Quality and safety concerns</td>
<td></td>
</tr>
</tbody>
</table>

We aim to offer women the choice of birth place, but it must be recognised that this directly impacts how continuity models could work. We will not be able to deliver on continuity without significant investment in both workforce and finance and options are being developed to enable the system to address this issue.

Smoking in pregnancy is by far the largest modifiable risk factor for a pregnant woman and presents an ongoing challenge, particularly for our areas of highest deprivation. Some of our local populations carry some of the highest rates of smoking in pregnancy across England. As such, substantial work needs to be done in this area with additional dedicated resource aimed at supporting a multi-agency holistic lifestyle approach. Lifestyle targeted interventions are planned. Reducing smoking rates in pregnancy will significantly contribute to the safety ambition and also give infants and families the opportunity to have better health outcomes throughout their lifetime.

It is clear that a single approach to smoking does not yield changes in behaviour and therefore we are working towards a new multi-faceted approach with a multidisciplinary team. A presence in the community is essential for a team approach to be successful. This could be through a community hub (a local centre where women can access different aspects of their maternity care). Ideally a “hub” should also include other multi-speciality community providers such as specialist nurses and GPs.

Investment in developing community hubs is essential if we are to deliver midwifery services to women and families in continuity of carer models. Plans to develop multi-disciplinary team hubs sit within the Primary Care Networks and estates pipeline. However, we have immediate resource needs for these hubs and this also is a significant risk to delivery of the continuity of carer trajectories.

Our local successes
Whilst these challenges are being faced there have been a number of successes, including the wide engagement with stakeholders across Norfolk and Waveney to define and deliver transformation, as well as early success within our quality improvement projects.

These include improving the pathway for women having an elective LSCS (Caesarean section), reducing the number of babies receiving unnecessary antibiotics, reducing waiting times for women having an induction of labour by working collaboratively across the trusts and also improving the outcome for babies born before 27 weeks gestation by ensuring they are born in the most appropriate setting to care for them.

What the public tell us

We have gathered feedback from the three separate Maternity Voices Partnerships that represent service users. We have also undertaken other engagement events, including a “Who’s Shoes” and a “What Matters to Me” event, with additional events planned for the future. Here’s a summary of what people have told us:

- Midwives are kind, caring, compassionate and do their job well, particularly those in our hospitals and delivering babies.

- Building a relationship with the midwife is important.

- Service users don’t like to repeat their story to different midwives, particularly women with complex medical, mental health and social needs.

- Some mums have told us they don’t think it is realistic to be cared for by the same midwife throughout their maternity journey. Around 12% said they would be happy to be cared for by different midwives throughout their maternity journey, 31% wanted to be cared for by the same midwife during the antenatal and postnatal periods, 34% liked the idea of a small team of midwives caring for them throughout, 19% wanted a dedicated midwife throughout, and 2% didn't express an opinion. (The importance of the information we are delivering to women and families is key. If families are unaware of the significant evidence base that demonstrates improved outcomes, they are unlikely to understand the relevance).

- Feeling involved in making decisions makes the maternity experience more positive.

- Some said they felt unsupported and confused after getting conflicting or inadequate advice - particularly around breastfeeding.

- Some women when having their second or third child said they did not feel they received enough support.

- Of those that had written a Birth Plan, 18.5% said their plan was followed, 52% said their plan had to be adapted but was followed as closely as it could be with safety in mind for both mother and baby.

- Some women said they felt their mental health needs were not properly considered when they were in labour and when giving birth.

What our stakeholders and our staff tell us

Whilst our stakeholders and staff welcome and embrace the maternity transformation programme, implementing continuity of carer remains our highest risk, both from a workforce and a financial perspective.

For workforce, units in Norfolk have historically struggled to recruit enough midwives in all of the acute units (this is also reflected in the national picture).
From our own staff survey, midwives have reported barriers to being able to change the way they work to make continuity happen. Findings indicate that they believe there is a significant gap between the number of midwives required to deliver continuity plans, and the number willing or able to do so. Those most willing and able to work in these models are newly qualified midwives with less than two years’ experience. In addition, midwives expressed concerns about what the change means for them in practice.

In order to succeed, all midwives will need to support the plans and look at how change can be sustained long-term with new ways of working while also maintaining their own wellbeing. Significant workforce and financial resource may be required to transition this large scale change across Norfolk and Waveney.

Therefore further plans are being put in place to develop business cases across the system to look at this in depth before final decisions can be taken about how best to move forward.

The national priorities we must deliver

The LTP continues to champion the agenda of Better Births but goes one step further to look at addressing the ‘gaps’.

Better Births Focus:

- Improving Safety – the ‘Halve It’ campaign aims to reduce perinatal mortality and morbidity by 50% by 2025. This includes the full implementation of the Saving Babies Lives Care Bundle version 2 by March 2020 and the Neonatal Critical Care Review (once published). All Type 1 diabetic women who are pregnant will have access to CGM (Continuous Glucose monitoring). This will be a challenge for the infrastructure of the current systems.
- More personalised care – continuity of carer (CoC) (target for 2020: 35% of all women who book for care, target for 2021: 51% of all women who book for maternity care and target for 2024: 75% of all women from BAME and most deprived backgrounds to receive Continuity of Carer.
- All women to have personalised care plans by March 2021. Women will be able to start these themselves before their booking appointment. They will be intuitive and interactive allowing both women and professionals to share and create plans of care between them – accessible digitally across a smart phone or similar device. Information on their choices across the LMS will allow them to start making decisions about their preferred provider as well as their preferred place of birth either at home or the alongside Midwife led Birth Units for uncomplicated pregnancies or in a Hospital Delivery Suite for pregnancies that may have a higher chance of complications.
- Increased access to evidence-based specialist perinatal mental health care (nationally an extra 24,000 women to access specialised help by 2023/24, specialist services available up to 24 months post-birth, new maternity outreach clinics and access to care for fathers/partners.
- We are one of 19 pilot sites across England testing digital access to maternity records. By March 2020 all women booking into Norfolk and Waveney will be able to see their maternity care record digitally. Further development of the digital offering will be tested including appointment booking and appointment reminders.
- We are working with Just One Norfolk to offer a single source of reliable health advice and support by developing the maternity section of their website. This allows a single point of signposting across the system with the same consistent messaging and support.
- Digital is the cornerstone of maternity services moving forward and will enable women and fathers / partners access to all the information they need to make choices about their care – through accessing our LMS wide Choices leaflet as well as being involved in planning and participating in their care.
- Digital is the enabler to access all health records across the system and will have a significant impact on safety by accessible sharing of timely information across our STP.

How are we going to deliver?

Addressing the Gaps:
• Workforce challenges - the LMS has significant gaps in its current workforce which must be addressed to facilitate our growth towards 35% of women on a continuity pathway by March 2020 and 51% by March 2021.
• Our current staffing models need to change to support new ways of working.
• There is a significant amount of work to do to create new models that will facilitate delivery of Continuity of Carer. The workforce will need to undergo a system wide large scale change to include detailed financial modelling of proposed costs to the system.
• Inequalities in maternal and perinatal mortality (with the target pushed to 75% from a BAME background and those living in the most deprived areas to receive Continuity of Carer by 2024, making these groups the focus of improvement works to be carried out.
• More access for fathers / partners to healthy lifestyle support alongside mothers.
• Fathers / partners to feel actively included in all aspects of care. Supported by the Fatherhood Institute, we are working towards recommendations from the report funded by the Nuffield Foundation- Who’s the bloke in the room? - A review of UK evidence about new fathers and health services. It details how expectant fathers in Britain are key influencers on maternal and infant health and well-being, including pregnant women’s smoking, diet, physical activity and mental health, and on children’s later development.
• All transformation work has a family centred approach.
• Antenatal care – improving maternal smoking cessation – with the development of new smoke free pregnancy pathways, including focused sessions and treatments for all pregnant women who smoke. Consultation on folic acid and recommendations to fortify flour to happen in 2019, and the formation of maternal medicine networks. Maternal medicine networks are being set up over the next few years to address health inequalities and avoidable maternal deaths. The majority of maternal deaths seen in Britain are due to pre-existing or new onset medical or mental health conditions. We are one of only two systems in the East of England that has applied and we have been successful in bringing this pioneering service to Norfolk and Waveney.
• To help tackle health inequalities in Norfolk and Waveney we are exploring developing Community Hubs that provide accessible care from a wide range of professionals.
• There is an ambition that all type 1 diabetic women have Continuous Glucose Monitors for the duration of their pregnancy as this directly impacts on the long-term health and outcomes of the neonate.
• Postnatal care – improved access to physiotherapy with the development of MDT pelvic health clinics and pathways, focus on more targeted and ongoing support to improve infant feeding advice and support for families and an intention that all maternity services not currently accredited by a nationally recognised programme such as Unicef Baby Friendly Initiative, to begin process in 2019/20.
The following programmes of work seek to deliver both our local priorities and national requirements as outlined:

<table>
<thead>
<tr>
<th>Workstream</th>
<th>Year One 2019 - 2020</th>
<th>Year Two 2020 - 2021</th>
<th>Year Three 2021 - 2022</th>
<th>Year Four 2022 - 2024</th>
</tr>
</thead>
</table>
| Transformation | Continuity of Carer: 35% of women to be booked onto a defined CoC pathway by March 2020  
LMS develop their service users’ voices through the further development of Maternity Voice Partnerships and linking them into the One Norfolk Service user groups  
Undertake full system wide service review of postnatal care in all acute and community maternity settings and to include Primary Care. Develop improvement plan for submission to NHSE by Spring 2020 | Continuity of Carer: 51% of women to be booked onto a defined CoC pathway by March 2021  
Developing Maternal Medicine Networks, which enable women to access the specialist care they need in pregnancy in the right places and as close to home as possible. NNUH has put in a bid (2019) mostly likely success in 2020/2021  
Implement postnatal improvement plan across system | Continue to improve the CoC pathways and ensure compliance  
Undertake full CoC implementation evaluation | Continuity of Carer: 75% of women from BAME and most deprived backgrounds to be booked onto a defined CoC pathway by March 2024  
Improved access to women’s pelvic health including physiotherapy  
Improved parental accommodation for NICU by 2023/2024  
Development of care co-ordinators role for families in NICU |
| Safety | Recommitment to the 50% reduction target for perinatal mortality by 2025  
Ensure Trusts achieve their CNST targets to generate revenue to support safety work (this will be on an annual basis)  
Full implementation of Saving Babies Lives Care Bundle V2 by March 2020 (This is a series of five interventions to reduce still birth. It includes helping women to stop smoking, improve foetal monitoring in labour, managing reduced foetal movements and monitoring foetal growth. It now also includes the development of pre-term birth prevention pathway and support of neonatal transformation services  
Reduce our ATAIN (At Term Admissions in Neonates) rates across the system to <4%  
Development of a system wide safety and quality forum to lead on system wide learning, alignment of system | Recommitment to the 50% reduction target for perinatal mortality by 2025  
Ensure our ATAIN (At Term Admissions in Neonates) rates across the system remain at <4%  
Continue to ensure engagement with LMS Safety and Quality Forum  
Neonatal work – increase cot capacity across the system | Recommitment to the 50% reduction target for perinatal mortality by 2025  
Target for SATOD (Smoking at time of delivery) rates to be at 6% by 2022 | |
| Choice and Personalisation | Produce an LMS DOS (directory of services) to demonstrate the choice offer available to women and families within Norfolk and Waveney
Develop a system wide maternity choices pathway (linking with the digital transformation work) | All women to have a personalised care plan |
|----------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------|
| Perinatal Mental Health (PNMH) | Targets are to provide additional services to 4.5% of the live birth population for 2019/2020 | Targets are to provide additional services to 7.1% of the live birth population for 2020/2021
Pilot Maternity Outreach Clinic in STP area already established
A £4m Mother and Baby Unit which offers new mothers with serious mental health problems specialist help closer to home welcomed its first patients on 28th January 2019
Norfolk and Suffolk NHS Foundation Trust’s (NSFT) Kingfisher Mother and Baby Unit (MBU), which is at Hellesdon Hospital in Norwich, helps to ensure mums and their babies can stay together while the mother receives inpatient care for conditions such as severe postnatal depression, serious anxiety disorders and postpartum psychosis. |
| Workforce | Look at workforce modelling across the three acute trusts to ensure enough resource to meet national objectives
Our large scale change workforce model would be designed to meet the needs of our workforce and our women making Norfolk and | With next tranche of funding recruit workforce lead and setting up an LMS workforce forum to drive this programme forward
Single service contract work to deploy midwives to all areas within the systems and support those |
<p>| Workforce | | |</p>
<table>
<thead>
<tr>
<th></th>
<th>Waveney an attractive location to work. Review of Maternity Support Workers role within the trusts and across the system to ensure optimising capacity. Ensure this is equitable across the system. Look at system leadership and ensure adequate succession planning (close working with HEE to develop preceptorship and mentoring programmes).</th>
<th>more challenged with higher vacancy rates Training passports (training together and better system level MDT training).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing Data and Information</td>
<td>Make use of STP data sharing agreements</td>
<td></td>
</tr>
<tr>
<td>Harnessing Technology</td>
<td>With transformation funding support the development of digital IT midwife in each Trust Implementation of electronic hand held records for service users Implement new service user feedback tool once rolled out from national team Friends and Family Test to be further developed and promoted in each unit. Analysis of annual CQC survey results to determine improvement strategies</td>
<td>Development of a Single Point of Access to maternity services Look at System wide IT midwife role</td>
</tr>
<tr>
<td>Reforming the Payment System</td>
<td>Blended payments to be introduced by NHSE – further outputs with timescales can be added once we know what the milestones are</td>
<td>Roll-out of maternity digital care records with all women able to access records through their smart phone by 2023/24</td>
</tr>
<tr>
<td>Prevention</td>
<td>Consultation for and implementation of an accredited infant feeding programme Scoping of weight management programmes in pregnancy Smoking Cessation in Pregnancy work – dedicated specialist midwives in each Acute Trust.</td>
<td></td>
</tr>
</tbody>
</table>

**Monitoring progress against our targets**
Progress is monitored monthly for each unit and compiled onto a dashboard. We track ourselves as an LMS against the East of England and England as a whole. This serves as assurance and enables us to detect any deviations quickly and act upon these. The tables following are a snapshot of some of our current performance against our trajectories for our main deliverables:

### Smoking at Time of Delivery (SATOD)

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>10.60%</td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td>6.00%</td>
</tr>
<tr>
<td>East of England</td>
<td>10.90%</td>
</tr>
<tr>
<td>Norfolk and Waveney</td>
<td>17.03%</td>
</tr>
<tr>
<td>JPUH</td>
<td>18.50%</td>
</tr>
<tr>
<td>QEH</td>
<td>22.20%</td>
</tr>
<tr>
<td>NNUH</td>
<td>10.40%</td>
</tr>
</tbody>
</table>

### Number of Women Receiving Continuity of Carer During Pregnancy, Birth and Postnatally

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
<th>March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td>0.00%</td>
<td>20.00%</td>
</tr>
<tr>
<td>East of England</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Norfolk and Waveney LMS</td>
<td>0.00%</td>
<td>9.10%</td>
</tr>
</tbody>
</table>

### Number of Personalised Care Plans (Not able to currently measure data)

<table>
<thead>
<tr>
<th></th>
<th>2018/19</th>
<th>March 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Target - March 2021</strong> 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>East of England</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Norfolk and Waveney LMS</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>
### EQ1 Stillbirth Rate

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of stillbirths during a calendar year</th>
<th>2016 (Baseline)</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>40</td>
<td>32</td>
<td>30</td>
<td>28</td>
<td>26</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
<th>The number of live births and stillbirths occurring during a calendar year</th>
<th>10253</th>
<th>10,121</th>
<th>10,106</th>
<th>10,076</th>
<th>10,076</th>
<th>10,076</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>Rate per 1,000 live births and stillbirths</td>
<td>3.9</td>
<td>3.14</td>
<td>2.95</td>
<td>2.75</td>
<td>2.56</td>
<td>2.36</td>
</tr>
</tbody>
</table>

### EQ2 Neonatal Mortality Rate

<table>
<thead>
<tr>
<th>Numerator</th>
<th>The number of neonatal deaths during a calendar year</th>
<th>2016 (Baseline)</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>13</td>
<td>12</td>
<td>11</td>
<td>10</td>
<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator</th>
<th>The number of live births and stillbirths occurring during a calendar year</th>
<th>10,253</th>
<th>10,121</th>
<th>10,106</th>
<th>10,076</th>
<th>10,076</th>
<th>10,076</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>Rate per 1,000 live births and stillbirths</td>
<td>1.3</td>
<td>1.2</td>
<td>1.1</td>
<td>1.0</td>
<td>0.9</td>
<td>0.8</td>
</tr>
</tbody>
</table>

### EQ3 Percentage of women placed on a Continuity of carer pathway

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of women who reach 29 weeks gestation in March, who are marked as being on a continuity of carer pathway and have a named lead midwife and team as part of their maternity care plan</th>
<th>2017/18 (Baseline)</th>
<th>2018/19 (Baseline)</th>
<th>2019/20</th>
<th>2020/21</th>
<th>2021/22</th>
<th>2022/23</th>
<th>2023/24</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>独自被标记为在连续照顾路径中，并且有指定的主导助产师和团队作为其产科护理计划的一部分。</td>
<td>0</td>
<td>76</td>
<td>0</td>
<td>409</td>
<td>409</td>
<td>409</td>
<td>409</td>
</tr>
</tbody>
</table>

<p>| Denominator | Number of women who reach 29 weeks gestation in March | 801     | 801     | 801     | 801     | 801     | 801     | 801     | 801     |</p>
<table>
<thead>
<tr>
<th>EQ4  Brain Injury Rate</th>
<th>2017 (Baseline)</th>
<th>2020</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
<th>2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td></td>
<td>47</td>
<td>41</td>
<td>39</td>
<td>36</td>
<td>34</td>
</tr>
<tr>
<td>Denominator</td>
<td></td>
<td>9,798</td>
<td>10,121</td>
<td>10,106</td>
<td>10,076</td>
<td>10,076</td>
</tr>
<tr>
<td>Rate</td>
<td></td>
<td>4.80</td>
<td>4.08</td>
<td>3.84</td>
<td>3.60</td>
<td>3.36</td>
</tr>
<tr>
<td>Rate per 1,000 live births</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The number of brain injuries occurring during or soon after birth:
- 2017 (Baseline) 47
- 2020 41
- 2021 39
- 2022 36
- 2023 34
- 2024 32

The number of live births occurring during a calendar year:
- 2017 (Baseline) 9,798
- 2020 10,121
- 2021 10,106
- 2022 10,076
- 2023 10,076
- 2024 10,076

Rate per 1,000 live births:
- 2017 (Baseline) 4.80
- 2020 4.08
- 2021 3.84
- 2022 3.60
- 2023 3.36
- 2024 3.12
How will this be clinically led?

The LMS sits within the Acute STP workstream with the CEO of the James Paget University Hospitals Trust acting as our Senior Responsible Officer for the programme. The LMS Board is chaired by a Consultant Obstetrician and there is strong clinical leadership with a consultant midwife who directly oversees and leads the transformation work, reporting into the LMS Board. The heads of midwifery at each Trust provide strategic direction and operational leadership to the workstreams and the workstreams are led by specialist consultants, midwives and commissioners. The LMS has clear cross cutting projects with Workforce, Estates, Primary Care, Digital and the Mental Health workstreams so to this end, our Programme Managers meet monthly to support those initiatives to ensure our STP has a joined up strategic approach across its system.

The LMS Board consists of senior colleagues from both within the NHS and outside organisations across Norfolk and Waveney. It is made up of midwives, obstetricians, neonatologists, health visitors, board level safety champions, in addition there is representation from Public Health, Maternity Voices Partnerships, GP leads, mental health, finance and commissioning. We work in partnership with East of England Neonatal Network, the Regional Maternity Clinical Network and Eastern Academic Health Sciences Network to facilitate our quality improvement projects. Our stakeholders meet bi-monthly to discuss options and approve next steps. The heads of midwifery and clinical leads meet bi-weekly to steer transformation activities.

The acute Trusts have been working together in a system wide approach to transformation since early 2018. Norfolk and Waveney has a birth rate of around 10,200 babies per year, and although PHE predictions show a declining birth rate, it predicts an increase in the complexity of the women and families cared for which significantly increases the demand for skilled clinicians and facilities from which to deliver care. There are local plans within the county councils that show significant increase in housing developments locally and this will need to be factored into all predictions for future care requirements. We have current projects running across eight workstreams, each of these with clear trajectories and deliverables.

What is the impact on our wider determinants of health?

Health inequalities have a significant impact on outcomes for mother and baby – see Appendix 3.

A greater focus will be on the health of our population, particularly around pre-conception care and the emergent Maternal Medicine Networks with more support for collaboration between Trusts and across boundaries.

Our ambition is to provide equitable access to all maternity services across our LMS. Where every woman can access information on her choices for maternity care before booking, can expect her care to be personal to her, planned with her and jointly evaluated by her and her professionals at every contact and to be cared for throughout that journey by a lead or buddy midwife from a small team. Care should be safe, kind, family friendly and delivered in a professional manner.

The majority of care will be delivered from community hubs situated in our areas of highest deprivation to reach our most vulnerable communities. We will use the National Deprivation Index to ensure that the women who need care the most can access it locally and that debt, poverty, lack of education and employment will not be barriers to receiving safe, timely, targeted care. Hubs will be local and accessible and will integrate community and primary care services both before and after pregnancy. Care will flow seamlessly from one professional to the other.

The maternity transformation programme feeds directly into the prevention workstream and is key to ongoing child health and development.

How will we engage going forward?

Service Users: Across the LMS we work with our three Maternity Voices Partnerships (MVPs), who are the voice of service users. We engage with them to help us decide how to deliver services in the future in a way that matters to those using it. For specific areas of work we host local engagement events, which include ‘Whose Shoes’ events, ‘15
steps’ and ‘What matters to you’ events as well as using social media platforms, newsletters, an LMS email box and local surveys. We have employed a service user to sit on our LMS Board and be the voice of users to support in the bigger Board decisions.

Staff and wider stakeholders: We will continue active engagement with staff and stakeholders, using their knowledge, expertise and local understanding of systems and cultures to drive transformation in a way that works for all and integrates into cross cutting workstreams. We rotate meetings between units to ensure all staff and stakeholders have local access to transformation activities and provide dial in facilities to ensure ease of access to those meetings. We work with Healthwatch and report back to Norfolk Health Overview and Scrutiny Committee. We will collate and share themes and feedback to our stakeholders from those accessing our new debriefing services to discuss and plan future service improvements.

What does this mean for our workforce?

Transforming the workforce will only succeed with a large scale change implementation plan with multiple stakeholders supporting the strategic direction. It is predicted that it will take additional financial support and uplift in workforce as well as significant training to ensure that safety is maintained. There are plans to:

- Develop an LMS wide workforce plan
- Develop business cases where necessary to support implementation of continuity of carer pathways
- Share and standardise training
- Create new models with greater use of Midwifery Support Workers
- Support the existing workforce to work within continuity models
- Plan for future workforce needs
- Promote a modern employment culture – promoting flexibility, wellbeing and career development
- Engage with the proposed national workforce group by NHS England, NHS Improvement and HEE to ensure rapid implementation of workforce actions.

What does this mean for our technology?

There must be adequate investment in digital infrastructure to move our digital elements forward. Investment in additional server space, laptops for community midwives and connecting access to digital care records across our STP is absolute priority to enable choice, personalisation and safety. If the majority of midwives caring for women are to be community based, we require secure, mobile access to digital records and access at all community hubs.

What does this mean for our buildings?

Provision of community hubs for use by the midwives alongside the multi-disciplinary team is absolutely key to our continuity of carer success. There is no current space in the acute trusts or existing bases to accommodate these models of care. We therefore have an urgent need to develop hubs.

In order to provide the full range of choice for women, in line with national recommendations, estate investment is required to support a free standing midwifery unit (FMU). We have an outline plan for this unit alongside essential requirements and potential locations. It would directly support demand and capacity requirements at the specialist neonatal tertiary unit and allow more women and their babies to access the care they need in Norfolk and Waveney, thereby significantly reducing the need to transfer out of area. This would have a direct positive impact on ambulance availability.

What will be different?
Case study: Charlotte lives in an isolated village close to the coast in Norfolk. During the winter, when there is little work, she struggles to make ends meet and has very limited money for transport. There are currently no buses that go through her village and she would have to walk over a mile to the nearest bus stop where there is a limited timetable of services. Given this set of circumstances, Charlotte finds it impossible to attend appointments at her nearest hospital. She often sees a different midwife at each visit and rarely goes into details about her medical history with these new faces as she assumes the midwives will have access to her notes, but she also finds it hard to retell her story to unfamiliar people.

Following a blood test at her last appointment, the midwife does not mention any results, so Charlotte presumes they are ok. Charlotte apologises for having missed another hospital appointment but she does not say why and the midwife makes her another. The midwife completes an antenatal check and reports that baby appears to be growing well. Charlotte is feeling more and more anxious as the weeks go on, but the midwives do not appear to notice. Charlotte is dreading labour this time and hopes the midwife who carers for her during labour will be kind.

In this case study, Charlotte has a high chance of a poor outcome which will significantly impact on her health and the health of her new family which could lead to a life time of care requirements.

If Charlotte was to access continuity of carer modelled maternity services, she would have a named midwife who is responsible for coordinating and providing all of her pregnancy, birth and postnatal care, locally from a Community Hub, close to Charlotte’s home. Charlotte’s named midwife would work alongside a buddy who covered her care when she was not available. Charlotte could contact her named midwife, or her buddy, directly at any time with any concerns she might have. It is likely that any complications arising would be recognised promptly and responded to appropriately.

Charlotte and her named midwife would get to know each other well, so there is a much higher chance that she would pick up on subtle cues that Charlotte is feeling anxious. Even though Charlotte is considered to be high risk, she would be able to see the same consultant locally at the Community Hub and only have to attend the hospital once for a scan. Her midwife would be able to help organise the appointment for a date and time convenient to Charlotte allowing her to book a taxi or organise a lift from friends or family. In these circumstances Charlotte would feel much more confident, safe and prepared for labour this time. There is clear evidence that this leads to improved outcomes for women and their babies.

Charlotte is planning to breastfeed this time around as she knows her midwives are on hand to help her and is looking forward to using the Infant Feeding Cafe at the Community Hub.
Mental Health - Adults

Our priorities for adult mental health

Our priorities for adult mental health are to:

1. Implement an integrated model of community mental health services. This will be delivered as part of wider steps across the partnership to put in place integrated health and care provision, within communities and primary care. Within this we will:
   a. Increase access to psychological therapies (known as IAPT), so that more people are able to access support for common mental health needs such as anxiety and depression.
   b. Further develop support within communities for people with dementia and reshape diagnosis pathways so that getting a dementia diagnosis is easier and quicker.
   c. Put into place solutions to ensure staff within integrated teams can appropriately share information to support care and treatment and provide a single online place for people to access information about mental health, support available and use online tools to support their own mental wellbeing.

2. Further develop services for people with Serious Mental Illness (SMI), such as personality disorders, eating disorders and early intervention psychosis, as part of this ensuring that people with serious mental health illnesses are supported with their physical health care needs.

3. Improve support for people at points of mental health crisis and as part of this put in place alternative support and services for people in crisis that enables them (where appropriate) to be supported within our communities and not need a hospital stay.

4. Stop people being sent to hospitals outside of Norfolk and Waveney for acute mental health care and reduce the number of people in hospitals with specialist mental health needs outside of our partnership area.

5. Reshape inpatient care supported by the provision of £38 million national capital monies.

The above priorities contribute to our system goals in the following ways:

The delivery of these priorities will be taken forward through the adult mental health transformation programme. Through this approach we will ensure that the future workforce needs of the new integrated models of care are identified, and that delivery is shaped to the needs to each Primary Care Network (PCN) area, with a focus on reducing inequalities and supporting more people to access timely mental health support and treatment within their own communities.

It is through the delivery of mental health care and support within PCNs that we will join up with wider health and care provision thereby reducing the need for people to tell the story of their mental health needs more than once. We will develop a single ‘trusted assessment’ – a care plan used by all those supporting a person. This, alongside digital systems that are compatible with each other, will allow, with consent, access to the care plan by all appropriate staff. This will ease the burden on staff especially those working out of hours and/or trying to support someone in a moment of crisis as they quickly and easily access the ‘trusted assessment’. The person in question does not feel they have to repeat their story at a time when they are already feeling vulnerable and unwell, and the staff member has all the information swiftly to hand to offer the most appropriate care.

We will reduce variation in mental health needs, by using population health management data and other supportive information to ensure that as our mental health primary care delivery is embedded this is shaped around the needs of people in each PCN area.

We will improve the opportunities for people to support themselves, and we will support people to make healthier choices with regards to their own mental wellbeing.

We will fully utilise the opportunities that digital solutions offer. This will include the development on an online mental health portal for Norfolk and Waveney and, as already outlined, we will develop our trusted assessment approach to ensure a single record of people’s health and care needs, enabling all services working with someone to collaborate more and reduce the amount of time people wait to receive the care they need.

We will work with all our providers to develop a collective understanding mental health workforce needs, developing and implementing new approaches to supporting that workforce, with the aim of reducing the number of staff
leaving services and we will create new roles and ways of enabling more people to enter the mental health and care workforce.

Our local system

Norfolk and Waveney has a higher than average level of identified mental health disease (150,000 people). The prevalence of mental illness across our partnership exceeds national average by 0.3% in common mental health disorder and dementia. In general Norfolk and Waveney has a similar profile of mental health prevalence for depression, common mental health disorders, and new cases of psychosis. QOF prevalence across all ages is on part with national figures of 0.94 % of the population (2017/18 QOF figures).

Mental health profiles vary by CCG area, necessitating a differentiated approach by region. Some CCG area nuances can be explained by broader determinants of health, deprivation and social factors.

The mental health landscape is complex across our system, with the exception of the main mental health provider (Norfolk and Suffolk Foundation Trust) there are multiple provider groups and stakeholders.

30% (£0.5B) of our system budget is allocated to mental health across health care and adult social care, £131m of which is commissioned in specific mental health services across some 22 contracts.

Our local successes

In spring 2019, the Norfolk Joint Health and Wellbeing Board committed to sign up to the Public Health England initiative Prevention Concordat for Better Mental Health. In April 2018, our partnership was awarded grant funding by NHS England for Norfolk to develop local responses to suicide prevention. Key focus areas were middle aged men, high risk industries, and the acute sector and education settings. In October 2018, a multi-agency suicide prevention conference was held in Norwich bringing together experts in the field to share knowledge and expertise and membership of the National Suicide Prevention Alliance was also confirmed in October 2018.

Norfolk and Waveney has specialist perinatal mental health provision and our partnership has been successful in securing an additional non recurrent £177,000 to use for enhanced triage with the Wellbeing service and delivery of a joint training plan. In addition to this the STP is working with a voluntary sector partner “Get Me Out Of The Four Walls” to provide a support service to women with emerging perinatal issues and to support them following specialist Perinatal interventions.
Our Early Intervention Psychosis (EIP) teams are making good progress in terms of waits to treatment and quality standards. As at July 2029, the Trust were supporting over 70% of people who need treatment for EIP within two weeks. This is against a national expectation of 56%.

Recently our system has been heavily focused on reducing the number of inappropriate patients placed in a bed out of our immediate area. Earlier in 2019 the number of such patients had reached unacceptable levels and our system was subject to local, regional and even national scrutiny. Together with the support of the National Intensive Support Team a significant and ongoing plan of action was developed (outlined below – see Challenges section) which has resulted in numbers reducing dramatically. To date we are on track to continue reduce the number of inappropriate out of area placements over the course of 2020/21 such that these admissions will no longer happen.

Norfolk and Suffolk Foundation Trust (NSFT) has shown excellent results from both its Recovery College and its Co-Production Training Package currently being developed. Both are good examples of how NSFT is actively using peer support and review, alongside a standardised package of co-production training for its staff, to ensure the experiences of its own patients are central to how services evolve.

Our local challenges

NSFT is experiencing a number of challenges as highlighted by the most recent CQC report released in November 2018. This rated the trust as inadequate for the third time and outlined a range of areas for improvement. This includes staffing levels, care plan updates, leadership, and the management of patients on waiting lists. We are working closely with the Trust to support them in responding to the outcomes of the CQC inspection on all areas identified for improvement and to ensure that where the quality of care needs to improve this is happening.

- There is a higher level of demand for acute inpatient hospital admissions than the capacity in place to support these and there are issues with the capacity of the Trust to support people at home and avoid admissions. This resulted in a high number of people placed in an acute mental health inpatient bed outside of the Trusts own bed stock and away from their homes. Work is being taken forward through the below outlined actions and projects, which has already resulted in a significant reduction in the number of people who need mental health hospital care being admitted to a bed outside of Norfolk and Waveney. This work will continue to be implemented in 2020/21, so that by the end that year, these admissions will not happen. Increased bed capacity, with 15 additional beds being opened on Yare Ward.

- The development of a new Community Wellbeing Hub in Norwich, due to be open in mid-2020. The hub will support people experiencing emotional distress by creating a more joined approach to care and better continuity between urgent care and community services. It will support a reduction in referrals to crisis teams and subsequently reduce the number of people attending hospital for emergency care. Work is also being taken forward to create similar hubs in Great Yarmouth and King’s Lynn.

- Increased capacity within the Trusts Crisis Resolution Home Treatment Teams (CRHT) to support people at points of crisis.

- Increased capacity within psychiatric liaison services within the James Paget University Hospital (JPUH) and Queen Elizabeth Hospital King’s Lynn (QEH).

- Plans to reduce waiting times for NSFT services, ensuring that people can access this more quickly.

- Funded the Trust to put in place increased support and specialist provision for people with personality disorder.

- Project to reduce the length of time that people need to be in a hospital bed and improve access to ongoing support within communities so that people can leave hospital when then need to.

Our Improved Access to Psychological Therapy (IAPT) service is not currently meeting national access expectations. By the end of 2019/20 we aim to achieve an access rate of 19%, this is against a national expectation of 22%. We are working with the Trust to put in place plans to enable more people to access to psychological therapies and over the
course of this plans implementation we will bring the number of people accessing this support back in line with national expectation.

Actions being taken to enable this include, working with GP surgeries to raise awareness of the services, enabling people who are seeking support a greater choice of venues and appointments to better suit their needs, and ensuring that everybody contacting the service now receives a 1-1 assessment of their needs either other the phone or face-to-face. In the future IAPT services will form part of our integrated model of primary care mental health support.

Currently, a variety of information management systems are used both within and across provider groups with inconsistent levels of access to data, which do not enable a shared view of a patients mental health needs and treatment.

Statutory homelessness data for the period January to March 2019 has identified that, amongst households who sought help with their housing, the most common support need was mental health problems. The Ministry of Housing, Communities and Local Government’s H-CLIC Homelessness returns show Norfolk and Waveney has 270 households with health-related support needs owed a prevention or relief duty.

**What the public tell us**

In developing the 2019 Norfolk and Waveney’s STP Adult Mental Health Strategy we gathered feedback, views and experiences from more than 2,500 local people.

Although the experience of people who use services varied highly, there were a number of consistent themes emerging about the provision of care and services that are now being addressed, through the delivery of this plan. These themes include:

- Services seen as complex, slow and hard to access and navigate, for example, crisis services
- Services perceived to be poorly integrated between different organisations
- Quality and consistency perceived to be highly varied (for example waiting times)
- Provision of care needs to be more focused on treatment than prevention
- Service users do not feel community care is being fully utilised

**What our stakeholders and our staff tell us**

Recent conversations with our stakeholders and our staff informed the Norfolk and Waveney’s STP Adult Mental Health Strategy. A summary of feedback we received when engaging people in this process recently is included in the table below:-
The national priorities we must deliver

The Five Year Forward View for Mental Health 2016 and the 2019 NHS Long Term Plan (LTP) require the Norfolk and Waveney system to deliver against a number of national priorities for adult mental health. A detailed overview of these is contained in the mental health appendices along with a timeline for implementation.

How are we going to deliver?

In March 2019, we published our Adult Mental Health Strategy. The key objectives within this are:

1. To increase our focus on prevention and wellbeing
2. To make the routes into and through mental health services more clear and easy to understand for everyone
3. To support the management of mental health issues in primary care settings (such as within your GP surgery)
4. To provide appropriate support for those people who are in crisis
5. To ensure effective in-patient care for those that need it most (that being beds in hospitals are other care facilities)
6. To ensure the whole system is focused on working in an integrated way to care for patients

The outcomes of the review and the identified objectives have supported our partnership to develop the following ambitions for the future of adult mental health support and care across Norfolk and Waveney.

- We will reshape our community mental health support services (completing this by the end of April 2022) so that a team of multi-disciplinary professionals, with wide experience and expertise, is available and accessible at a local level - in or close to GP surgeries that represent the NHS front door for the vast majority of our population.
- This will ensure that people who need mental health help and support, can access it quickly, and before their condition becomes more challenging to live with.
- By 2023/24 the our ambition is that the majority of mental health care and treatment is delivered at community levels, within integrated health and care systems, with quick and easy access to specialist provision where needed.
The ambitions and strategy objectives have been translated into an Adult Mental Health Transformation Programme, which is being delivered through a series of Commitment areas and cross-cutting enabling support projects, including a new Enhanced Pathways focus. An overview of these is contained in the below diagram.

It is through this programme that we will deliver the adult focused mental health objectives contained within the LTP and the remaining objectives from the Five Year Forward View for Mental Health (FYFVMH). See appendix for our full strategy. An overview of each commitment’s objectives is contained below.

The work being taken forward to transform adult mental health services is working closely with that of the Children, Young People’s and Young Adults mental health transformation work. This work is supported through the STP Mental Health Programme Board, meaning that there is collective shared oversight of developing plans, future delivery models, joined up workforce planning and shared approaches in key areas such as crisis support and inpatient care.

Work has been taken forward to understand the activity across the 0-25 and 26+ age ranges, plus the existing financial commitments, this information is being used to help the partnership determine the future shape of mental health support, treatment and care across all ages.

In year 1 (2020/21) we will:

- Further implement provision within primary care and NSFT to increase the number of people with Serious Mental illnesses to receiving physical health checks, so that by March 2021 these will have been provided to over 4,000 people.
- Have a core team of mental health staff delivering support to people with mental health needs in every PCN, this will include access to psychological therapies, peer support staff and clinical staff.
- Have increased the capacity of all three NSFT crisis teams and the psychiatric liaison teams within the JPUH and QEH.
- Continue to deliver our plans to stop people being admitted to a mental health acute bed outside of NSFT provision, so that these admissions no longer happen by the end of March 2021.
- Have new Crisis House and Wellbeing Hub services up and running.
Increased support for people with dementia, embedding this within our integrated health and care teams in PCNs.

Identified and agreed projects and ways of joint working to support more people to access appropriate housing, care and nursing homes placements.

Have developed our future plans to improve and increase the therapeutic care provided to people admitted to our mental health hospital.

Increase the number of women who can access community perinatal support so that this reaches over 700 people and will agree our plans of how this support will be extended to parents of babies up to 24 months old and to ensure partners can easily access mental health support when needed.

Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21.

Prevention and Wellbeing Commitment

The prevention and wellbeing Commitment is ensuring that as a community, we are doing everything we can to help Norfolk and Waveney be a mentally healthy place to live. The group is focusing on the following areas:

- Development of approaches and support to employers to enhance mental wellbeing in the workplace and communities.
- Design and delivery of public awareness campaigns that challenge mental health stigma and discrimination.
- Work to promote community resilience
- Suicide, reduction, prevention and awareness training.

Our partnership’s commitment is to reduce suicide rates in Norfolk and Waveney by 10% in 2020/21. We have received national funding to support this. Delivery is aligned to The Norfolk Suicide Prevention ‘I am (really not) okay’ strategy and action plan (2016-2021).

Primary Care Commitment

Our partnership is moving quickly, to integrate mental health services within the emerging Primary Care Networks across Norfolk and Waveney.

This directly responds to our system goal ‘I only have to tell my story once’. Bringing staff and organisations together in an integrated and collaborative way closer to the communities that people live, in will bring benefits to both service users and our staff. Working to a single trusted assessment (described below) will ensure no one have to repeatedly describe their personal circumstances to different staff involved in their care.

By capturing the wider determinants of health, such as poverty and debt, that may be affecting an individual’s mental and physical wellbeing, the proposed model will also address another of our system goals: ‘To make sure that people can live as healthy a life as possible’. This directly focuses on preventing avoidable illness and tackling the root causes of poor health.

We are working with five PCNs to implement an initial integrated mental health team model in late 2019. We will learn from these five areas, as we expand this provision to all Norfolk and Waveney PCNs in 2020/21, and then build on this to ensure the delivery of a fully integrated model being operational across all areas by the end of March 2022. The model in each PCN area will be shaped around the needs of the population in that area and this will support a reduction in variation of care moving forward.

Principles of the new model:
Support will be focused on individual’s health and care needs ensuring a holistic approach including consideration of physical health issues and wider identified needs (for example, housing and money).

The GP will remain the responsible clinician and support will be provided by the appropriate person as close to home as possible.

There will be no wrong door to accessing support and treatment.

The needs to families and carers will be fully considered and supported where needed.

Shared learning and joint working arrangements between people working with individuals with mental health needs will be enabled, ensuring an integrated joint approach to care and support.

Services will seek to adopt a single ‘trusted assessment’ meaning a person only has to be assessed once and this assessment, will be further developed over time as a person’s needs change. It will be accessible to all appropriate staff involved in their care.

More people will be supported for their mental health needs in primary and community care settings.

As implementation expands, these services will integrate with wider health and care provision at PCN level. By the beginning of 2023/24 the expectation is that the majority of mental health care and treatment is delivered at community levels.

Currently our IAPT service, known locally as the Wellbeing Services, is either working within or close to GP surgeries, however there is not a consistent level of availability for the service across our partnership. The Wellbeing Service offers access to talking therapies for people experiencing mild to severe depression and anxiety, phobias and experiences of trauma. The work outlined above will integrate the Wellbeing Services with the PCNs mental health teams. Working in this way will allow for more streamlined access to psychological interventions.

We are committed to achieving and maintaining the national expectations around access, the recovery rate and waiting times from referral to first treatment. We are committed to the achievement of these standards such that over the course of the plan over 333,000 people will be accessing this by the end of 2023/24.

We are also working to further develop our IAPT offer jointly with physical health care services to support people’s mental wellbeing in a number of long term conditions (LTC). It is well recognised that people with long term physical conditions such as diabetes, heart and lung disease and chronic pain experience more mental ill health. By improving mental health there will be a significant improvement in physical wellbeing. This will make it easier for people with a physical LTC such as diabetes to access psychological therapies. We have already supported a number of clinicians to complete national LTC training – which helps psychological therapists to better understand the needs of those people with an LTC and the Wellbeing Service is ensuring all clinicians receive this training over the next few years.

Our plans to transform community mental health services will also have a specific focus on meeting the needs of older people. We recognise that the national dementia diagnosis standard is particularly important. As at September 2019, it is estimated that 16,618 of people aged over 65 in Norfolk and Waveney are living with dementia, and 10,644 (64.1%) have a formal diagnosis. We are working proactively to raise this to 66.7% and to ensure that this maintained in future years.

Our partnership’s Dementia Transformation Programme commenced in the autumn of 2018. Further to extensive consultation and engagement with people affected by dementia including family carers, the programme has currently four focuses:

1. The development of new approaches that deliver dementia diagnosis closer to home
2. The development of a new dementia support service, for everyone affected by dementia
3. The development of a new proposal for dementia training and education
4. The development of new peer and community-led dementia support

The community-led dementia support focus has a workstream that has developed a future model for the delivery for people affected by dementia including family carers. The proposed future service includes:
• A single point of access for all people affected by dementia including family carers
• Access to local named support for all, which will be delivered within PCN integrated teams
• Access to support, at the same time as access to diagnosis
• Direct support for people with dementia and their family and carers
• A focus on supporting people to live a full and meaningful life, maximise their independence, participate in their communities and experience a good quality of life

Pathways Commitment

We plan to develop a core digital offer for people with mental health related needs. The aim is to develop a central online resource for both the public and services across Norfolk and Waveney, which will enable people to identify and receive self-directed support, be linked to telephone an on-line support and provide an access point into help and services. Our plans for this are emerging and we will be taking forward further engagement work to further define the offer to be implemented. Our plan is to have a working example in the first half of 2020 with a full site later in 2020.

The Norfolk and Waveney Adult Mental Health Strategy (March 2019) identified that the routes into and through mental health services were not clear or easy to understand. We have reviewed the current provision and found that there are many directories of services which can be difficult to navigate. We have been working with colleagues from the Department of Psychology at University of East Anglia who have designed and published a wellbeing app for their students. We have obtained the services of a company that “uses evidence-led design, behavioural research to create digital experiences that work”. With their support we plan to develop a website in 2020/21 that enables people with mental health issues to access guidance and support at any time. This support will not only act as a portal into a large knowledge base but also provide simple mental health first aid such as mindfulness and cognitive behavioural therapy. The University of East Anglia (UEA) are supporting us to develop an app, which will enable people access immediate online advice and find information on support services that they can access. We are planning to have this in place alongside the website by the end of 2020/21.

Enhanced Pathways Commitment.

It is important that our future plans not only ensure an integrated approach to the delivery of more common mental health needs such as depression and anxiety, but that also the needs of people with more complex and severe mental health illnesses (SMI), receive integrated, easy to access primary and community care focused support and treatment.

In Norfolk and Waveney, the life expectancy between people who use mental health services and those who don’t is slightly higher than the national gap. In Norfolk and Waveney this gap is 20.5 years for men and 16.5 years for women – around 20-25% less in terms of years lived (The Strategy Unit, 2017)\(^7\). People living with an SMI aged 30 to 44 have death rates around 5 times the general population and it is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented. People living with an SMI are also more likely to have multiple physical health conditions (Public Health England, 2018)\(^8\).

The Strategy Unit (2017) identified that Norfolk and Waveney could save £8.4m if the rate of attendance at and admittance via A&E for people with psychoses and personality disorder was reduced to that of the rest of the population. People with mental illness are also more likely to have higher rates of poverty, homelessness, incarceration, social isolation and unemployment.

In order to drive forward the work we need to do to address the needs of people with SMI a further Commitment - the Enhanced Pathways Commitment - is being established. The Enhanced Pathways Commitment will, in the first

\(^7\) The Strategy Unit (2017) (commissioned by NHS England) *Making The Case for Integrating Mental and Physical Heath Care*

\(^8\) Public Health England (2018) Research and analysis. *Severe mental illness (SMI) and physical health inequalities: briefing*
instance, bring together an overview of the existing work on each of the below pathways of care and then (learning from other STP areas who have been identified nationally to take forward this work more quickly) develop future approaches to the integration of provision for people with SMI into the developing primary and community services. Key focuses for this work include:

1. SMI health checks: We are on track against national target (delivery of annual physical health checks to 60% of people on the General Practice SMI register) and work collaboratively with NSFT and Primary Care to deliver this ambition. We aim to deliver physical health checks to 4,806 people with SMI by the end of March 2020 and over the course of the LTP plan, this will rise to 6,696 by the end of March 2024.

2. Eating Disorders: Our partnership is working to embed an all age approach to the future delivery of eating disorders services. This will mean that there will be no divides between services and that people with eating disorders will receive treatment that is uninterrupted and focused on their clinical needs no matter their age or severity of their eating disorder.

3. Individual Placement Support (IPS) services: We have commissioned Norfolk and Waveney Mind to provide employment advisors for individuals receiving secondary care mental health services. The 10 staff are embedded within NSFT’s community teams, supporting an integrated approach to delivery. An assessment of provision against fidelity will be completed in 20/21.

4. Early Intervention in Psychosis (EIP): Our system will continue to meet the standard for patients with a suspected first episode of psychosis receiving a NICE-approved package of care within two weeks of referral. We will support all areas to achieve national quality standards. This includes a review of capacity and additional provision for patients with an At Risk Mental State (ARMS) by 2023.

5. Personality Disorders: We are rolling out community provision for people with personality disorders across North Norfolk, South Norfolk and Norwich in 2019/20. The ambition is to then further develop this to cover the whole of Norfolk and Waveney by the end of 2020/21.

6. Our partnership has been successful in securing the community perinatal mental health provision. By the end of 2019/20, a minimum of 460 women will be accessing specialist perinatal mental health provision, rising to 725 by the end of April 2021, 879 by the end of April 2022, and then 1,018 from April 2023 onwards. We will continue to further develop the perinatal provision, expanding access, further developing pathways with maternity provision and ensuring that new fathers are also able to easily access mental health provision if they need it. These development areas will be taken forward through joint work with maternity services, and in the further development of current pathways, embedding these within the developing integrated mental health provision and will work with Primary Care Networks (PCNs) to ensure that through the development of population health management approaches the perinatal mental health needs for both mothers and fathers is identified.

Crisis Commitment

The Crisis Commitment has combined the further development of support for people at points of crisis, with the existing work of the Crisis Care Concordat (‘the Concordat’). The Concordat brings key people together to improve coordination of services involved in crisis response, comprising the police, ambulance, British Transport Police, Acute Trusts and Social Care. This aim is to enable a single Norfolk and Waveney wide approach, and ensure the engagement of all relevant stakeholders.

The Crisis Commitment group is working to develop clear pathways of care to effectively respond to the needs of people in crisis, ensuring that these are developed across all ages and working with the Children, Young People’s and Young Adults Transformation Programme to do this.

We have three clear areas of focus for our crisis work:

- Many patients already use 111 to access health advice, support and care. Our plan to be delivered in 2020/21 is to enable people who call 111 to have access to mental health clinicians who will be able to
provide support and advice over the phone or when needed book patients in to appointment clinics for a further assessment of needs and to access direct support.

- The provision of a crisis house, which will provide people with a place to stay for support at points of crisis for a short period of time, whilst longer term needs are identified and plans put into place to support these. Crisis houses have been shown to act as a real alternative to inpatient care.

- Further development of crisis responses within NSFT via the enhancement of overnight services, Crisis Resolution Home Treatment, and improved Mental Health Liaison Services within the Queen Elizabeth Hospital King’s Lynn (QEH) and the James Paget University Hospital (JPUH). Mental Health Liaison Services are specific specialist mental health services based at acute hospitals and available 24hrs a day, seven days a week.

Our partnership has been successful in securing additional Investment in 2019/20 to boost community support, including CRHT, establishment of Crisis House in Norwich, increasing Mental Health Liaison services. This work will ensure Crisis support is easy to access and that pathways of care are developed across all ages, including for older people.

Inpatient Commitment

Our partnership is committed to stopping the placement of people needing an acute inpatient stays outside of local beds. NICE guidelines suggest that a bed occupancy rate of 85% is optimal and reduces risk of unnecessary harm and ensures a safe environment. It enables flexibility of response to when an admission is needed and reduced the risk of out of area placements. It is the ambition of the mental health trust to achieve this bed occupancy rate and has a number of plans in place.

Deliverables implemented in 2019/20 and 2020/21 are:

- Implementation of Personality Disorder (PD) Pathway and provision within community mental health teams. This will see an upskilling of staff within community teams to support people with PD and the implementation specialist support staff to work with people with more complex PD needs. The impact of these changes will be an ability to provide enhanced care and support in the community, and reduce the need for unnecessary hospital admission.

- Opening of an additional acute inpatient 15 beds in Central Norfolk, to meet current needs and reduce out of area admissions.

- Design of implementation of strengthened rehabilitation and reablement support. This will be focused on supporting those people with the most complex and long term mental health needs, providing intensive community based packages of care and accommodation where needed. The ambition through this work, is to support as many people as possible, to move from country-wide highly specialist medium to long term placements, where appropriate packages of care can facilitate this within Norfolk.

- Implementation of Red to Green on all wards (which measures if each day supports a person to move forward with their care whilst in hospital) and partnership responses to reduce hospital length of stay to meet the national ambition of 32 days (or fewer) meaning less people being hospital for longer than needed.

Currently the mental health trust has a higher length of stay than average. Plans are underway to reduce this including bolstering community mental health (and thus reducing the need for admission), implementing discharge planning on admission, improvement in therapies provided on the wards and reducing delayed transfers of care by working collaboratively with social care, housing associations and other voluntary sector organisations.
The recent award of national funding to redevelop our inpatient services is a huge opportunity. Plans have already began looking at best practice and how psychiatric wards can be designed to provide optimal care that is safe and effective.

How will this be clinically led?

Adult mental health transformation is informed by the Five Year Forward View, the Long Term Plan and local strategic review. This work is driven forward by the STP Mental Health Programme Board chaired by an experienced GP with an interest in mental health. Clinical representation from other GPs and our GP provider organisations are also present, along with clinicians from other services. These include psychiatrists and psychologists, social workers, nurses and voluntary workers.

Each of the Commitments has a GP representative and two of them are either the nominated chair or clinical lead. Clinical leads have key roles in shaping services such as our dementia redesign piece which seeks to improve whole pathways of care for people with dementia; from pre-diagnosis through to diagnosis and active treatment.

It is through the engagement at all levels of transformation that clinicians are leading on the work and planned developments outlined in this chapter.

What is the impact on our wider determinants of health?

When people are better supported with their mental wellbeing their ability to cope at times of stress, maintain positive relationships, work and keep a stable home is increased.

Improving people’s mental health and wellbeing has a significant impact not only on individuals, their families and communities but also on the capacity of wider health and care services. Successfully enabling mental health support and treatment to deliver care at a primary care level and ensuring that this care is integrated within other health and care services, will ensure more people can be supported, earlier, closer to their homes and reduce the need for crisis and emergency care and the number of hospital admissions respectively.

For example, in our work to provide physical health checks to people with serious mental illness, we are supporting people to improve their wider health and care, in areas such as smoking, weight management and alcohol/drug use.

Also our work on supporting the mental health needs of people with long term physical health conditions, such as diabetes, will support those people to improve both their physical and mental health, reducing for example related hospital admissions.

Lastly our plans for the implementation of the crisis house include how people can be supported with wider aspects of their health and wellbeing, such as healthy eating, exercise and self-care.

Our plan outlines further work to better support the housing needs of people with mental ill health, this will focus on both how our partnership can both support people to stay in their homes and find appropriate accommodation for those that need it.

Our providers are working actively to support people to engage in healthier choices, as an example all our mental health hospitals are smoke free.

We will continue through the implementation of this plan to identify opportunities to support people’s wider health and care needs, with a focus on prevention and care at the earliest opportunity.

How will we engage going forward?
Our Adult Mental Health Strategy was the product of large scale engagement with some 2,500 people with lived experience of mental health, their families and carers, professionals, the voluntary sector as well as the wider community. This engagement is ongoing and embedded firmly within our work moving forward.

The transformation articulated in our strategy is being delivered through a dedicated Adult Mental Health Strategy Assurance and Advisory Group. This group is made up of representatives from all stakeholder groups including a large number who have lived experience of mental health and their carers. It acts in an advisory capacity for the Commitments on all things relating to engagement, consultation and engagement. It ensures people with lived experience are actively involved in the co-design and implementation of the strategy.

Examples of how people with direct experience of mental health are informing transformation through this approach include:

- Co-producing the implementation of a summit focused on mental health and housing.
- Developing services that place people’s skills, networks and community resources (their assets) alongside their needs to improve care and support.
- The development of qualitative outcomes measures (that tell us about what happened, where, when and who with) so that we can evidence and understand the impact of our transformation.
- Coproducing our plans for delivery of the new crisis house in Norwich.
- Developing templates for improved communication between practitioners and people experiencing serious mental illness in primary care.
- Developing and overseeing the implementation of the Personality Disorder Strategy.
- The development of plans to deliver the new website and app.

As the transformation promotes further implementation activity, the involvement of people with lived experience of mental health, their carers and the wider public will increase, through ongoing delivery of engagement activity, across a wide range of channels and platforms, both traditional and technology driven.

What does this mean for our workforce?

Our local ambitions and the delivery of the LTP objectives will require a changing mental health and care workforce to support this moving forward. This will include expanded workforce in key area such as crisis support, a community workforce directed towards primary care and working in an integrated way, a balance of workforce between statutory and voluntary sector partners and the capacity which ensures specialist clinical oversight and treatment is secured in support of the new models.

We are working in partnership to develop a whole system approach to our workforce plans moving forward, including the future requirements for the mental health workforce. A mental health workforce group is being convened which will pull the workforce requirements from each commitment and develop plans from this, ensuring they meet the national workforce requirements of the LTP. These will be fed into the wider partnership workforce planning work outlined in the workforce chapter of this plan.

What does this mean for our technology?

As we move to become more integrated across our services, communication and working between data systems and data processes will be critical to success. Addressing data issues, connectivity, information sharing and the development of new tools that support patients to self-serve and self-navigate digitally, is an integral part of delivering the change articulated in this document.

One of the key features of both the adult and the children and young people mental health strategies is the single trusted assessment that is viewable on different IT platforms. Work is being undertaken via the primary care commitment to explore this further.
Similarly the pathways commitment referenced above is looking to technology to offer alternative treatment choices such as phone apps and a central online resource and website.

What does this mean for our buildings?

Recent Norfolk and Waveney estates modelling suggested that there are demand and capacity mismatches across the estates footprint. Acute inpatient beds are under pressure and the provision of social and community beds is not meeting current demand. The recent award of £38m in national funding to redevelop our inpatient services is a huge opportunity to shape our mental health inpatient services into wards which provide high quality care, in settings which are designed to enhance people’s experience, meet their acute needs and enable the implementation of an improved therapeutic offer, which supports the engagement of wider services in the delivery of care to people who need a mental health related hospital admission.

We have a system-wide estates strategy for the next five years, for mental health the focus is on redeveloping our buildings to provide integrated care to patients, provide accommodation for key workers and private residential housing (including some with care) for patients.

What will be different?

The two below scenarios outline how patient care will look in the transformed primary care integrated model of working.

**Case study:** Mark was concerned about his anxiety and was feeling very low. He went to his GP, who was immediately able to discuss with Mark’s needs and assess any presenting risk factors. The GP then booked an appointment for Mark with a mental health practitioner, who had appointments at the surgery. The practitioner worked with Mark to better understand how he was feeling and what support he felt would make the biggest difference to his mental health. From this a wellbeing plan was developed with Mark, which included the engagement of 1-1 support from a local IAPT practitioner and access was facilitated to wider community support including an appointment with a community advice worker with expertise around debt. Lastly Mark was offered the opportunity to attend a peer-led support group meeting near to where he lives (within the PCN locality). Mark’s needs as identified at the appointment (with his consent) were then appropriately shared with the services engaged in his care so that those services did not need to reassess his needs. Mark was provided with a follow-up appointment for two months’ time to see how he felt about the progress being made.

**Case study:** Catherine has a long-term serious mental illness (SMI) for which she takes anti-psychotic medications. Since her medication was changed last year her mental health has been stable but she has gained 10kg in weight. She finds exercise difficult, her diet is poor as she tends to snack rather than eat proper meals and whilst she drinks little alcohol she does continue to smoke.

Her GP surgery is signed-up to the physical health check scheme for patients with SMI. She gets a call from the nurse inviting her to come for a health check and a chat about any issues concerning her. The practice is flexible as to when they can do this and assure her that everything can be done at one visit.

When she attends she is welcomed by the practice nurse who explains the purpose of the appointment. After a discussion about Catherine’s needs the nurse takes a finger prick sample of blood for analysis. She then performs a physical health check including height weight and blood pressure.

Unfortunately the blood sample shows that Catherine is at risk of diabetes and her cholesterol is too high. The nurse explains what this means and that with help and support Catherine can reverse these risks.
Together they come-up with an action plan. Catherine wants to take things one step at a time but agrees to be referred to smoking cessation clinic (which is located in the same building) and to take some information away about healthy eating. She promises to become more active and arranges with the nurse to come back in a few weeks to talk about exercise classes. The appointment is made and whilst Catherine is anxious about the health problems identified she is appreciative of the support she has been given.
Planned care and long term conditions

Our local priorities for planned care and long term conditions

- Improve the outcomes and experiences of patients using planned care (specialist clinic appointments, tests and surgery)
- Make patient journeys as straightforward as possible and standardised across Norfolk and Waveney
- Improve and extend the lives of patients with long-term conditions, such as heart and lung disease, so that how healthy you are or how long you live does not depend on where you live in Norfolk and Waveney
- Be forward thinking about the way in which we deliver care to patients

The above priorities contribute to our system goals in the following ways:

- By seeking to improve patient journeys and make them more straightforward, standardised and with improved outcomes we should, by default, impact positively on our ambition of providing seamless integrated care.
- By seeking to improve and extend the lives of patients with long-term conditions, we should reduce health inequalities and help people to live as healthy a life as possible.
- By being forward thinking about the way in which we deliver care to patients we are seeking not only to improve patient care and outcomes but also to improve the working lives of our staff.

Our local system

Every year, tens of thousands of Norfolk and Waveney patients are referred for appointments with consultants, allied health professionals or specialist nurses, scans or planned surgery at the Queen Elizabeth Hospital, Norfolk and Norwich University Hospital, James Paget University Hospital, or one of several community centres commissioned by the NHS. Local health professionals have told us that they are differences in how referrals are made, and what treatments that are given. We want these differences to be minimised so that there is less confusion and everybody is treated equally.

Our challenges and successes

In February 2019 Norfolk and Waveney became the first STP in the East of England to have identical commissioning policies across multiple Clinical Commissioning Groups. There has also been an increase in collaborative working, with 40 patient representatives, clinicians, managers and NHS England transformation team members coming together for an Elective Care Summit in January 2019, and we have kept up the momentum from this by setting-up a monthly Planned Care Board which has agreed priorities and started to implement changes for patients who go to gastroenterology, neurology, gynaecology and dermatology clinics.

In addition, leading hospital specialists from the three hospitals have expressed an interest in working together more closely, and in January 2020 urology will became the first specialty for which the clinicians from Queen Elizabeth, Norwich and James Paget will formally become a single team.

As in many areas, however, waiting lists are significant concern. Between April 2018 and April 2019, James Paget University Hospitals and Queen Elizabeth Hospital King’s Lynn managed slight reductions in their waiting lists, however at the Norfolk and Norwich their waiting list grew significantly, and has continued to grow this year. All three hospitals have taken actions to address this through additional weekend sessions and finding extra space for operations. We recognise, however, that this alone will not fully solve our problems. Furthermore, national policies such as increased taxes on smaller pension pots, and pressures from emergency care resulting in a reduced the number of beds available for planned operations, are all having an impact.
What the public tell us

So far, engagement with the public has mainly been via lay and Healthwatch representatives, or relevant third sector officers on working groups in including the STP Planned Care Board and Clinical Policies Development Group. We are striving to work more closely with the public, particularly around outpatient transformation as this will have the most immediate and visible impact on their experience. Further work to develop the engagement plans will be developed in early 2020 when communication and commissioning teams aligned to these projects will be finalised.

What our stakeholders and our staff tell us

Feedback from the groups at the Elective Care Summit centred around three themes:

- The need to develop agreed pathways for patients, communicate these effectively, give professionals the relevant education and training they need to develop their part of the pathway. In many cases, a GP, practice nurse or allied health professional may not use a pathway particularly often, if the patient has something relatively rare. We therefore also need to make it much easier for them to find the most up-to-date information and adapt their computer systems so that referral letters are generated with all the relevant information for the specialists to consider.
- We will be looking at ways in which specialists can support patients, carers and health professionals in ways other than outpatient appointments. There are a number of chronic diseases that may flare up at any time and in these instances the current usual practice of booking the next appointment after a set period from the previous appointment may not be the best. In many cases, it may be more suitable for the patient to be seen in primary or community care as the patient has a long-term condition or has other health problems which are relevant to treatment decisions.
- The need for integrated system leadership, including a coherent strategy, consistent approach to potential barriers (such as information governance concerns) and clinical ownership.

The national priorities we must deliver

Local health systems are required to:

- Identify which specialties they intend to prioritise as they work towards removing the need for up to a third of face-to-face outpatient visits, reducing outpatient visits by 30 million a year nationally, and reducing the need for unnecessary patient and staff travel.
- Set out how they will expand the volume of planned surgery year-on-year, cut long waits, and reduce the size of waiting lists over the next five years.
- Ensure that no patient will have to wait more than 52-weeks from referral to treatment (RTT). They will also need to implement a planned NHS-managed choice process across the country for all patients who reach a 26-week wait, starting in areas with the longest waits and rolling out best practice through a combination of locally established targeted initiatives and nationally-driven pilots.
- By 2023/24, scale their provision of First Contact Practitioners (FCP) so that all patients across England have access. These refer to allied health professionals such as physiotherapists whom patients can ask to see directly (for example through calling their general practice) instead of a GP or practice nurse.
- Make use of the data, tools and practical support offered by the national improvement and clinical improvement programmes, including GIRFT and NHS RightCare.
How are we going to deliver?

The four priority specialties were chosen at the Elective Care summit as being dermatology, gynaecology, neurology and gastroenterology. For these specialties, scoping has been undertaken at the STP Planned Care Board and the following projects initiated with the first milestones for delivery by March 2020:

- For neurology, the STP Planned Care Board noted that there is a significant number of outpatient appointments and GP appointments which are concerned with headache. A Headache Service Development Group has been established and is examining the Rightcare Headache and Migraine Toolkit, and is also exploring an e-consulting model as well as examples from the Wave 5 Handbook, which contains best practice guidance from NHS England in relation to neurology.

- For gynaecology, a programme of work was authorised at the STP Planned Care Board in August 2019 and includes work to reduce unnecessary investigations and outpatient appointments for heavy bleeding and termination of pregnancy. Once implemented, there will be further examination of Elective Care Transformation Collaborative Handbook, which contains further suggestions for improved pathways.

- For gastroenterology, new pathways in relation to endoscopy were released in August 2019. The next stage is to examine Referral Assessment Services for referrals into the specialty as a whole. This is where the GP and hospital consultant use the existing Electronic Referral System to recommend the most appropriate option, including a gastroenterology outpatient appointment, endoscopy or advice and guidance. Presently, many patients are being referred for what might be not the most clinically appropriate of these three options; the new system will allow the consultant and GP to give the correct option first time and avoid unnecessary referrals and attendances at the hospital. This was implemented at the James Paget Hospital in 2019 and plans to introduce this at the Queen Elizabeth Hospital have been drafted for approval.

- For dermatology, an ambitious work plan which was presented to the STP Planned Care Board in July 2019, including integrating the clinical staff at the three hospitals into one team to increase the capacity in Norfolk overall for seeing patients, exploring the role of physician associates and general practitioners in providing specialist care, and better management of the more common skin conditions such as eczema, acne, actinic keratosis and solar keratosis in the community.

In addition to priority specialties, commissioners and hospitals have started to develop broader transformation programmes of outpatient transformation. The James Paget University Hospital and Great Yarmouth and Waveney CCG have set up an Outpatient Transformation Programme Board with a programme with specific goals in terms of reducing the number of times a patients need to go to hospital, and budgets allocated to implement the alternatives. The programme is organised into workstreams split into how referrals are received and processed by the hospital, and trials of innovative service models. Specific projects include:

- Group sessions to support patients attending outpatient clinics
- Expanding the Referral Assessment Services concept, described above for gastroenterology, to other specialties such as haematology and paediatrics
- Patient initiated follow-up, so that patients do not automatically return after a set period determined at their previous appointment, but instead provide feedback electronically on their condition which means that they can postpone their appointment to a later date if all is well, or bring it forward if not.

A similar steering group has been established at the Norfolk and Norwich Hospital, and a central Norfolk RTT and demand workshop was held in September 2019 where partners agreed to explore and progress these ideas, and internally the Trust has a five year strategy in place for outpatients with an outpatient steering committee that reports to the Hospital Management Board. Key achievements and projects include:

- A virtual follow-up orthopaedic fracture clinic model for children; in this, clinicians look at x-rays and medical notes and an orthopaedic physiotherapist or nurse will telephone patients to discuss treatment and management.
• One stop clinics provided by urology, breast surgery and head and neck surgery. In these sessions, patients get their procedure or scan back-to-back with their clinic appointment.

• Over the next year the Trust is testing out the use of video consultation as part of a large pilot.

West Norfolk CCG and the Queen Elizabeth Hospital are developing key schemes in relation to:

• Consultant Connect service, which was showcased in NHS England’s best practice guidance, which connects GPs to specialists for telephone advice on patients.

• Referral Assessment Services (explained above) for Gastroenterology.

• A triage service for ophthalmology – in this, patients with eye conditions would have their clinical details assessed by the specialists to direct them towards clinics which are dedicated to their particular eye problem.

However further improvements in outpatient services are needed to deliver both sustainable and more personalised care for our patients and to fully deliver the NHS long term plan objectives of digitally enabling outpatients and to reduce face-to-face outpatient attendances by a third within five years.

For the zero-tolerance of 52-week waits for patients awaiting planned care, the STP Planned Care Board has also taken the responsibility for the overview of waiting times and has reviewed an options appraisal for the 26-week wait choice policy. At present, these summaries are undertaken by Great Yarmouth and Waveney CCG on behalf of partner organisations, and as part of the move to a single management team and a single CCG, it has been proposed that this function be strengthened through the appointment of a Senior Programme Manager for Elective Care Access and supporting project manager through the restructuring process.

Musculoskeletal Disease

To date, Norfolk and Waveney has undertaken two pilots of First Contact Practitioner services, in Great Yarmouth and Waveney and in North Norfolk. The STP Planned Care Board has reviewed the evaluation of both sites. There were significant differences in how effective these schemes were in reducing waits and referrals for planned care at the hospital, recruiting physiotherapists and patient satisfaction.

In addition, in the last two years, musculoskeletal triage systems have been implemented in the West Norfolk and Great Yarmouth and Waveney, and plans and finances have been agreed for a Foot and Ankle Conditions Triage Service in Central CCGs, which will (in addition to traditional orthopaedic referrals) look at podiatry referrals, biomechanics and orthotics.

Further engagement with primary care will therefore be taking place to refine the model across Norfolk and Waveney. During this process, none of the existing contracts for physiotherapy services are being commissioned or extended beyond mid-2021, so that a new service model can be rolled out from this date. A system-wide workshop has been planned for early December 2019 to commence work on strategic alignment of these services.

Respiratory Disease

Our 105 GP surgeries serve a combined population of 70,873 asthma patients and 22,910 Chronic Obstructive Pulmonary Disease (COPD) patients. According to 2017/18 QOF prevalence data this equates to 6.88% and 2.22%, respectively.

The Norfolk and Waveney Respiratory Programme focuses specifically on reducing unwarranted variation in clinical practice, access to care, utilisation of services, outcomes and quality for those with, or at risk of, asthma and COPD.

We have identified local outcomes for respiratory patients:

• Increased percentage of people with asthma or COPD who feel supported to manage their condition

• 25% reduction in volumes of A&E attendances where asthma and COPD is the primary diagnosis

• 25% reduction in the percentage of non-elective admissions to acute hospitals where asthma or COPD is the primary diagnosis.
Key milestones that support the delivery outcomes are:

- Development of a community respiratory service specification taking into account current establishment and future delivery models.

- Establishment of a Pulmonary Rehabilitation Sub Group to support colleagues delivering these services to attract and retain patients in this programme. To share best practice and seek to provide equality of provision across Norfolk and Waveney. This group will also support the MYCOPD app pilot which is being rolled out across Norfolk and Waveney to support patients to manage their condition.

- Establishment of a Training Sub Group to support demands across Norfolk and Waveney. In particular this group will oversee the delivery of ARTP spirometry training programme which is being delivered by the National Institute for Clinical Science, liaise with the Norfolk and Waveney Training Hub to coordinate future training and has produced guidance for colleague in primary care.

- Full deployment of the British Thoracic Society approved discharge bundles across Norfolk and Waveney.

A bi-monthly clinical respiratory working group was formed to examine these areas, and is comprised of respiratory clinicians from across the acute trusts, community health care provider and primary care. It has concluded that the Norfolk and Waveney geography lacks consistent patient pathways for asthma and COPD patients. The following is in development to address this:

- Community respiratory services taking into account current establishment and future delivery models.

- Pulmonary Rehabilitation - a programme of exercise supported by physiotherapy to help patients with lung disease. A sub-group has been set up to support colleagues delivering these services and to attract and retain patients in these programmes.

- The MyCOPD app pilot which is being rolled out to support patients to manage their condition.

- Establishment of a Training Sub Group in particular to support better use of spirometry, a test most commonly used to measure the breathing patterns of COPD patients.

**How will this be clinically led?**

The STP Planned Care Board has five GPs, two acute trust Associate Medical Directors, and a member of the regional Clinical Senate, with an open invitation to other clinicians. In addition, a GP provider organisation management and GP lead are part of the membership. To canvass wider clinical support, key work programmes have been taken through relevant clinical committees in CCGs, including three Clinical Executives, a joint Planned Care Board between CCG and an acute trust, and a Clinical Reference Group.

The group recognises that as more specific pathways develop, further discussion with be required with the appropriate subject matter experts; this is already in place for four priority specialties above. At the time of writing, clinicians from the STP Planned Care Board and the leads of each of the five GP provider organisations have agreed to meet to discuss the programme of work and further involvement at grassroots level.

So far, clinical involvement has been a key influence to:

- Following the latest high quality evidence
- Ensuring that pathways take into account key local services and patients’ individual personal needs
- Identifying potential professional educational needs
- Identifying vulnerable populations for whom the modifications to pathways might be required

**What is the impact on our wider determinants of health?**
The proposed formation of a single CCG would also allow the Strategic Commissioning team to more easily organise consultant input into major planned care disease areas where primary care, community care and acute care need to work together with public health colleagues, most notably the Rightcare areas of respiratory and cardiovascular disease. The prevention chapter details many of the social, community and behavioural determinants of outcomes.

Contacts with health services for patients undergoing COPD, cardiovascular disease patients or planned surgery are an ideal opportunities to reinforce messages in relation health improvement. For example, Great Yarmouth and Waveney CCG and the James Paget University Hospital are piloting advisory leaflets on smoking and weight loss specifically aimed at those about undergo an operations, and the cardiology teams at the James Paget University Hospitals and the Norfolk and Norwich University Hospital are incorporating smoking cessation into their shared pathways. Norwich and Great Yarmouth and Waveney have also introduced reviews of COPD patients prior to winter, to review their inhalers and agree what their management plan is should their symptoms get worse, and one of the provisions of the review is that existing smokers should be referred into smoking cessation services.

An NHS Smokefree subgroup of the Tobacco Control Alliance has been established, chaired by a Consultant in Public Health, and has agreed the following aims:

- All NHS trusts in Norfolk have committed to being Smokefree, have a named champion at board level and a named staff lead and have signed the NHS Smokefree pledge
- All clinicians in primary and secondary care are confident in following the Ask, Advise, Act protocol so that all patients who smoke are offered support to quit
- The smoking status of all patients in primary and secondary care is asked and recorded
- All primary and secondary care disciplines supporting all promotional campaigns to reduce smoking prevalence
- All clinicians and healthcare professionals working in primary and secondary care are confident to discuss e-cigarettes with patients who smoke and others in the patient’s household
- All clinicians and healthcare professionals working in primary and secondary care are confident to discuss second and third hand smoke with patients who smoke and others in the patients household

How will we engage going forward?

We have Healthwatch representation at each level (STP Planned Care Board, the parent Acute Transformation Board) and although at present this is sufficient at the moment where simple pathway changes are proposed (such as whether an endoscopic or radiological investigation is used). As the proposals develop, there may be more substantial changes (such as interaction between patients and doctors through means other than face-to-face appointments) and this is where further engagement work will be required.

What does this mean for our workforce?

At present most of the focus is on sustainability of the specialist workforce, and notably in year one with the formation of the Ear, Nose and Throat hospital team covering both the James Paget Hospital and Norfolk and Norwich Hospital, and the urology single acute clinical team covering all three hospitals. There are also agreed plans for oncology and haematology teams to follow in year one. As specialties are examined across the whole geography and across primary, community and acute boundaries, opportunities for the involvement of non-acute staff, such as GPs with extended roles, will be thoroughly explored.

What does this mean for our technology?
The capability for Referral Assessment Services, described above, already exists within the existing e-Referral system, and one of the main tasks will be adjust clinical timetables to enable consultants to review the referral requests regularly and give timely responses. Providers are exploring existing technological solutions used in other areas in relation to virtual consultations and reviewing them with local clinicians to see which ones would best fit Norfolk and Waveney patients and service models. As part of the hospitals’ wider update in relation to technology, as with other specialties, consultants will need to be able review notes from patients seen at one of the two other hospitals.

What does this mean for our buildings?

Norfolk and Waveney held a minor surgery workshop in July 2019 as part of its exploration of community capacity for these operations, and other diagnostics and procedures. As part of the restructuring process for the commissioners, a Senior Programme Manager is proposed which will focus on community-based planned care and map out potential opportunities to increase capacity, subject to affordability.

What will be different?

Case study: A 60 year-old man with bowel problems may be referred for an outpatient appointment with a gastroenterologist, and when he or she turns up, be told what is needed is an endoscopy or a scan. Alternatively, the GP may suspect a particular diagnosis and refer this patient to endoscopy, but when they arrive the specialist may say that the patient could have been treated by the GP with specialist advice, or that they don’t need an endoscopy but a review in an appointment. Under the proposed changes, in key clinical specialties, primary care would share the patient’s clinical information securely with the hospital and within a week the consultant would feedback which is the best option to proceed with initially; this would avoid unnecessary waits and hospital visits.

Thinking about ‘patient initiated follow-up’, a 45-year old woman with a disease caused by inflammation might currently be seen in an appointment and then asked to come back after 12 months for a review. The trouble is that she might have a flare up before her next appointment, or be absolutely fine on her present treatment. Under the scheme, she will be able to provide information electronically to the hospital team which would enable the review date to be changed, or avoided altogether.

For the vast majority of patients, the creation of single clinical teams for some specialties will not affect where they receive their care. The present situation will continue - in most cases, care will be at their closest hospital, or Norfolk and Norwich if it is a highly specialist treatment, or further afield for the rarest conditions. For example, a teenager living close to the James Paget Hospital, needing their tonsils removed would still be treated in Gorleston, only the clinical team that does this will be shared between the hospitals. Having a single clinical team for these specialties will mean that if, for example, later in life they were to move to Norwich have an ENT problem, they would receive care from the same team that treated them in Gorleston.
Cardiovascular Disease

Our local priorities for cardiovascular disease

- To improve prevention, early detection and treatment of cardiovascular disease (CVD)
- Use intelligence from PHE Fingertips, NHS RightCare and established local information systems to focus on areas showing adverse variation in outcomes
- Embed CVD prevention in practice at all levels of services
- Improve and extend the lives of patients with heart disease, so that how healthy you are or how long you live does not depend on where you live in Norfolk and Waveney
- Be forward thinking about the way in which we deliver care to patients

Our local system

CVD covers some of the big causes of death and disability in Norfolk and Waveney, including heart attacks and stroke. The estimated adult population with hypertension is 275,400 and for those with undiagnosed hypertension this is estimated to be 111,800. GP registered population with Atrial Fibrillation (AF) is 23,200 and estimated population with undiagnosed AF is 9,600.

A Norfolk and Waveney CVD Programme Board has been established for over a year to oversee a programme of work focussed on improving CVD outcomes. There have been some notable successes, having reduced strokes and myocardial infarctions in the area this year. It was shortlisted for the NHS Clinical Commissioners Healthcare Transformation award for Improving Outcomes and Reducing Variation.

Along with further improving outcomes for CVD, we are looking at streamlining policies and pathways across the three acute hospitals and providing more equitable access to diagnostics. This would aim to address the inequity in service provision, as well as reduce variation in outcomes due to population demographic.

Our local challenges

Our local challenges for CVD relate to having a high concentration of older people living in North Norfolk and concentrated areas of high deprivation in Lowestoft, Great Yarmouth, Norwich and King’s Lynn. This is mirrored in population health data relating to social deprivation, smoking, obesity, prevalence of Hypertension and Atrial Fibrillation, among others. The PCNs in Norfolk and Waveney are staring to work at population health level and focussing on the issues relating to their population. The CVD Programme board pulls together local representation and programmes for improving CVD outcomes.

Our local successes

We have has success in reducing the number of strokes and myocardial infarctions in our population. There are further challenges which we are aware of and working towards addressing. One example is the relatively high prevalence of 0.9 for heart failure in Norfolk and Waveney. This is higher than the average of 0.77 for England, as well as higher than the 0.81 for Midlands and East. There is opportunity for improvement in clinical pathways for heart failure to include earlier detection, increased take up of diagnostics, reduced admissions and readmissions and more support for end of life.

What the public tell us
Healthwatch provide the platform for public engagement with representation on the monthly CVD programme board. Input is received from patient representatives on governing bodies and local delivery groups. We are building patient feedback and evaluation into our projects at initial stages. Equality impact assessments have been conducted and approved through governance and clinical quality teams.

What our stakeholders and our staff tell us

The workstreams of the CVD programme were selected based on discussions and agreement at an initial stakeholder forum. This included clinical representation from the acute trusts, CCGs, Local Pharmaceutical Committee, community trusts, ambulance trust and Healthwatch. Based on the feedback the following five areas of work were selected:

- Prevention and management in primary care
- Referrals
- Elective procedures
- Urgent pathways
- Heart failure / cardiac rehabilitation

The above areas were taken forward as separate workstreams with involvement of the relevant clinical staff and project support. Further details of the work done is included in the “How are we going to deliver?” section below.

The national priorities we must deliver

The NHS Long Term plan was published earlier this year and has specific ambitions relating to cardiovascular diseases. We are working towards these ambitions as a system:

- Prevention based on ABC
- Detect 85% of expected number of people with AF
- Treat 90% of patients with AF who are already known to have high risk of stroke
- Detect 80% of expected number of people with high blood pressure
- Treat 80% of the total number of people already diagnosed with high blood pressure
- Deliver NHS long term ambitions for Cholesterol, in term of risk assessment and treatment

Hypercholesterolaemia

- Support the NHS Long Term Plan ambition of expanding access to genetic testing for Familial Hypercholesterolaemia (FH) to improve the number of those with FH have been identified, to at least 25% in the next five years through the NHS genomics programme.

Heart Failure

- Use a proactive population health approach focused on moderate frailty will also enable earlier detection and intervention to treat undiagnosed disorders, such as heart failure.
- People with heart failure and heart valve disease will be better supported by multi-disciplinary teams as part of primary care networks, 80% of heart failure is currently diagnosed in hospital, despite 40% of patients having symptoms that should have triggered an earlier assessment.
- When admitted to hospital, we will improve rapid access to heart failure nurses so that more patients with heart failure, who are not on a cardiology ward, will receive specialist care and advice.
- Greater access to echocardiography in primary care will improve the investigation of those with breathlessness, and the early detection of heart failure and valve disease.

Cardiac Rehabilitation

- By 2028 the proportion of patients accessing cardiac rehabilitation will be amongst the best in Europe, with up to 85% of those eligible accessing care.
How are we going to deliver?

CVD Programme is being delivered through the different workstreams of the CVD programme board. Details of the completed and current work, is as below.

1. Prevention and Management in Primary Care

The prevention workstream of CVD RightCare aims to improve the Prevention and Management of high blood pressure, atrial fibrillation, high cholesterol and familial hypercholesterolemia in Primary care. The programme of work on each of these is well underway:

- Earlier identification and improved management of patients with hypertension in community pharmacies – Norfolk and Waveney ran a public health campaign in April 2018 to increase awareness of high blood pressure. We also identified patients at high risk of having high blood pressure through cross-referencing of GP medical records (Eclipse, SystmOne, EMIS) and Quality and Outcomes Framework (QOF) data and invited these individuals to the practice for a blood pressure test. Currently the group is implementing a community pharmacy project focussed on detection of hypertension and atrial fibrillation. This project is live in four out of five CCGs and roll out to be completed in November. We have focussed our work on patient population of GP surgeries with the highest deprivation and hypertension prevalence.

- Increased identification and improved management of patients with AF – We have been successful in securing 169 handheld NHS England funded mobile ECG devices (AliveCor Kardia Mobile) for detecting AF as part of the national Academic Health Science Network (AHSN) roll-out. These have been distributed to GP surgeries, community services and hospitals across Norfolk and Waveney. This programme has contributed to the national AHSN evaluation.

- Improved management of patients with a higher risk of CVD not currently on a register – A GP LCS for identifying high risk patients and following-up on patients not optimised has been implemented in two CCGs. The selection criterion is based on the undiagnosed risk factors for CVD – BMI, Age, Alcohol consumption. This LCS aims to reduce the gap between the expected and known prevalence of hypertension and improve the treatment of this cohort of patients. This LCS is included in the contract for Great Yarmouth and Waveney CCG. Work is on-going to introduce this across Norfolk and Waveney STP.

- Increased identification and improved management of patients with familial hypercholesterolemia, with the provision of a cascade testing service. A business case was approved by the CVD programme board and submitted to Joint Contracting and Commissioning Executive (JCCE). This is awaiting further information from specialised commissioning on the funding of the genetic testing element.

Further work on prevention will be developed with the Primary Care Networks (PCN) and localities in the STP, based on intelligence and opportunities that have been identified.

2. Referrals

This workstream completed a joint review of referrals to cardiology. This was undertaken by consultants and GPs in each of our acute trusts. Information was collated from the three audits, one for each acute trust and a report was submitted to the planned and unplanned care clinical network for Norfolk. After reviewing the report, the steer from the network was to focus on Atrial Fibrillation (AF). As a result, the AF pathway for primary care was designed, in collaboration with clinical colleagues in primary and secondary care. This has been published on Knowledge Anglia.

3. Elective Procedures
This project was established in 2018 in response to analysis that showed the Norfolk and Waveney CCGs were outliers in relation to some elective procedures, and in some cases there were differences between the central CCGs and their West and Great Yarmouth and Waveney counterparts. The first meeting took place on 19 June 2019 to:

- Analyse of the different procedures’ activity and average spend across the three acute trusts and five CCGs
- Establish reasons behind the difference on spend in comparison with similar CCGs
- Develop an action plan to address the findings

The specific procedures with the highest opportunity according to the data pack are:

- K636 Coronary Arteriography – Opportunity 123 procedures, 112 in west Norfolk
- K634 Coronary Arteriography using two catheters – Opportunity 969 procedures, 274 for Great Yarmouth and Waveney CCG, 264 for South Norfolk CCG and 253 North Norfolk CCG.
- K606 Implantation of intravenous dual chamber cardiac pacemaker system

The number of Arteriography’s is thought to be high due to the lack of Cardiac CTs. That there is lack of capacity in Cardiac CTs is acknowledged as a constraint in the local acute trusts. The main message therefore is that the number of procedures are related to the lack of availability of appropriate diagnostic imaging.

There is long waiting list for Cardiac MRI, Cardiac Stress MRI and Cardiac CTs. In some cases an Angiogram and a Cardiac CT are interchangeable. The clinical team will therefore look at current pathways and treatment thresholds with a view to streamlining this. This work has been taken up by our Acute Transformation workstream.

4. Urgent Pathways

The aim of this group is to look urgent NSTEMI, pacemaker and vascular pathways. The group has met and explored the various scenarios and has decided to focus on NSTEMI because acute providers understand the potential benefits and are open to remodelling the pathway.

Currently patients from West Norfolk and from Great Yarmouth and Waveney quite often start with an admission at the JPUH or QEH, and are then transferred to NNUH or Papworth for their treatment.

The project arranged a NSTEMI pathway redesign workshop on 18 May 2018. This brought together clinicians, paramedics, urgent transport providers and operational managers from the region. The session was facilitated by Dr Richard Jones and Dr Toomas Sarev (Service lead for Cardiology at the Norfolk and Norwich University Hospital).

It was decided by the participants to create a patient flow sub group. This group is looking at actions and ideas that were generated at the workshop. The redesigned pathway was expected to streamline the patient journey for NSTEMI between the trusts. This would reduce ambulance transfers, treatment time for patients and the spend on each episode of care.

We examined the pilot of direct admission via ambulance to Papworth from West Norfolk for high-risk NSTEMIs; as the ECG tracing can vary more for a NSTEMI whereas it is quite characteristic for a STEMI. Whether to (a) review the outcomes data from the Papworth pilot prior to proceeding, or (b) adopt at an earlier stage, when we might have learning from the operational aspects but no outcomes data, was considered.

The work described in the previous paragraph to smooth the tertiary referral process from the JPUH to NNUH continues to progress, as not all patients can be diagnosed in the ambulance and many will only be diagnosed once they are admitted. Further streamlining of clinical pathways will continue to be developed.

5. Heart Failure and Cardiac Rehabilitation
The group was formed to include key staff and has had active engagement and representation from heart failure nurses across Norfolk, the British Heart Foundation, the primary care CVD lead, GP Dr Sarah Flindall and Dr Sunil Nair (lead consultant for Heart Failure at the NNUH).

The group decided that it would focus on the following:

- Map the existing services across Norfolk and Waveney in order to identify gaps or discrepancies.
- Agree on the priorities for improving outcomes for patients who would benefit from cardiac rehab and heart failure services.
- Design services to enhance the provision of cardiac rehab including that for Heart Failure patients.

There was consensus on the following observations:

- The services offer high quality care for patients under their care. However the services are not widely advertised to primary care clinicians due to the limitations on capacity.
- There is disparity in provision across Norfolk and Waveney.
- There is disparity in the availability of cardiac rehabilitation and heart failure patients had least access.

As a result of the work of the group, it has been decided to establish an end-to-end heart failure pathway, to include prevention in primary care, care in hospitals, cardiac rehabilitation for heart failure and end of life care. A workshop is planned for February 2020 with include clinical staff and other stakeholders to take this forward.

How will this be clinically led?

The STP CVD Programme board has been in place since early 2018. This has clinical representation from the acute trusts, CCGs, Local Pharmaceutical Committee, community trusts, ambulance trust and Healthwatch. The programme is supported by the primary care lead doctor for cardiovascular diseases. Clinical support has been instrumental in the success of our programme in:

- Developing pathways for atrial fibrillation
- Implementing the hypertension locally commissioned service
- Conducting virtual clinics for the AF optimisation programme in Great Yarmouth and Waveney
- Running the AF clinics in West Norfolk CCG
- Developing the Familial Hypercholesterolaemia business case
- Agreeing the way forward for Heart Failure
- Streamlining patient transfers and direct admissions for NSTEMI

What is the impact on our wider determinants of health?

The CVD Programme Board has actively participated in the public health work at Norfolk and Suffolk county councils. We input into and invite input from Active Norfolk and One Suffolk, who work on increasing activity in our population. We are working on including smoking cessation in pathways for CVD. We have included advice on lifestyle, smoking and alcohol into the our project, working with community pharmacies. This project is being rolled out in areas where we have highest, deprivation and prevalence of hypertension in our population. We aim to further expand this work based on population health information of our PCNs. The prevention chapter details many of the social, community and behavioural determinants of outcomes.

We are reinforcing the message through our programme to health professions and organisations and further spreading the message using the Making Every Contact Count methodology.

How will we engage going forward?
This plan will form the basis of further work on CVD alongside national recommendations. The engagement will continue with our stakeholders through the CVD Programme Board and through interaction with other groups, for example with the respiratory programme, where we are developing cardiac rehabilitation for heart failure patients. We will engage with service users through Healthwatch and our colleagues in PCNs.

**What does this mean for our workforce?**

The impact on workforce will be in terms of different ways of working, where focus is on the earlier part of the cardiovascular disease pathway. This is in line with the CVD ambitions for prevention in the NHS Long Term Plan, where prevention and earlier detection is the underlying theme across cardiovascular conditions. This is ultimately expected to reduce the number of strokes and heart attacks. This indicates increased involvement of the colleagues in community pharmacies working alongside colleagues at PCN level. Specific projects will have indications for workforce where we need to increase the service offering. However the pathways will be developed from end-to-end including use of technology to assist as appropriate.

**What does this mean for our technology?**

We have used technology to extract current intelligence from our general practices and develop locally commissioned services based on this. The project for detection of AF and Hypertension with community pharmacies was also based on NICE approved technology for detection. We have assessed the use of apps in our pathway development.

**What does this mean for our buildings?**

At present the CVD work has not identified any requirement for additional buildings. However as our work plan becomes more concrete and we implement our plans we expect to see a reduction in admission to acute care for stroke and heart attacks. This is also expected to be the case for patients suffering heart failure as we detect more in primary care and reduce admissions and readmissions to our hospitals. There would be implications for increased diagnostics and this may require additional capacity. We will work together with our hospitals to plan for this.

**What will be different?**

We expect to measure the difference our work makes to clinical outcomes. A dashboard has been in place for the CVD programme board. This looks at process and outcome measures, which are in line with the recommendations in the NHS Long Term Plan, and include:

- Number of patients with AF – Measures increase in detection of AF and the reduction of the gap between known prevalence and expected prevalence.
- Number of patients with known AF anticoagulated – Measures increase in anticoagulation of patients with known AF.
- Number of patients with Hypertension – Measures increase in detection of hypertension and reduction of the gap between known prevalence and expected prevalence.
- Number of patients on treatment for hypertension – Increase the number of patients on treatment for hypertension.
- Number of patients with Familial hypercholesterolaemia – Measures increase in the number of patients treated for Familial hypercholesterolaemia.
• Number of patients admitted to hospital with primary diagnosis of heart failure – Measures reduction in emergency admissions for heart failure.
• Number of patients admitted to hospital with primary diagnosis of stroke – Measures reduction in admission for stroke.
• Number of patients admitted to hospital with primary diagnosis of Myocardial Infarction – Measures reduction in admissions for heart attacks.
**Specialised Services**

NHS England ‘Specialised Services’ has a statutory duty to directly commission (purchase) certain services on behalf of the entire population of England.

The immediate strategic priorities for Specialised Services are:

1. Cancer
2. Mental Health
3. Learning Disability and Autism
4. Cardiovascular Disease
5. Healthy Childhood
6. Prevention, long term conditions and equity of access
7. Personalised medicine and genomics

The strategic priorities are based on the themes of the Long-Term Plan and include clinical objectives such as the development of gender dysphoria services.

To support the Long Term Plan’s ambition for national direction balanced with local autonomy, specialised commissioners will work with local systems to support joined-up decision making.

Even where NHS England remains ultimately accountable, local systems will consider where they could work more closely with national leads to improve the care delivered to patients, particularly in those clinical areas where Specialised Services are delivered alongside locally-commissioned services, such as cancer, mental health or kidney care.

**Delivering the Long Term Plan**

Specialised commissioners in the East of England will:

- Be part of local systems in the development of local implementation plans.
- Work with local systems to identify how Specialised Services could be more integrated into wider pathways of care.
- Streamline services and support local ambitions to transform acute services.
- Identify opportunities to reduce unwarranted variation and manage demand.
- Encourage the use of, and benefits from, new technologies and innovative treatments.
- Maintain financial stability and support the regional ambition of balanced health economies.
- Share financial risk, where in the interest of patients and the public.
- Maintain focus on quality and national standards of care and compliance with national Specialised Service specifications.

Key work areas for Specialised Services in the East of England Region:

- A Specialised Commissioning Planning Board will be established, with representation from the six STPS at a senior level to oversee the development of strategy and delivery of Operational Plans.
- Specialised commissioner representation on STP/ICS governance and working groups.
- Cancer Alliances, Operational Delivery Networks and other clinical networks will be empowered to manage and direct improvements in clinical services across the Region.
- Building on GIRFT, Rightcare and other improvement methodologies, projects will be initiated to reduce unwarranted variation and improve quality and efficiency in specialised pathways.
- A Radiotherapy Network has been set up to improve access across the region.
- A review of services at the Mount Vernon Cancer Centre.
• Provider Collaboratives are being developed to ensure mental health, learning disability and autism services are integrated locally and are delivered as close to home as possible.
• The aim for learning disability and autism services is joined up and seamless care, reducing reliance on inpatient care and ensuring that, where inpatient care is required, it is of high quality.
• Improving outcomes and experience for people accessing specialised cardiovascular services.
• Review of the Vascular service model in Norfolk
• Commissioning a regional service for Mechanical Thrombectomy.
• Capacity review of Neonatal Care aligned to Local Maternity Systems.
• Development of the Paediatric Critical Care Operational Delivery Network including High Dependency Units.
• Recommissioning a Paediatric Intensive Care transport service.
• Commissioning Intestinal Failure services for the region.
• Enable people to benefit from the latest advances in genomics and personalised medicine through implementation of the new Genomic Laboratory Hub service.
Stroke

Our local priorities for stroke

Within SSNAP our local Stroke Network is focused on improving the key quality indicators for stroke services, namely:

- 20% of patients thrombolyised (clot-busting) by 2025
- Tenfold increase in numbers of patients receiving thrombectomy (clot retrieval) by 2022 – we will need to work closely with commissioners and network partners to achieve this goal
- 90% of patients admitted to the stroke unit within four hours by 2021
- Expand beyond the current 40% of patients undergoing early supported discharge by 2023
- 95% of patients receiving a six month review by 2022

The above priorities contribute to our system-wide goals in the following ways:

The Stroke Network’s purpose is to continuously improve the quality of stroke services across Norfolk and Waveney. In doing so it will ensure patients receive the same high quality care and experience, no matter where they live in Norfolk and Waveney. We will judge our services using the national quality audit dedicated to stroke services – Sentinel Stroke National Audit Programme (SSNAP). The Network recognises that it is our current and future staff that will deliver our excellent stroke service. Consequently, the Network will focus its energy and efforts on attracting and retaining the best staff.

Our local system

The population of Norfolk and Waveney is older than England and is aging, all things being equal we would expect more strokes. This is reflected in GP records for the diagnosed prevalence of stroke.

Age standardised mortality rates for stroke have declined over the last 10 years for both men and women but the number of deaths for men has remain relatively stable. Deaths from stroke make up about 20% of all circulatory deaths (about 500 per year) in Norfolk and Waveney.

Age specific admission rates for stroke show that they are potentially increasing for some age bands (older women) but declining for others (older men). There are about 2,100 emergency admissions for stroke and if age specific trends continue this is expected to increase to about 2,350 by 2025/26.

North Norfolk CCG and West Norfolk CCG have higher than expected non-elective admission rates given their demographic and deprivation profiles. However, in 2018/19 there were 54 fewer strokes in West Norfolk compared to the previous year, which is a consequence of a targeted Atrial Fibrillation (AF) programme. Further details are included in the chapter on Cardiovascular Disease (CVD).

However, at a GP surgery level most practices are within expected limits of variation and there are only a few localities areas across Norfolk and Waveney that have higher than expected emergency admissions.

Our emergency admissions data shows that most strokes arrive through hospital Emergency Departments with a diagnosis of cerebral infarction, will undergo a CT scan and be discharged back to their usual place of residence. About 14% will die in hospital and the average length of stay across Norfolk and Waveney is less than the England average of 14.5 days.

The CCG outcomes indicator set for stroke indicators shows a slightly above average set of outcomes for the CCGs across Norfolk and Waveney.
However, there are a number of modifiable risk factors that if addressed can reduce risk of stroke. There is a large prevention opportunity across Norfolk and Waveney in terms of undiagnosed hypertension (high blood pressure), atrial fibrillation (irregular heart beat), obesity, diet and exercise, smoking and alcohol.

There is also a secondary prevention opportunity in managing those with high blood pressure, irregular heartbeat, and stroke.

Our stroke services are provided by our three acute NHS trusts, with support from partners, including the ambulance service, community services, social care and the Stroke Association. Each of our hospitals has a Primary Stroke Centre, which provides patients with thrombolysis (clot busting), hyper-acute beds for the first 72 hours of treatment, acute beds for ongoing treatment and care, and follow-up appointments with doctors. These services are delivered by multidisciplinary teams (MDT), made-up of doctors, nurses, healthcare assistants, occupational therapists, speech and language therapists, physiotherapists, psychologists and dietitians; with support from paramedics, radiographers, pharmacists and administrative staff. Each hospital also provides an out of hour’s service, as strokes can occur at any time of day. The James Paget University Hospital and Queen Elizabeth Hospital make use of a regional telemedicine service to support them to deliver their out of hour’s service.

In-patient rehabilitation is provided for those patients who require more rehabilitation to reach their goals. This is provided as part of the acute service at James Paget University Hospital and Queen Elizabeth Hospital. For Central Norfolk patients, they can be transferred to Beech Ward, which is a dedicated stroke rehabilitation ward, in the Mulberry Unit at Norwich Community Hospital.

There is variability in the provision of Early Supported Discharge (ESD), which supports stroke patients to return home with regular visits from community nurses and therapists to help with rehabilitation. Currently, we have services for Norfolk and Norwich University Hospital and James Paget University Hospital, but no dedicated service for the Queen Elizabeth Hospital. The service for Central Norfolk is provided by Norfolk Community Health and Care NHS Trust (NCH&C), with East Coast Community Health (ECCH) providing the service for Great Yarmouth and Waveney. Both services support local patients to return home following their stroke, no matter where they have had their initial treatment, this includes overseas.

To support the reduction in the number of patients having initial and further strokes the acute hospitals provide planned and urgent outpatient appointments. Within these they assess patients who may have had a Transient ischaemic attack (TIA) – also known as minor stroke – as well as review patients who have recently had a stroke to check how they are recovering.

Our local successes

The Norfolk and Waveney Stroke Network was re-established in October 2018 to facilitate collaborative working and to continuously improve the long term health outcomes of patients at risk of, and experiencing a stroke. Its membership includes doctors, nurses, therapists and managers from CCGs, NHS England and NHS Improvement, NHS Trusts, Stroke Association and Healthwatch Norfolk.

The Network’s focus to date has been on improving current services and developing our five year plan. The Sentinel Stroke National Audit Programme (SSNAP) assesses the quality of stroke services against nationally recognised standards of excellence. The table shows the SSNAP Patient-Centred Performance in East of England for April to June 2019:
Our local challenges

Our three services have shared challenges – it should be noted these are similar to those faced by other medical services, in particular neurology and older people’s medicine:

- Increasing demand due to greater incidence of stroke
- Growing number of patients requiring more time for rehabilitation
- Limited investment in IT systems has resulted in out of date IT software and hardware
- Difficulties with nurse recruitment
- Difficulties with medical doctor recruitment
- Need for larger teams to expand therapy services to seven days per week
- Restricted access to imaging (including MRI scan, CT angiogram, CT perfusion, ultrasound of carotid arteries)
- Current capacity of beds insufficient to ensure direct admissions of all stroke patients to Hyper Acute Stroke Unit
- Consistent access to stroke thrombectomy (clot removal) service
- Availability of suitable social care providers for patients with complex needs
- Inequity in access to long term community neurological rehabilitation services, which enable patients to received rehabilitation for a short period of time, or slower rehabilitation over a long time period.

What the public tell us

We receive comments from our patients and their families in a number of ways, including conversations with staff members and volunteers, letters and thank you cards, and responses to questionnaires (e.g. NHS Friends and Family Test). Points of learning from complaints about our service are taken seriously, with senior doctors, nurses and therapists making sure their staff change their practice accordingly.

The Stroke Network and Stroke Association are working together to improve communication and engagement with residents about stroke. From April 2020 we will be speaking with local stroke groups to share our plans, and seek their members support with delivering them. Where local stroke groups do not exist we will consider setting one up, to ensure that locality is represented, e.g. North Norfolk.
Currently we have limited information about the outcomes and experiences of patients and their families who have received treatment, care and support from our stroke service. To gain this information, we are planning to set-up a Patient Reported Outcomes Measures (PROMs) system for regularly asking patients about their level of disability, well-being and health-related quality of life. Alongside we will set-up a Patient Reported Experience Measures (PREMs) system for regularly asking patients and their families about their experiences of treatment and care.

What our stakeholders and our staff tell us

In May 2019 the Stroke Network and its members organised and held events as part of the Stroke Association’s Make May Purple Campaign. The aim of their campaign is to raise awareness of stroke, using FAST (Facial drooping, Arm weakness, Speech difficulties and Time). A wide range of events were held by NHS and Stroke Association staff at Norfolk and Norwich University Hospital, James Paget University Hospital, Norwich Community Hospital, Cromer and District Hospital, and Queen Elizabeth Hospital. Themes from the staff, patients and members of the public who attended the events included the need to regularly promote the prevention of strokes, greater use of technology to support stroke patients and their families (e.g. My Stroke Guide and assistive technology), and wider range of post-stroke support (e.g. patient / carer forum).

Our staff members are encouraged to suggest ways to improve our stroke pathway. A recent example is the development of a tone and postural management service, which supports patients who have had a severe stroke to avoid muscle tone and postural problems developing due to limited movement of their arms, legs and bodies. Another example, which is being discussed, is the need for a team of nurses and therapists to support neuroscience patients to manage their conditions (e.g. stroke, Parkinson’s, multiple sclerosis) within in their own homes.

The national priorities we must deliver

The NHS Long Term Plan contains four objectives for stroke care, which are detailed below.

- In 2019 NHS England and NHS Improvement will, working with the Royal Colleges, pilot a new credentialing programme for hospital consultants to be trained to offer mechanical thrombectomy (clot removal).
- By 2020 NHS England and NHS Improvement will begin improved post-hospital stroke rehabilitation models, with full roll-out over the period of this Long Term Plan.
- By 2022 NHS England and NHS Improvement will deliver a ten-fold increase in the proportion of patients who receive a thrombectomy (clot removal) after a stroke so that each year 1,600 more people in England will be independent after their stroke.
- By 2025 England will have amongst the best performance in Europe for delivering thrombolysis to all patients who could benefit.

The Implementation Framework provides further detail on how in 2019/20 the national stroke team will assist systems to develop and deliver their plans by:

- working with the Stroke Association to support a number of ICS areas, focusing primarily on stroke rehabilitation service configuration and improvement
- continued improvement of Sentinel Stroke National Audit Programme (SSNAP), the national audit for stroke, providing effective data reporting, dashboards and evidenced guidance to drive full system stroke improvement
- developing and publishing a CQUIN for:
  - six months reviews post-stroke
  - thrombectomy staffing
- publishing, in summer 2019:
  - an outcomes-based Integrated Stroke Delivery Network (ISDN) service specification
– a health economic modelling tool
– the nationally commissioned evidence-base for stroke service improvement

How are we going to deliver?
Our Five Year Plan is structured around the NHS Midlands and East Stroke Pathway, which is divided into seven phases, as illustrated below.

Summary stroke pathway diagram (NHS Midlands and East, 2012)

We have a number of projects already underway, as detailed below, which will be incorporated into workstreams that align with the phases of the pathway. The diagrams illustrate the phases, key activities and timescales.

- Earlier identification of strokes

- Appraise our model of Hyper-Acute Services
• Review our Early Supported Discharge Service to respond to capacity and assess issues.

• Establish a local Mechanical Thrombectomy (clot removal) service at the Norfolk and Norwich University Hospital

• Improve post-hospital stroke rehabilitation
Alongside this we have been making progress on a number of enabling activities, including:

- improving our digital services
- increasing our involvement in research and innovation
- identifying future workforce requirements
- strengthening relationship with stroke survivors and their families.

We recognise the need to work with neighbouring areas to realise the quality improvement and transformational goals of the Long Term Plan. To achieve this we will proactively engage with neighbouring STPs/ICSs, through the existing Delivering Improvements in Stroke Services (DISS) ‘regional stroke network’, chaired by NHS England and Improvement’s Deputy Medical Director. Our initial focus to April 2020 will be on agreeing terms of reference, funding and hosting arrangements for relevant staff, management structure, agreeing ISDN boundary and cross-boundary mitigating actions.

**How will this be clinically led?**

The Stroke Network has a clinical lead who is an experienced senior stroke consultant. They are supported by clinicians from across our stroke services, in particular the senior doctors, nurses and therapists who attend the monthly meetings, and are involved in the project teams. Our approach ensures all decisions made by the Network improve the stroke services for Norfolk and Waveney.

**What is the impact on our wider determinants of health?**

It is important to remember that stroke is a preventable condition, like other cardiovascular diseases (CVD). Details on CVD and the wider prevention programme for Norfolk and Waveney are described in other chapters. To support the prevention of strokes the Stroke Network has identified a number of ways to improve the current pathway, including:

- Changing the services we offer to patients who have had a Transient ischaemic attack (TIA) – also known as minor stroke, to help them to make changes to reduce the risk of a full stroke.
- Working with primary care to ensure patients who would benefit from statins and anti-coagulants are prescribed them, alongside promoting a healthier lifestyle.
- Speaking to patients six weeks after their stroke
• Reviewing progress with patients six months after their stroke to provide an opportunity to increase the choice that people have over the way their care is delivered and planned, based upon what matters to them and their individual strengths, needs and preferences. It provides an opportunity to identify unaddressed needs and consider wider support such as social prescribing.

How will we engage going forward?

The Network wishes to involve patients and the public in its work in a number of ways. This includes by working with the Stroke Association’s existing local groups, as well as with stroke survivors and their families, as part of our six month reviews. We also use Make May Purple and World Stroke Day as opportunities to engage. The focus of these conversations will be on the different phases of the pathway the Network is working on. The views of stroke survivors and their families will be shared with the Stroke Network, with representatives invited to attend as required.

What does this mean for our workforce?

Our workforce, like other health and care services, face a number of current and future challenges. In particular having enough trained doctors, nurses and therapists to deliver a high quality service in hospital and the community. We are, with partners (UEA/Anglia Ruskin), responding to this in a number of ways:

• Recruiting stroke consultants from outside of Norfolk and Waveney, by promoting the excellent strokes services we have, and the lifestyle Norfolk and Waveney provides for individuals and families. We will continue to search nationally and internationally.
• Retention of stroke consultants through closer working between services at QEH, NNUH and JPUH; research and teaching opportunities with UEA; and expansion of MDT to include new roles to take on routine work from consultants.
• Expanding our staff team by considering how new roles (e.g. nursing associates, advanced care practitioners, and clinical associate psychologists) would fit into our multidisciplinary team, and the tasks and duties they could do.
• Encouraging individuals to join the NHS and social care as apprentices, so that they can learn their chosen profession whilst earning a salary.
• Improving the recruitment and retention of staff by understanding why they leave and/or are not attracted to working in stroke services.
• Training our interventionists, nurses and AHPs to provide stroke thrombectomy. We have identified a training partnership with Royal Stoke University Hospital, which is part of the University Hospitals of North Midlands NHS Trust.
• Promoting opportunities for individuals to develop and progress within their profession, e.g. specialist paramedics, advanced nurse practitioners, consultant nurses/therapists.
• Offering greater flexibility in rotas and work locations, so that individuals have the ability to work at different hospitals and stages of the pathway, e.g. QEH hyper-acute stroke unit, Beech rehabilitation ward and Great Yarmouth and Waveney community based early supported discharge team.
• Identifying opportunities to retain our staff, especially those who can retire but wish to continue working. These opportunities may include, part-time hours, involvement in research and development, and clinical education.
• Exploring, with the Eastern Academic Health Sciences Network (EAHSN), how technology can help staff members to treat and care for patients. For example artificial intelligence (AI) supporting with diagnosis of stroke, and wearable technologies helping with the monitoring of daily exercises as part of a rehabilitation plan.

What does this mean for our technology?
Currently, our three acute trusts do not have systems that are fully interoperable and their functionality can inhibit effective care, for example:

- JPJUH clinicians cannot see the JPJUH hospital electronic health record what has happened previously at NNUH and vice versa, unless the acute trust writes to the other, advising of patient correspondence. So, for example, should a Great Yarmouth patient be admitted to NNUH in the first instance and then subsequently has a second stroke, requiring admittance to JPJUH, clinicians at the JPJUH cannot see previous NNUH correspondence to the patient’s GP.
- Acute hospitals use different PACS. JPJUH Clinicians cannot see NNUH PACS and vice versa. Clinicians have to request copies of diagnostic images, which takes time.
- A consultant is potentially faced with up to eight different clinical system passwords when treating one patient.

The desired functions from our stroke teams of an Electronic Patient Record include:

- Available across whole stroke pathway, starting with emergency call through to discharge to GP.
- Provision of real time patient information.
- Mapped against the NHS Midlands and East Stroke Pathway.
- Ideally one system for all providers in Norfolk. If not possible then interoperability between the systems and access to view across multiple sites. For example radiology reports from JPJUH need to be viewable at NNUH.
- Information gathered by primary care providers (contact numbers, medical history, information about medication and allergies, information about current medical issues) can be shared by emergency departments. For example, if a person is allergic to a certain drug, this lifesaving alert is passed on even if the patient is unconscious.
- There is a record of recently-run medical tests, so unnecessary duplication can be avoided.
- Hospital notes, discharge plans, and follow-up instructions are readily available, which makes the transition from one setting to another smoother.
- One log in to access notes, scans, reports and results. We need to stop staff needing to log into multiple systems to provide care.
- Access to systems (e.g. PAS, Microsoft Office) is required in multiple settings within NHS estate (e.g. ward, outpatient clinic, office / meeting rooms), community and patient homes, and staff homes).
- Integration with Capture Stroke and SSNAP data uploads.
- Needs to be fully compliant with information governance.

For effective delivery, an Electronic Patient Record will need hardware in place, with sufficient processing power and storage. Allowance will also need to be made to accommodate sustainability. Whilst plans are in place to upgrade current out dated hardware, these plans will need to take into account Electronic Patient Record delivery requirements. To be effective, it is anticipated that a range of hardware will be required:

- To support ward rounds, where often a number of consultant ward rounds are taking place at once, a number of mobile units, with large screens and adequate processing power will be required, to support delivery. For example, at JPJUH there can be three ward rounds going on at the same time on the stroke unit, each would require a mobile unit.
- Tablet devices with scanning software, to support capture and uploading of real time date. Devices would also be able to deliver information to patients, their carers and family.
- Laptop units to facilitate mobile working e.g. drug rounds or therapy intervention.

What does this mean for our buildings?
The future estate requirement for stroke is likely to increase due to higher incidence of diagnosed stroke, and introduction of stroke thrombectomy (clot removal). Our exact requirements are not known at present, as we need to undertake our appraisal of options for hyper-acute services, and await service models/specifications from the national stroke team.

**What will be different for patients?**

As our plans are put into place there will be a number of positive changes to our stroke services. The most noticeable for patients will be:

- 24/7 access to thrombectomy (clot removal) treatment, as described by Ronnie’s story, available at: [https://www.longtermplan.nhs.uk/areas-of-work/stroke/](https://www.longtermplan.nhs.uk/areas-of-work/stroke/)
- Greater awareness on how to avoid suffering a full stroke, following a Transient ischaemic attack (TIA) – also known as minor stroke, through talking with specialist doctors and nurses
- Improved community based services to support patients to go home from hospital, and regain their independence through rehabilitation delivered by nurses and therapists
- Enhanced knowledge of support available to patients and their families as part of six month reviews
- Improved quality of services, with SSNAP A rated services across Norfolk and Waveney

What this means in reality is:

At present we do not have a local thrombectomy service for our patients. Our plan will provide a local thrombectomy service at the Norfolk and Norwich University Hospital. This means that in future, patients would receive treatment locally at the Norfolk and Norwich University Hospital if their stroke was suitable for a thrombectomy. As a result, patients like this would make a quick recovery, enabling them to return to work after a few months with the support of community based therapists.

At present the stroke service at the Norfolk and Norwich University Hospital do not review patients six weeks after their stroke. In the future, the hospital will have a nurse-led six week follow-up service. This means that patients who experienced a Transient Ischaemic Attack (TIA), also known as a mini stroke, would be supported to ensure they receive lifestyle advice and that they are taking the medication prescribed by the doctor in the TIA clinic, which would reduce their risk of having a stroke.

At present the Queen Elizabeth Hospital does not have a dedicated early supported discharge service for stroke survivors. Our plan is to ensure all patients in Norfolk and Waveney has access to early supported discharge. This means that in future, patients would be able to return home with the support of the early supported discharge team. The nurses and therapists in this team would visit patients regularly for a period of time to help them regain their confidence with daily tasks.
Urgent and emergency care

Our local priorities for urgent and emergency care in Norfolk and Waveney

To address the continuing rise in emergency admissions to hospital and attendances at our emergency departments we have set ourselves the following key priorities to deliver over the next five years:

1. Crisis Response – Effective two hour crisis response service for patients who have an urgent care need that is not life threatening.
2. GP Streaming – A primary care led service within our hospitals emergency departments to treat or pre-book follow on appointments for minor illness or injury.
3. Discharge to Assess – A model of discharging patients from hospital when their treatment is complete and they are able to return home.
4. Digital Care Record – We will commence the implementation of a Norfolk and Waveney wide integrated care record from December 2019.
5. Same Day Emergency Care and Frailty Assessment – Allows for emergency patients who would otherwise have been admitted to a ward with certain conditions to be rapidly assessed, diagnosed and treated, and if clinically safe to do so, return home on the same day.
6. Urgent Treatment Centres – To complement the emergency services offered in our hospitals; open 12 hours a day, every day, offering appointments booked through 111 or a GP.
7. Continued focus on embedding SAFER bundle across our acute hospitals – Blends five elements of best practice to ensure patients move through health services as safely and efficiently as possible, ensuring all patients are in the right place to receive their care. (You can read more on the SAFER bundle in the section entitled ‘How are we going to deliver?’).

The above priorities contribute to our system-wide goals in the following ways:

- To make sure that people can live as healthy a life as possible – Our urgent and emergency care system will contribute to this goal by reducing variation in the range of services you can access across Norfolk and Waveney, for example we will have one model consistent approach to providing a two hour crisis response through the rollout of NEATs.

- For Norfolk and Waveney to be the best place for health and care professionals to work – We know that when our emergency services and departments come under pressure so do our staff and this contributes to the difficulties we have with recruitment and retention. By addressing our key priorities we should see demand smooth out across the system as we treat people in the right place at the right time, taking pressure off our emergency departments. As we improve outcomes this should also improve recruitment and retention.

- I only have to tell my story once – Key to this is the testing and rapid rollout of our summary digital care record that will allow clinicians operating across urgent and emergency care to see accurate information from primary care and the hospitals where we’ve been treated in the past. This single summary of our care could dramatically improve clinical decision making.
Our local system

From an urgent and emergency care perspective, our Norfolk and Waveney population is largely served by our three acute hospitals. All three of our hospitals face significant challenges around capacity, recruiting key staff and finance.

The Norfolk and Norwich University Hospital is one of the largest teaching hospitals in the country with approximately 1,000 beds. Its main purpose-built site is on the edge of Norwich and there is a smaller satellite at Cromer in North Norfolk which also provides for minor injuries. The Hospital provides hospital care mainly to the residents of Norfolk, North Suffolk and Waveney, but has a larger catchment area beyond Norfolk as a provider of specialist or tertiary services meaning it serves close to a million people.

The James Paget Hospital is a general hospital which has approximately 500 beds and is one of the largest local employers in the Great Yarmouth, Lowestoft and Waveney area which is the population it serves. The hospital provides acute care to approximately 230,000 residents, as well as to many visitors who come to this part of East Anglia.

The Queen Elizabeth Hospital is a general hospital on the outskirts of King’s Lynn which has approximately 500 beds and provides acute care to the residents of West and North Norfolk, Breckland, Cambridgeshire and South Lincolnshire. The population includes a high proportion of older residents although recent new housing developments has seen a large growth in principally young families.

Our hospitals are supported by a range of community and mental health services provided by Norfolk Community Health and Care NHS Trust, East Coast Community Healthcare and Norfolk and Suffolk NHS Foundation Trust. They operate from a variety of community hospitals, health centres and GP surgeries that support some of our most elderly or vulnerable groups in the community who can, if not well looked after, present at our hospital’s emergency departments.

Our local successes

Whilst we acknowledge we have a way to go, we have made good progress in terms of how our ambulance services are performing. More people are calling 999 or 111 resulting in an ambulance being sent, but the number of ambulances arriving at our hospitals is remaining steady, meaning more patients are being treated at home by the ambulance crews or being referred on to other services.

By changing the services we offer in primary care or in the community, we are able to provide a more appropriate response to meet the needs of our residents when they have an urgent need or a crisis. It also means we could reduce the number of ambulances being sent, freeing these crews up to attend life threatening incidents and allowing for a quicker response time.

This work is already underway as we have begun testing a two hour rapid response service we have called:

As the pressure on our hospitals has increased, we have worked with our community colleagues to look at more efficient and effective ways to support our residents when they need an ‘urgent’ response that may not be life threatening, but still requires us to act to meet their need in the most appropriate setting.
This work has resulted in the development of a more effective way of coordinating that ‘urgent’ response with the aim of agreeing and implementing an appropriate plan of action within two hours of the individual asking for support. We have called this service the Network Escalation Avoidance Team or ‘NEAT’.

The first ‘NEAT’ began testing this approach in Norwich in June 2017 and the team of clinicians has been refining the way they work with a range of underpinning community health and social care services. We are now rolling out this model and way of working to the other four CCG areas across Norfolk and Waveney. We are planning for the core of each service to be in place by the end of October 2019.

Since the early piloting of this ‘rapid response’ to often complex requests coming from the ambulance service, GPs and other community teams, we have seen a reduction in the number of ambulance crews needing to take often very frail patients with a range of long term conditions or social care needs into hospital. This has had the corresponding effect of also reducing the number of people who would have turned up in an ambulance needing to be urgently admitted to a hospital bed. This is reducing the pressure on our hospitals, but more importantly, this approach is allowing these groups of very vulnerable patients to remain independent and in their own homes for longer.

We have been developing a new approach to managing patients with multiple long term conditions more effectively in primary care. Using population health management (PHM) some of our GP surgeries within the newly formed primary care networks are starting to use technology, based on a database called Eclipse that generates primary care alerts called Patient 500, to identify early those patients who may be at risk of admission to hospital because of their condition(s). The database and the alerts, developed by a GP in West Norfolk, allows the practice team to review all of their patients with a range of conditions, such as diabetes, that if not well managed increase their risk of needing urgent or emergency care. The technology has been in use nationally by over 50 CCGs across England and when reviewing all of their patient records it suggests that we could reduce emergency admissions to hospital by 5% and A&E attendances or admissions by 10%.

Our GP surgeries are beginning to augment the use of Eclipse and Patient 500 in their primary care networks as they bring together a range of other services to wrap-around their population, supported by social prescribing, resulting in better coordination of public and voluntary sector health and social care services.

**Our local challenges**

Two of our hospitals, the Norfolk and Norwich and the Queen Elizabeth, have had recent inspections from the Care Quality Commission that have concluded urgent and emergency services ‘require improvement’ or are ‘inadequate’. To ensure it is fit for purpose and to tackle issues with capacity, and related pressures on staff, the QEH in particular has, as a priority, a desire to redesign its A&E footprint.

Apart from Norwich our population has a higher than the national average number of residents that are between the age of 60 – 79 years. Across the whole of Norfolk and Waveney we also see a higher than the national average number of residents above the age of 80 years. We know that these residents can require more support from urgent and emergency services as they often have a range of conditions which can, on occasions, overwhelm them and their families, resulting in attendance and admission to our hospitals. Once in hospital they can lose a degree of their independence resulting in longer than necessary stays in hospital. These patients then require more support from health and social care once they return home.

The number of people attending our emergency departments is rising year on year, currently approaching a 5% increase, and an increasing number of those are being admitted to a bed, again approaching a 5% increase. Whilst we are seeing an increase in the number of people being admitted to a bed we are also seeing a corresponding increase in the number of people staying in hospital less than a day, suggesting that they may not have needed a short hospital stay, but could perhaps have had their needs met from one of our community services. These
increases in attendances and short stays are placing a significant strain on our hospitals and making it harder for us to treat really sick patients that do need the full range of hospital services.

Our system conducted a review of demand and capacity in February 2019. The findings of this work provided evidence that the bed capacity we have in our hospitals is not currently sufficient to meet the demand, and that community, social care and home care capacity is also not keeping up with demand. This is often resulting in patients staying in hospital far longer than they should. These extended lengths of stay in hospital often mean that our emergency patients cannot access beds when they need them, which can result in extended waits beyond four hours in already pressured emergency departments. The headlines from this review are set out below:

- “There are demand and capacity mismatches across the system today which, given forecasted growth, could result in a ~500 bed deficit by 2023 in a "Do nothing” scenario
- The current system issues cannot be addressed by any single provider. Collectively interventions across the system could create a sustainable position today
- However, given forecast growth, there will be shortfall of ~140 beds by 2022/23 despite interventions. This means further capacity new models of care delivery are required”

What the public tell us

We still have more work to do to engage the public on the more effective and efficient organisation and deployment of urgent and emergency care and the appropriate use of these services. We are currently seeing increasing numbers of people with more minor illness or injury choosing to endure long waits in our hospital emergency departments because, perhaps, they do not feel that their needs can be met through other services such as primary care. This pressure puts our emergency departments under enormous strain and negatively impacts their ability to deal with more life threatening cases in a timely way; therefore we need to engage the public engagement in finding more appropriate ways to meet people’s needs.

Healthwatch Norfolk conducted some early engagement to help us develop our five year plan. The findings from the Healthwatch Report in to the views of residents on NHS Long Term Plan has given us some insights in to what patients tell us they want and need, which include faster and easier access to treatment in particular for those with long term conditions.

We propose to engage further with the public through audits at the front door of our emergency departments to give us greater insight in to the way we can change the organisation of services particularly for people who have a less serious illness or injury.

What our stakeholders and our staff tell us

We are in the process of developing targeted and objective engagement of our staff and stakeholders as to the way we should deploy urgent and emergency services in a more efficient and effective way. For example, we have listened to some groups of staff who are employed in community based urgent care services and this has led to the development of NEAT as mentioned above.

We will be doing further work with clinical and non-clinical staff over the coming months and will be seeking support from organisations such as Healthwatch to support some of this on the back of their engagement on the Long Term Plan that they undertook.

The national priorities we must deliver

The NHS Long Term Plan sets out a number of priorities to deliver a new service model for the 21st century. These include transforming ‘out of hospital’ care and fully integrated community-based care, as well as reducing pressure
on emergency hospital services that will improve urgent and emergency care for our population across Norfolk and Waveney.

In addition to the development of primary care and the primary care networks, which are picked up in another chapter there are four strategic priorities for community health services (i) delivering improved crisis response within two hours, and reablement care within two days; (ii) providing ‘anticipatory care’ jointly with primary care; (iii) supporting primary care to developed Enhanced Health in Care Homes; (iv) building capacity and workforce to do these three things, including by implementing the Carter report and digital innovation. Of these, (ii) and (iii) are a joint enterprise with GP surgeries as part of the primary care networks and are covered in another chapter of this document.

For (i) we have already set out our plans to deliver this through the development and rollout of the NEAT model earlier in this chapter. For (ii) we are working on plans to improve discharge from hospital through having a consistent approach to returning people to a level of independence as good as, or as close to they had when they entered hospital – this is often referred to as rehabilitation or reablement.

As part of reducing pressure on emergency hospital services we will be expected to improve the clinical assessment service provided through 111 to become a single point of access for both the public, GPs, ambulance services, community teams and social care to improve and simplify the process for an urgent response – NEAT is the beginning of this piece of work.

We are also required to look at alternative ways of treating people with a minor illness or injury that have not already been picked up by another service by simplifying and reducing the complex array of services available, such as minor injuries units, urgent care and walk in centres. From December 2019 these will either come together or be enhanced to become Urgent Treatment Centres with a common offer that the public can more easily understand. Another important part of reducing pressure on our hospitals emergency departments is to support people with minor illness or injury by having primary care clinicians working in emergency departments to appropriately treat or book forward appointments back into primary and community care settings.

How are we going to deliver?

2019-2021

2019/20 Crisis Response - To ensure we have an effective two hour crisis response service for patients who have an urgent care need that is not life threatening. This is the continued development and rollout of our NEAT model (discussed below) which is already supporting patients in Norwich CCG, is developing in North, South and West Norfolk CCGs and will be rolled out to Great Yarmouth and Waveney CCG.

2019/20 GP Streaming - We are testing and will roll out a primary care led service, often referred to as ‘GP Streaming’, within our hospitals emergency departments that can effectively treat or pre-book follow on appointments in primary or community care for patients with minor illness or injury.

2019/20 Discharge to Assess - We have developed and are now looking to implement and test a consistent model of discharging patients from hospital when their treatment is complete and they are able to return home. This will provide people with the appropriate support to return to the best possible levels of independence they can achieve whilst working with them to look at any ongoing health or social care needs that they may have.

2019/20 Digital Care Record – We will commence implementation of a Norfolk and Waveney wide integrated care record in December 2019. This work is currently led by our Partnership as part of the digital work being undertaken. We are looking at a number of potential providers and tools that already exist. In Norfolk and Waveney we already have the data available to deliver an integrated care record within our Eclipse model as mentioned later in the
chapter. The GP leading this work has begun to develop the capability based on this database that would allow an integrated care record to be in place by December 2019 if all providers agree to share their data. The integrated care record will dramatically improve decision making for frontline clinicians when they respond to patients either in crisis or when an emergency response is required and avoid unnecessary journeys to hospital which could otherwise have resulted in admission to a bed.

**2019/20 and 2020/21 Same Day Emergency Care and Frailty Assessment** – Our three hospitals are planning to fully implement a ‘same day emergency care’ approach. This allows for emergency patients who would otherwise have been admitted to a ward with certain conditions to be rapidly assessed, diagnosed and treated, and if clinically safe to do so, return home on the same day. This includes patients with conditions such as diabetes, pneumonia, and cellulitis. Working in this way is better for patients and their families. It also means that these patients are not occupying a bed, freeing-up space for the most ill patients who do need to stay in hospital.

**2019/20 and 2020/21 Urgent Treatment Centres** – Currently we have an array of services offering patients treatment for minor illness and minor injury that is confusing to navigate. We are in the process of reviewing these and are planning to pull this range of services together into a consistent and more easily understandable offer to our patients. These centres will be led by GPs and will complement the emergency services offered in our hospitals; they will be open 12 hours a day, every day, offer appointments that can be booked through 111 or a GP and be equipped to diagnose and deal with many of the most common ailments that people attend A&E for. Where we have the most confusing range of services is in and around central Norfolk, so we are planning to review and redefine where appropriate these existing services to meet the specification of an ‘urgent treatment centre’.

**Continued focus on embedding SAFER bundle across our acute hospitals** – Our three hospitals remain committed to rolling out the SAFER bundle. That blends five elements of best practice to ensure our patients move through our health service as safely and efficiently as possible ensuring all patients are in the right place to receive their care.

The SAFER bundle requires the Trusts to do the following:

- **S – Senior review.** All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
- **A – All patients** will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.
- **F – Flow** of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10 am.
- **E – Early discharge.** 33% of patients will be discharged from base inpatient wards before midday.
- **R – Review.** A systematic multi-disciplinary team review of patients with extended lengths of stay (>7 days – ‘stranded patients’) with a clear ‘home first’ mindset.

**Years 3, 4 and 5**

The changes we intend to make to support our population who are in need of urgent and emergency care are less well defined at this stage in our planning. We expect to see the changes we have made in years 1 and 2 to continue to be embedded and we expect to see further coming together or integration of urgent and emergency care services so that patients do not experience so many ‘hand-offs’ between the organisations that provide health or social care.

Areas we do expect to see more detailed plans will be:

- Strengthening of support to care homes to reduce the number of residents that attend our hospital emergency departments
• Increasing opportunities for our local populations as our primary care networks develop and join up the range of health, social care and voluntary sector services to improve their health and well-being.

How will this be clinically led?

We have prioritised the development of a clinical leadership structure to support the delivery of the urgent and emergency care agenda, and we have engaged with GP clinical leaders and the governing bodies of our CCGs to establish a locality (placed based) approach to clinical engagement.

Clinical executive teams within each CCG are already established and we have clinical leads with responsibility for delivering clinical change within their agreed portfolio across each CCG. These clinical leaders have clearly defined areas of responsibility and delivery in each CCG. Whilst they have a role in engaging with practices and partners their primary objective is to facilitate and ensure change happens. Our clinical leads are supported by a managerial structure, drawing on support from across the CCGs structures.

What is the impact on our wider determinants of health?

The wider determinants of health are linked very closely to our population health management approach. By working with the range of other public and voluntary sector services that contribute to our overall health and wellbeing we are actively targeting and prioritising the added value and outcomes this generates. For example a poor education could result in less job prospects, resulting in poorer income and therefore less opportunity to live a healthy lifestyle. In other words, by improving the effectiveness of the full range of public services, improvements in health and social care have more of an impact.

If we improve the integration of health and social care in our urgent and emergency care system we will have an impact on the wider determinants through the engagement of a wide range of partners whose aim is to keep people well for as long as possible to avoid an unnecessary stay in hospital. The greater impact will be through our primary care networks as they work with the full range of public and voluntary sector providers.

How will we engage going forward?

As our plans are developed and implemented we will test the changes we make through early engagement with clinicians as part of our CCG and locality structures, particularly through the Local Delivery Groups.

Where the changes we have set out earlier in this chapter involve significant change we will engage the public through appropriate consultation, for example the changes we wish to make regarding minor injury and illness. Other more subtle changes will be dealt with through the existing structures we have in place with patient participation groups (PPGs) or oversight and engagement with Healthwatch.

What does this mean for our workforce?

We have significant challenges with training, recruiting and retaining our workforce, especially our nursing staff. Via our workforce strategy (see appendix and workforce chapter) we have identified key actions to attract, recruit and retain nurses.

What will be different?

Cast study: How our NEAT service is improving care for people
Our NEAT services receive a referral from a GP. Mr T has diagnosis of progressive immobility, multiple system atrophy and supranuclear palsy. Sadly, this affects his speech, movement, ability to get out of bed and more. His wife is his main carer and she manages her husband’s medication.

He has a rash on his feet and is being treated for a urine infection with antibiotics. The main issue for him is getting out of bed to use the toilet. He can take half an hour to use commode. He has a catheter and is being cared for in hospital bed most of the time.

The Multi-Disciplinary Team (MDT) has a ‘huddle’ and agrees the following actions:

- NEAT co-ordinator to make a referral through to community nurses for a blood test to check inflammatory markers and kidney and liver function.
- Mr T is currently on waiting list for social care assessment. NEAT to ask for the referral to be prioritised. Duty social care manager to allocate the next day.
- Community physio already involved. Joint visit to be arranged with Homeward occupational therapist and the physio to review the situation.
- Homeward to complete daily observation visits and urine sample visit, starting the next day.
- Care at Home team has capacity to support two double up calls a day, NEAT to contact family again with plan.
- Feedback to referrer - GP surgery to update on the above.

Outcome:

- Care at home were able to contact family and start care for double up care twice daily.
- District nurses visited the following day to do urgent bloods, these came back abnormal.
- Homeward commenced for daily observations and urine dip.
- Community physio and Homeward occupational therapist saw the patient as a joint visit.

All of the above completed within the same day response.

Follow Up – seven days after referral:

- Medication changed to liquid form following advice from the nurse to the GP due to swallowing concerns.
- Speech and language service contacted due to swallowing concerns.
- GP reviewed and agreed repeat bloods for following week, results were abnormal but expected.
- Pressure relieving mattress put in for patient.
- He was allocated a social worker.
- Continuing Healthcare Checklist done – awaiting package of care to be sourced.
A single sustainable system - How will we evolve and transform?

Our emerging Integrated Care System (ICS)

Our Integrated Care System (ICS) is a local partnership of all the Norfolk and Waveney NHS organisations and local councils who are joining forces to take shared responsibility to improve our health and care system.

The NHS Long-Term Plan set the ambition that every part of the country shall be an integrated care system by 2021. This means that we will put our partnership working on a more formal footing, enabling better collaboration to help us to support the health and wellbeing of our population. The point of an Integrated Care System is that it enables decisions to be taken as close to the resident as possible while ensuring equity of access to, and quality of, services. The plan sees Integrated Care Systems’ as central to the delivery of the objectives in the Long Term Plan.

Our ICS Structure

<table>
<thead>
<tr>
<th>Area</th>
<th>Delivered through:</th>
<th>Purpose:</th>
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<tbody>
<tr>
<td>Neighbourhood</td>
<td>PCNs (17 PCNs)</td>
<td>• Defined by GP surgeries and their registered lists&lt;br&gt;• Strengthen primary care&lt;br&gt;• Promote prevention and self-care&lt;br&gt;• Responsive to the characteristics and needs of their local populations&lt;br&gt;• Care for their populations through multidisciplinary community teams&lt;br&gt;• Supporting and holding LDGs accountable to deliver strategic transformation in their communities and ensuring LDGs learn from each other, sharing best practice and innovation&lt;br&gt;• Working together to set the transformation strategy for Norfolk and Waveney, holding each other to account for the achievement of mutually agreed goals (including the achievement of each organisation’s statutory responsibilities)</td>
</tr>
<tr>
<td>Place</td>
<td>Local Delivery Group (5 former CCG areas, population: ~200k each)</td>
<td>• Continue to maintain a local focus through our five Local Delivery Groups&lt;br&gt;• Defined by the footprints of the five existing Norfolk and Waveney CCGs&lt;br&gt;• Integrate primary care, acute care, community/mental health and social care services together&lt;br&gt;• Greater district council involvement at this level&lt;br&gt;• Potential for provider-led partnerships&lt;br&gt;• Bringing local partners together to deliver strategic transformation for their communities, in the light of (or in line with) local needs and priorities&lt;br&gt;• Supporting and developing Primary Care Networks&lt;br&gt;• Holding system partners to account for supporting each LDG to achieve transformation within their geography</td>
</tr>
<tr>
<td>System</td>
<td>ICS (Population: ~1m)</td>
<td>• Develop the overall system strategy&lt;br&gt;• Develop plans for the future&lt;br&gt;• Develop accountability arrangements across the system&lt;br&gt;• Set and implement strategic change and transformation at scale (e.g. workforce planning, digital, acute transformation etc.)&lt;br&gt;• Manage performance and finances&lt;br&gt;• Holding LDGs to account for supporting PCNs to achieve agreed transformation within their neighbourhoods</td>
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We are currently in a period of change as we finalise our plans for becoming an ICS by 2021:
Our five CCGs are merging to become one overall CCG for our system. With one Accountable Officer already in place and the formation of a single management team we have moved a long way to streamlining our commissioning structure and processes.

Our acute hospitals are working more closely together to ensure we have sustainable high quality services across Norfolk and Waveney.

Our 17 Primary Care Networks are developing and are working together to enhance the services we deliver to our patients.

Our Place/s

Local Delivery Groups provide place-based governance for integrated delivery; but are not subcommittees of the CCGs. They aim to bring together commissioners, providers and communities to progress the transformation of services aligned to the ICS strategic vision. Membership is designed to reflect the local system, so each LDG includes representatives from district/borough councils, the voluntary sector and other partners.

Over the past 12 months, our LDGs have developed at different paces but all have taken a local focus to identifying and progressing priorities reflective of the needs of their local population. More development of the LDGs will take place over the next year as we make steps towards becoming an ICS. The development will enable LDGs to become accountable for the place-based operational delivery of the strategy which is agreed at system level by the system-level ICS.

Our System

Our STP and our emerging ICS brings together all the partners responsible for developing and delivering all the health and care for the population of Norfolk and Waveney. Rather than working as individual organisations we are breaking down the barriers that have traditionally kept us distinct and instead are finding there are many things that we have in common and can improve services together in our purpose of improving health and care for the people living in Norfolk and Waveney.

The partners engaged in our STP and who will be in our ICS are:

- Acute NHS Providers – the Norfolk and Norwich University Hospitals based in Norwich and Cromer, the James Paget University Hospitals based in Gorleston and Queen Elizabeth Hospital King’s Lynn
- Mental health Provider – Norfolk and Suffolk NHS Foundation Trust
- Community Providers – Norfolk and Community Health and Care based in Norwich and East Coast Community Healthcare based in Lowestoft.
- Ambulance Provider – East of England Ambulance Service
- Primary Care – Primary Care Networks, GP surgeries, GP Provider Organisations, community pharmacists, optometrists and dentists
- NHS Commissioners – One Clinical Commissioning Group and specialised commissioning
- Local government – Norfolk County Council, Suffolk County Council, district, borough and parish councils;
- Independent sector providers
- Voluntary, community and social enterprise sector – VCE infrastructure organisations, community foundations and other community or sector specific organisations
- NHS regulators and other bodies – NHS England/Improvement, Care Quality Commission (CQC), Health Education England
- Public representatives - Healthwatch and patient and carer groups
- Education and research - universities and health science networks.

Our key principles
The key principles that our partnership will work to are:

- We work together with a common purpose - the health and wellbeing of people in Norfolk and Waveney.
- People are equal partners in their care and will be fully engaged in decision-making.
- Clinical, professional and front-line staff are at the heart of our ICS and will be fully engaged in leadership and decision-making.
- We will create a sustainable, integrated system across the NHS, social care, county and district councils, the voluntary and community sector and other partners.
- We will put prevention first, support people to improve their health and wellbeing and tackle inequalities.
- We will reduce and wherever possible remove unwarranted variations in quality and access to services.
- We will build open, trusting and accountable relationships throughout the system.
- Decisions will be made at the right level, not centralised to one level, and will reflect the different needs and circumstances of different places.
- We will maximise funding for frontline services, streamlining administrative functions, removing duplication and waste, and freeing-up staff time to ensure the best value for the Norfolk and Waveney pound.

**Strategic commissioning in the ICS**

The NHS Long Term Plan states “Every ICS will need streamlined commissioning arrangements - typically a single CCG for each ICS area - to enable a single set of commissioning decisions at system level.”

By April 2020 the five Norfolk and Waveney Clinical Commissioning Groups will be merged into one Norfolk and Waveney CCG. We are the only area in the Eastern region to achieve this in 2020. In doing this we have shown a real willingness to work as a system and have demonstrated strong clinical leadership. We have secured the strong support of general practice in our area for this merger as well as from our stakeholders.

As part of our work on our CCG staff restructure we are creating more roles which sit across the CCG and STP. For example the Accountable Officer for the CCG is also the STP Executive Lead. This enables closer working across the system and greater synergy in our approach.

The merger of our CCGs is a very important step on our journey to becoming an ICS and will mean:

- We will avoid situations that we have had in the past with creating a disparity in health provision across the system and will ensure that we commission with one voice.
- We create much more efficiency with a single management team for commissioning, single strategic commissioning decision making.
- We will avoid duplication.
- We can strengthen relationships with providers through having one commissioning voice rather than five.
- Our relationships with all our providers and our Local Delivery Groups and Primary Care Networks will be stronger.

**Our STP governance structure**

The structure of our STP is shown below:
STP Chairs Oversight Group - Provides oversight to the system and includes the Chairs of all STP Partners (all NHS provider trusts and other providers, CCGs, county councils, Health and Wellbeing Boards).

STP Executive Group - Discusses and agrees operational and strategic issues across the system with membership consisting of all NHS and other provider trust Chief Executive Officers, Director of Adult Social Care, Director of Children’s Services and Director of Public Health.

These are our operational groups which report to the STP Executive Group, consisting of:

- the Financial Management and Planning Group consisting of all CFOs from across health and social care in Norfolk and Waveney
- the STP Workstream Delivery Group consisting of programme directors from all transformation and enabling workstreams.

STP Stakeholder Group - Has membership including the VCSE, Healthwatch, care sector and provides input to STP planning.

STP Clinical and Care Transformation Group - Is made up of clinicians from all partners to review pathway change and transformation at system level.

Our ICS priorities: Strategic Workstreams

Our leaders have already come together and highlighted a number of strategic priorities to tackle as an ICS. Each priority has a system-wide workstream to accelerate development.

Primary and community care: As a system we know we must focus on prevention wherever possible, we cannot meet our clinical priorities without focussing on primary care and community care;

Mental health: We will focus on prevention and maintaining well-being for our people to stay happy and healthy. If people are in need we will provide high quality services;

Acute collaboration: Transforming our acute hospital services in a way that improves the patient experience as well as making them more financially sustainable.
Urgent and emergency care services: To address pressures on urgent and emergency care services to enable good quality care for all.

Cancer: Commitment to improving the care, treatment and support all people who have been diagnosed with cancer and ensure that cancer is diagnosed early across our footprint.

Children and young people: Ensuring our children and young people have access to high quality physical and mental health services to give them the best possible start in life.

In addition, we have enabling workstreams for Workforce, Digital, Estates, Communications and Finance.

Our work with the Health and Wellbeing Boards

Our system sits across both Suffolk and Norfolk Health and Wellbeing Boards. Members of the Norfolk HWB includes the eight district councils, as well as the STP itself, NHS organisations and the VCSE. Both boards provide democratically elected oversight of the STP as well as an invaluable forum (both private and in public) for testing proposals and reporting on our work. It also provides an opportunity for members of the public to question HWB members, including the STP. The HWB has a significant role in the development of the ICS.

Development of our ICS Partnership Board

As set out in the Long Term Plan (2019) “the ICS will have a partnership board, drawn from and representing commissioners, trusts, primary care, local authorities, the voluntary and community sector and other partners.”

The Executive Team and Oversight Group have already had several discussions about the architecture and governance of our ICS. We have had a number of helpful conversations with other systems, particularly the first wave ICS’s, to learn from what has worked - and not worked - for them and have also engaged with a wide range of stakeholders at various engagement events during 2019. In the coming months, we will be giving further, more detailed consideration to these issues and engaging with all our stakeholders, including the Health and Wellbeing Boards, to ensure that there is widespread agreement and understanding about which decisions should be made at which level - neighbourhood/PCN; Place/Local Delivery Group; and System.

The ICS has already appointed an independent Chair in accordance with the Long term Plan who has a key role in developing the ICS in the coming years. The ICS will operate in a partnership rather than establishing as its own legal entity until such time that ICS are established by statute.
Primary Care

Our local priorities for Primary Care are:

- Integrated ‘out of hospital care’ and a more holistic approach to health and wellbeing, with a focus on prevention, self-care and supporting patients to live well at home for longer.
- Reduced pressure on emergency hospital services such as pro-active older peoples’ care by identifying the most vulnerable and high risk patients requiring focused and in-depth interventions.
- Workforce development and skill mix opportunities to deliver a more responsive and accessible NHS (in line with national directive on seven day a week working), for example GPs heading a team which includes different health workers such as physician associates and medical assistants.
- Primary care and digitally enabled health – utilising new technologies to enable information sharing and streamlining of records.

Primary care is under increasing strain trying to adapt to a very different situation from the one it was originally set-up to address. We are all too familiar with the current public health challenges, people are living longer, mainly because of better living standards, but also as a result of modern medical practice. People are smoking less, but they are also less active and more overweight which causes a whole host of different health problems, such as diabetes and heart disease. People are also living longer than ever before, but often with more complex, multiple long term conditions (LTCs), coupled with complex social issues.

Together with the public health challenge is the ability to provide sustainable and resilient general practice and the suitably qualified staff to work within these services. Across Norfolk and Waveney recruitment and retention of GPs and the wider primary care team is an increasing issue. As a system, we fall in line with national averages of an aging workforce, 23% of GPs are aged over 54 compared with 22% nationally. In addition to challenges recruiting, for various reasons including workload, income, pension changes and demography, we are facing loss from the primary care workforce, including both GP and nurse positions. If we do nothing by 2020 there will be a shortfall of 85 GPs across Norfolk and Waveney.

To respond effectively, we need to transform the way we deliver care – we can build on the best of our present system, and move towards making the system more sustainable. GPs are well placed to support patients to live well for longer and closer to home but they cannot do this in isolation.

Our approach is to integrate health and social care, working across multiple agency partners at three levels:
- ‘System’ (Norfolk and Waveney wide)
- ‘Place’ (our five CCG geographies – North Norfolk, West Norfolk, South Norfolk, Norwich and Great Yarmouth and Waveney)
- ‘Primary Care Networks’ (17 groups of practices across Norfolk and Waveney)

This is different because historically, GPs have worked within their own practices and self-managed patient demand. As pressure on health and social care services grows, practices are increasingly combining efforts and working together at varying levels of scale. By working together in a Primary Care Network GPs can strengthen in resilience and stability to lead and shape the design of care. Care interventions can be delivered at these three different levels, recognising the benefit of maintaining local delivery and developing relationships across Norfolk and Waveney.

Transforming primary care in summary

Primary Care Networks (PCNs)

Primary Care in Norfolk and Waveney is ready to take on the challenge of delivering the Long Term Plan. Our 105 GP surgeries serve a wide demography in both rural and urban environments with some of the most deprived and frail elderly populations nationally. Our GP Leaders recognise the challenge ahead and all general practices have signed up to be an active member of a Primary Care Network (PCN), of which there are 17 across the entire Norfolk and Waveney system, organised as such to enable multidisciplinary team working to deliver the new service model for primary and community care set out in the NHS Long Term Plan.
A Primary Care Network (PCN) is made up of groups of GP surgeries working together with a range of local providers, including across primary care, community services, social care and the voluntary sector, to offer more personalised, coordinated health and social care to their local populations. Local delivery of health and care will be through the developing PCNs, which were established on 1 July 2019.

We understand the demographic challenges of our system and underpinning the development of local plans is public health data on health inequalities and patient need. For example, in Great Yarmouth and Waveney multi-agency partners review population data to identify people who would benefit from pro-active case management to support them in the community and avoid unnecessary hospital attendances. This multiagency approach includes adult social care, the voluntary sector, the police, primary and community care, mental health and the hospital, more often than not, to identify community assets that are best placed to help with individuals’ needs.

In North Norfolk, we have an older and frail population and therefore PCNs have prioritised older peoples’ care, focusing on implementation of a new Enhanced Service for Care Homes pilot. The pilot, which is being delivered by the North Norfolk GP provider organisation, provides in-depth case management tailored to meet patient need working in partnership with the GP, care home staff, patients and their families. The North Norfolk Local Delivery Group are currently in the process of reviewing the effectiveness of the pilot across a range of outcome measures, including hospital avoidance.

We understand that actions from all parts of this system are needed to reduce inequalities. We are therefore supporting the PCNs to prioritise and develop plans that align to this ambition and is articulated in detail in the Norfolk and Waveney Primary Care Strategy (See Primary Care Appendix).

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

**Local Delivery Groups (LDGs)**

LDGs provide Place based governance for integrated delivery. There are five LDGs across our system aligned to our ‘CCGs and Place’ geographies. They aim to bring together commissioners, providers and communities to progress the transformation of services aligned to the ICS strategic vision. Our LDGs have developed at different paces but all have taken a local focus to identifying and progressing priorities reflective of their local population need.

We perceive that LDGs could become the Place-based partnership for our ICS, ensuring the development and delivery of integrated services for the local population. They will be essential to supporting PCNs in their development and have a pivotal role in unblocking issues of service delivery preventing integration.

Through LDGs local system partners will be able to work together to align their services with a focus on population health and wellbeing. They will also enable the strengthening of local communities with the aim of reducing ill health and dependency by addressing the health and wellbeing needs of local populations, with a focus on the wider determinants of health.

Our PCNs build on years of collaborative working between GP surgeries and community partners to improve care for patients. We understand that in order to deliver more sustainable and personalised care, General Practice, through PCNs, will be the driver for developing integrated care delivery. However, to further support and enable local partnership working at this level, Local Delivery Groups are essential for bringing together a broad range of providers and stakeholders to progress innovative pieces of work to support care closer to home and tackling the wider determinants of health. At this level there is greater involvement from our district councils, particularly housing, leisure and community development essential to progressing the development of new relationships between all of our ‘out of hospital’ provision.
Over the next five years LDGs will continue to ensure we maintain a focus on local delivery aligned to the our Partnership’s overarching goals of prevention and reducing inequalities, integration and collaboration, and workforce recruitment and retention.

LDGs are also responsible for developing a pro-active approach to supporting patients to live healthier and happier lives in the community, linking in the preventative workstreams on: Healthy Lifestyles in Communities, Population Health Management, Developing Health Coaching skills in our workforce and Tackling Inequalities and wider determinants. It is at place level where we are able to address health inequalities specific to the geography and demography of local communities.

Across Norfolk and Waveney we have pockets of deprivation and correlating health inequalities which is detailed in the Joint Strategic Needs Assessment. This provides the catalyst for further interrogation of provider data and population health management approaches at local level to inform PCN/ MDT discussion.

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

**Integrated ‘out of hospital care’**

To deliver care closer to home where clinically appropriate we need to increase capability and capacity across primary and community care services. Through a locally commissioned review of demand and capacity we know that in a ‘do-nothing’ scenario our the system would have a shortfall of around 925,000 primary care appointments (circa 17% of total demand) each year by 2022/23. This shortfall would have a significant impact on the wider health economy:

- Driving around 20,000 patients to seek help from their local Emergency Department each year.
- A significant number of patients could also deteriorate in health through not receiving the correct primary care requiring them to be admitted to hospital.
- Provide a poor experience of primary care to a significant proportion of our population.

The review proposed three themes to be developed across the Norfolk and Waveney system:

- Implementing Primary Care Networks (PCNs) are a national priority area and a necessary focus area for the STP.
- PCNs across the STP face unique demographic and workforce challenges and vary significantly across their publicly reported outcome measures.
- Tailored strategies that take into account observed variation will be needed to address the current and future STP challenges both within primary care and across the system.

To address this, at Place level, our five Local Delivery Groups are putting plans into action, with a firm understanding that relationships have to be forged between providers and clinical disciplines if we are going to make a difference.

An example of integrated out of hospital care delivery is the Norwich Community Fully Integrated Care and Support service (CFICS). The CFICS takes a multidisciplinary team approach to proactively identify patients with complex or chronic conditions and links them into a wide range of community health and wellbeing services supporting independence at home.

The local review also outlined the need to significantly enhance community capacity across the system. Plans are being implemented to boost community-based capacity and capability through a range of initiatives including:

- Virtual wards (Norwich and West Norfolk)
- Supported care (North and South Norfolk)
- Palliative care advice line (24hour)
- Care at home teams (West Norfolk)
- Adult community services integrating through PCNs (Great Yarmouth and Waveney)

We understand that PCNs provide an opportunity for integrated out of hospital working and the four main organisations providing adult community services (Adult Social Care Norfolk and Suffolk County Councils, Norfolk Community Health and Care and East Coast Community Healthcare) have already clustered their operational teams around our PCNs.

Reducing pressure on emergency hospital services

Primary care is well versed in managing on the day urgent care, however we know there are some unnecessary differences in quality of care delivered between practices across Norfolk and Waveney (for example Care Quality Commission ratings and patient satisfaction with access as reported through the national GP Access Survey) and that our A&E attendances and emergency admissions activity has been growing on an annual basis. To respond we need a better understanding of why some practice populations have seen higher levels of growth than others and we are working with PCNs to unpick this. We will support PCNs to maximise funding for new roles, such as physicians associates and physiotherapists through the GP contract when introduced in 2020 to enable them to continue to develop their clinical teams.

We need an alternative approach to support the avoidance of unnecessary hospital attendances and admissions. It is in this area where we have made great strides, for example, the Norwich Escalation Avoidance Team (NEAT) pilot aims to help people avoid a health crisis and subsequent hospital admission. By providing a single point of contact to a range of NHS and social care professionals, GPs, community nurses, mental health workers, paramedics from the ambulance service, social workers or therapists, can all access the service and seek an appropriate response for the patient heading into crisis. The NEAT pilot has been running for two years and we have now rolled this out across each Place.

Primary care is at the centre of supporting patients to access the right services at the right time and ‘On the day teams’ are in place across many practices, providing same day assessment and access to general practice services. Practices are also piloting weekly Multi-Disciplinary Team meetings to identify and proactively manage those identified as at risk, such as patients with multiple long term conditions, from emergency admission with a view to expand this approach across their PCNs. In Norwich and Lowestoft a shared home visiting service is being piloted to both reduce emergency activity and to support the resilience of general practice. This will be evaluated and learning used by the PCNs to develop their services.

We also recognise that increasing capacity and tackling perceptions of ‘access to GPs’ will be crucial in reducing pressure on other parts of the system. As a system we have been delivering improved access (general practice appointments delivered in hubs outside of normal opening hours) in addition to extended access (general practice appointments in individual practices delivered outside of normal opening hours) since September 2018. We have delivered over 70,000 extra GP/nurse appointments to patients and each Place has tailored a service to meet patient and practice expectations and this is continually evolving. As this service develops further and becomes part of PCN delivery models it will be able to target patients that are accessing hospital services (such as A&E) and further reduce demand on emergency services.

How our workforce will be configured?

The biggest challenge to our transformation plans will be ensuring safe and effective staffing levels across the system. However, we have robust workforce plans in place and as we co-produce services with PCNs, working with
clinical directors, we will determine the number and type of additional community health and care roles required to meet patient need.

Our primary care workforce plan sits as part of the wider STP Workforce Strategy and it details interventions to recruit and retain the numbers of GPs, practice nurses and other clinical and non-clinical practice staff. Our plan also outlines how we intend to support these roles to work in new ways as part of PCNs.

In summary, some of the new roles we expect to work as part of a new primary care integrated team include:

- **Nursing Associate**
  Nursing associate is a new role within the nursing team. Nursing associates work with healthcare support workers and registered nurses to deliver care for patients and the public.

- **Advanced Clinical Practitioner (ACP)**
  Is a role that can be undertaken by General Practice Nurses or other highly experienced registered health and care practitioners such as pharmacists, paramedics or other allied health professionals. ACP roles involve a high degree of autonomy and clinical decision making and often include leadership, management and/or educational skills as well.

- **Clinical Pharmacist**
  Clinical pharmacists work at general practice and are in patient facing roles. They give advice on multiple medicines; provide health checks for patients; assist with medicine prescriptions working alongside GPs.

- **Social Prescriber**
  A social prescriber will give people time, focusing on ‘what matters to me’ and taking a holistic approach to people’s health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.

- **Physician Associate**
  Physician associates support doctors in the diagnosis and management of patients, and will therefore have regular direct contact with patients. Often they are graduates who have undertaken post-graduate training and are working under the supervision of a GP.

- **Advance Practice Physiotherapists (First Contact Physiotherapists)**
  These are advanced practitioners working within primary care with extensive expertise in the clinical assessment, diagnosis and management of musculoskeletal conditions.

We must not forget the significant contribution that volunteers make in health and social care and we have plans to harness this valuable resource. The King’s Fund report ‘Volunteering in General Practice’ (2018) identifies specific ways in which volunteers can engage and support general practice. There are over 300 volunteering NHS role types within the STP and we have well established volunteering programmes across our provider trusts and STP organisations, embedding volunteers as a core part of our workforce.

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

**Primary Care and digitally enabled health**

Primary care will continue to harness new technology as set out in our “Digital Strategy for Primary Care”, to support and enable more accessible advice and services, supporting people with long term conditions to live independently at home, avoiding the need for unnecessary hospital appointments.

We are implementing an online consultations system across Norfolk and Waveney, which will be available to all patients by 2024. The system will provide a digital ‘front door’ to primary care and give better opportunities to sign post patients to the right care and ensure GP time is focussed where it is most needed. In line with the national roadmap, the online consultations system will be linked into the NHS App.
We are committed to improving interoperability across care settings (where different clinical systems can talk to each other) and implementation of new internet connections across our health and social care sites will provide clinicians with seamless access to the clinical data they need to deliver care in any location.

Internet connectivity has historically provided a challenge for clinical teams working in our more rural areas, however the advent of 5G will mean increased coverage in Norfolk and Waveney enabling the use of tablets and remote working for clinical teams.

From our patients’ perspective, GP surgeries already offer patient Wi-Fi, and we plan to introduce access to tablet devices in waiting rooms so that patients can access online consultations and advice, and self-monitoring tools, supported by digital navigators. Better use of technology will also ensure a seamless journey for the patient from NHS111 to out of hours and primary care, promote wellness and self-care and ensure that clinical time is focussed and available for patients who need it most by the deployment of efficient triage and signposting methods.

**EU-exit readiness**

The medicines team across the STP is monitoring and disseminating advice from NHSE on Brexit readiness. Most of the planning is happening at a national level and is set out on the NHSE website. Locally we are asked to promote national advice on the prevention of medicines stockpiling. Advice on this issue has been sent to GP surgeries on a number of occasions. Our teams already have processes for disseminating advice on dealing with specific medicines shortages. The department of health and social care have a team who will monitor shortages and provide advice and mitigation where necessary, these include the implementation of serious shortage protocols should these be needed. As a system all of our chief pharmacists and the local pharmaceutical committee have met and agreed that we will work together to manage any shortages as a system for the benefit or all of our patients.
Primary Care: Great Yarmouth and Waveney locality

Our key priorities as a Great Yarmouth and Waveney ‘place’ partnership are:

- To ensure that we have the mechanisms in place to come together as local system partners, bringing together leaders from health, social care, voluntary sector, district councils and wider communities, to shape the planning and delivery of healthcare for the population of Great Yarmouth and Waveney
- To deliver an integrated model of care tailored for the local population, particularly that informed by the emergence of Great Yarmouth and Waveney Primary Care Networks and the five year transformational community contract with East Coast Community Healthcare and partners
- To ensure we have a detailed understanding of our local population needs today, and in the future, and the mechanisms in place by which this knowledge informs and shapes the services we commission and deliver

This chapter describes how we intend to work at Great Yarmouth and Waveney ‘place’ and ‘neighbourhood’ level to improve health and wellbeing for the local population across all ages and population groups, and to deliver our partnership’s goals around prevention and tackling health inequalities, integration and workforce. It will describe how we will come together to organise and work in partnership at ‘place level’, how we have tailored our model of care to respond to population need and how we will work to understand the needs of our local population.

About Great Yarmouth and Waveney

The Great Yarmouth and Waveney ‘place’ covers a population of just over 250,000 local residents, from Martham in the North, to Southwold in the South of the locality. The geography spans two counties – Great Yarmouth and Gorleston in Norfolk, and Lowestoft and South Waveney in Suffolk. Just over half of the population – 51% are female, with 49% males, and the population has a higher number of people over 65 years – 25% compared to 18% as the England average.

Great Yarmouth and Waveney faces particular challenges relating to health and the wider determinants of health. There is marked deprivation in the locality. Great Yarmouth is the twentieth most deprived lower tier local authority nationally with 16 of its 61 most deprived small areas in the 10% most deprived areas in England, and Waveney has 9 of its 73.

Life expectancy varies in accordance with levels of deprivation. Of the population 77% would rate their health as good or very good, compared to 81% nationally. Just under 11% of the population have a long term health problem or disability which affects their ability to undertake day to day activity, compared with just over 8% nationally.

Levels of long term conditions such as diabetes, COPD and lifestyle factors such as obesity is higher in the locality than the national average. These factors have, and will continue to shape our priorities for improvement as a locality. For example in our newly commissioned integrated community diabetes service provided by East Coast Community Healthcare has embedded a new model of service delivery that is focused on prevention and early detection of diabetes in general practice and the community.

Providers of health and care

Within the geography there are a number of key partners who are part of the Norfolk and Waveney Health and Care Partnership and play a leading role in delivering health and care:

- The James Paget University Hospital Trust (JPUH) – delivering acute hospital care
- East Coast Community Healthcare Community Interest Company (ECCH) – who deliver integrated community healthcare services
- Norfolk and Suffolk Foundation Trust (NSFT) – who deliver mental healthcare
- Norfolk County Council (NCC) and Suffolk County Council (SCC) – who deliver Adult Social Services and Children’s Services
Coastal Health is the GP provider organisation who represents the 19 local GP surgeries and plays a role in the development of the four Primary Care Networks in the area. These providers work closely with local district councils (Great Yarmouth Borough Council and East Suffolk District Council), voluntary sector and over 250 local community groups.

We have a unique opportunity in Great Yarmouth and Waveney to capitalise on the aspect of our working that comes with spanning two county boundaries, two county council commissioners and providers, and interfacing via this with our connections beyond the Norfolk and Waveney STP footprint with sharing with Suffolk and North East Essex STP. Suffolk County Council have responsibilities for a range of aspects covering the Waveney population; notably public health commissioning, social care provision, children’s and mental health county council commissioning. Our interface with these key partners, via Suffolk-wide and Great Yarmouth and Waveney locality forum is critical to ensuring together we adequately design, plan for, commission and deliver services to meet local population need.

Primary Care Networks

In Great Yarmouth and Waveney there are four PCNs; Great Yarmouth and Northern Villages (circa 71,000 population), Gorleston (circa 44,000 population), Lowestoft (circa 82,000 population) and South Waveney (circa 59,000 population). Each PCN has a clinical director appointed; a named GP practising in that PCN area with responsibility for leadership of PCN development.

Geographically our primary care networks form natural clusters, all of which have different population characteristics and different geographical considerations. Links with general practice, the custodians of the patient story, is central to the provision of responsive, joined up care. Links with wider communities and partners is central to the provision of proactive care and support which is tailored to meet both local needs and accessible and inclusive to all.

Great Yarmouth and Waveney – place based system as part of the wider Norfolk and Waveney ICS

Working in partnership to deliver through our Local Delivery Group and local relationships

Delivering transformational change and improvement in health and wellbeing for Great Yarmouth and Waveney will require leadership that is ‘system’ focussed, collaborative and partnership driven. This leadership will need to bring together partners from across health and care, statutory and voluntary sector, district councils and community groups to align strategic priorities, plans and assure delivery and service improvement.

The Local Delivery Group (LDG) is the Great Yarmouth and Waveney leadership forum dedicated to the oversight of place based delivery of the Norfolk and Waveney Integrated Care Partnership. The unique membership of front-line clinicians, multiple local authority partners and vibrant local agencies is celebrated and the opportunities this offers recognised. The vision statement designed by LDG members is to provide ‘A single place to develop shared solutions, bringing our collective authority and assets together to support the health and wellbeing of our population’. This vision is underpinned by an approach to how we will seek to work together, which will include:

- Bringing together an intelligence led population health approach, identifying hidden need and delivering a system wide, community asset based responses
- Developing a shared, in depth understanding of community assets and provider resource, taking a system approach to transformation
- Fostering a culture of genuine engagement linking public, patient, carer and workforce from across statutory providers, third sector and wider community
- Working with partners to address the wider determinants of health, with a focus on prevention and improving health and wellbeing
- Delivering a shift from a reactive and planned, proactive model of care
• Sharing best practice and evidence based models to transform care, improve outcomes and eradicate health inequalities
• Accelerating the early adoption of a place based Integrated Care Partnership as part of a Norfolk and Waveney Integrated Care System

The Local Delivery Group has established priorities, these are:

• To promote wellbeing, prevention, independence and self-care - supporting people to stay healthy and independent with access to the right information.
• To strengthen primary, community, social care, and carer services – underpinned by Primary Care Network development – supporting a model of proactive care and mitigating unnecessary episodes of acute hospital care
• To simplify urgent and emergency care - supporting residents to timely access the most appropriate provider for their urgent health and or care needs.
• To ensure consistent and evidence-based pathways in planned care - provide planned care that is person centered, outcome focused and respectable.

Importantly, we have also identified key supporting and enabling priorities:

• To deliver system efficiency and effectiveness through collaborative demand management
• To adopt partnership approach to manage the wider factors in society that impact on health and wellbeing such as the availability of suitable housing and environment
• To take an innovative approach to attracting and developing our workforce – through the introduction of new joint roles and the pooling and integration of staff resource
• To maximise the use of our estates – for example through colocation, improved utilisation and planning for future infrastructure
• To use technology and digital capability to improve care - helping residents to stay healthy, manager their own care and supporting services to deliver more productively
• To be proactive in the way we engage with each other, local stakeholders and partners to ensure openness and transparency in developing our local plans

The LDG is inclusive in its approach and its constituent members:
The ability to leverage local expertise, capacity and representation across a broad range of health and care stakeholders at a senior level, who have clear and established relationships, ensures that priorities and plans across system, place and primary care network level are aligned.

The role and ambition of our LDG will become ever more important in supporting a Great Yarmouth and Waveney Integrated Care Partnership as a fundamental building block of a future Norfolk and Waveney Integrated Care System. Underpinning the LDG and its priorities will be programme infrastructure and pooling of staff resource – ensuring we have the capacity and governance to deliver. We will work increasingly as ‘one team’ for the local ‘place’, integrating the shared capacity and expertise we have across local provider and commissioning partners to develop an Integrated Care Partnership approach.

Our integrated model of care – designed to meet local population need

In Great Yarmouth and Waveney during 2018/19 a procurement was undertaken of community healthcare services resulting in the award of a five year outcome based community contract to East Coast Community Healthcare (ECCH) and partners. The scope of services procured included those traditionally delivered community based services such as district nursing, physiotherapy and community hospital bed provision, but also too services that had been acute hospital based – such as specialist palliative care and intermediate diabetes care.

The procurement provided an opportunity to drive improvements in the way in which community services integrate with general practice, social care, mental health, acute hospital care and wider communities. It also allowed for opportunity to commission a new model of care that responded to patient feedback around the need for improved integration between services and care providers, to tackle key health challenges for the local population such as diabetes and COPD prevalence, and to align community services to Primary Care Network localities.

The Great Yarmouth and Waveney model of service delivery is designed to integrate workforce and services at a number of levels. At the heart of the model of delivery is integration of the community workforce around individual GP surgeries, aligning workforce, sharing patient and caseload management and ensuring each GP surgery has named community practitioners who can coordinate care and resources on a daily basis. Through closer partnership working and integration with the voluntary and community sector, and initiatives such as social prescribing, services will be embedded into the communities they serve, better meeting local need and harnessing community assets and support.

Larger teams of integrated community practitioners, working alongside colleagues from social care and mental health, have been aligned to each of the four Primary Care Networks in Great Yarmouth and Waveney. Detailed needs analysis and assessment of each of the Primary Care Networks has been undertaken, and the workforce number and makeup in each area has been tailored to meet population need. This alignment of staff has dissolved the previous model of separate services or teams by professional staff group, meaning patient care and experience will be of more integrated, joined up care.

Where it makes sense to do so specialist care is provided in an integrated way at Great Yarmouth and Waveney ‘place’ level. For example, a new model of Specialist Palliative Care service provision – a collaboration between ECCH and St Elizabeth Hospice (SEH) – is organised at place level, and comprises 6 specialist palliative care services at Beccles Hospital, a 24/7 advice line for patients and professionals and specialist palliative care day service provision.
Tailoring our approach in accordance with each PCN population need

A detailed assessment considering PCN population health need alongside key relationships with local voluntary and community organisations and groups has informed how we will connect into our local communities for each PCN – through key roles such as the GP, through signposting and through onwards referral and shared care.
Adult social care providers from both Norfolk and Suffolk and East Coast Community Healthcare have already clustered their operational teams around our four Primary Care Networks, with co-location in place and a multi-disciplinary ‘one team’ approach established and continually being developed.

Lowestoft Primary Care Network has been nominated locally as a pilot site for the new multi-disciplinary mental health teams which are being created. Once learning has been gathered through pilot work this approach will be rolled out across the Networks from 2020 and beyond.

**Leadership and governance to underpin Primary Care Network development**

Our networks are working with the NHSE Time for Care team under the ‘Vision for Delivery Programme’ to ensure that the collaboration network working offer delivers benefits for both the population at a time when general practice is facing challenges with meeting population need and workforce sustainability. Networks are exploring ways to pool clinical and administrative resources, as well as introducing truly multi-disciplinary teams embedded in general practice which should help to free up GPs' time to spend with patients in most need, and to improve access to more integrated services for our communities.

Senior level support is available for each PCN through the Associate Director of PCN Development within the Great Yarmouth and Waveney Locality Team, providing both resources and expertise to guide networks in their development. Members of the locality team attend monthly meetings, held at all four Networks, and are working alongside clinical directors to support them in their new formal roles of leading network development.
Commissioning and provider colleagues from across Great Yarmouth and Waveney meet regularly with both the networks and their clinical directors and have a number of plans in place which provide a framework to monitor both contractual targets and developing wider community links and partnership working. The Great Yarmouth and Waveney Local Delivery Group has oversight of progress and has identified the development of PCNs as a local priority.

All networks and the local system have undertaken detailed discussions, using the NHS England ‘PCN Maturity Matrix’ tool, to evaluate their level of maturity and future development needs. There is clear consensus locally of where both individual networks and the local system are and priorities are starting to emerge, with tailored plans for each PCN to support future development.

Examples of changes being driven by or underpinning some of our Primary Care Network plans include:

- **Clinical Record Systems** - We are nearing the end of a programme to roll out a single clinical system across general practice and East Coast Community Healthcare and are now embarking on ensuring that the opportunities offered by this which will eliminate the need for paper correspondence associated with referrals. Shared systems also have a role in promoting effective multidisciplinary and organisational team meetings. MDT meetings can play a key role in bringing professionals together when a holistic view of multiple and complex needs (wider than health) is useful in ensuring people can receive care in a way which supports all their needs.

- **Continuity of Care** - All networks are using practice data to identify cohorts of patients (e.g. living with five or more long term conditions) for whom there is evidence that continuity of care results in better outcomes. As well as helping to identify where evidenced based interventions can be best directed it will also highlight groups who will benefit from advanced care planning, GP led. The tool being developed will support effective use of clinical time and resource within practices and promote better outcomes through GP led co-ordinated care across wider teams.

- **Local teams, with named nursing leads for all PCNs** - Community services (district nursing, therapy staff, etc.) are now all working in dedicated teams aligned to PCNs with staff embedded in general practice. This shift away from traditional service lines (out of hospital teams, etc.) to a locally co-ordinated teams who sit together with social care colleagues provides opportunities to work more flexibly to meet demand local, increase professional trust across organisations and provide care which feels more ‘joined up’ for patients.

What will the benefits of Primary Care Network and integrated community services be?
Encouraging GP surgeries to coalesce around geographic localities, and clustering integrated health and care provision to these Primary Care Networks, is expected to benefit our local population by better tailoring services to local need, by integrated general practice and wider community care and by enhancing the accessibility and sustainability of services. We believe locality working supports our ambition for residents, regardless of their health needs, to play a central role in their own wellbeing. We believe the key tools for people being able to optimise their health and wellbeing are ones found within their local community, with primary care at its heart, and include:

- being able to access the services they need through primary care, the custodians of their story
- ensuring the role of their family and carers is recognised and appropriately supported, through local support networks
- having the opportunity to be part of their community and build personal resilience
- pathways which are focused on the needs of the individual not based on organisational structures

**Our service improvement plans to deliver our ‘place’ based priorities**

As with other ‘place’ localities in the Norfolk and Waveney system, the population of Great Yarmouth and Waveney will benefit from the plans set out in this document relating to improving health and wellbeing, disease prevalence, treatment and outcomes. Overlaying this, and to deliver the priorities set out by the Great Yarmouth and Waveney Local Delivery Group, there are a number of service improvement initiatives that are planned for the coming years that includes, but is not limited to the following:

- Consolidation of integrated triage and caseload management between general practice and community services, embedding ‘daily huddles’ between GPs and community practitioners and PCN and ‘place’ level multidisciplinary triage (2019/2020). Furthering of integration of the clinical workforce between General Practice and wider community teams, developing additional roles for each PCN in line with national requirements (2019/20 onwards).
- Development of the local Network Escalation Avoidance Team (NEAT) approach to coordinating and unplanned care response, increasing the multidisciplinary practitioner capacity within the NEAT team, and the numbers of cases considered. Colocation of social care personnel with ECCH single point of triage and MDT review (2019/2020).
- Implementation of the High Intensity User Service to provide an integrated and coordinated multiagency response for frequent attenders to hospital, putting in place sustainable preventative solutions for individuals with the greatest need (2019/20).
- Development of a strategic and coordinated approach to urgent care response in the Great Yarmouth and Waveney area, streamlining and consolidating existing separately commissioned and delivered initiatives where it makes sense to do so for the local population. This will include aligning the developing Primary Care Networks with the NEAT service, the High Intensity User Service and the Integrated Discharge Team at JPUH (2019/20 onwards).
- Review of the provision of Specialist Palliative Care services in the locality following year 1 of the new community contract provision; evaluating the impact of service provision to date, the usage and operation of bed based provision, day services and advice and guidance services and future plans for further development (2020/21).
- Consolidation of our approach to clinical engagement to inform day to day care delivery and future service planning. We will encourage this through targeted engagement forum such as the Clinical Summit – which brings together GPs and JPUH hospital consultants to explore shared issues and opportunities for change, through our PCN Clinical Director leadership roles and through regular mechanisms such as GP surgery forum and through professional clinical networks (2019/20 onwards).
- To underpin the work of our Local Delivery Group by April 2020 we will have developed a population health data pack which articulates a partner supported ‘Case for Change’ – setting out a recognised articulation of ‘place’ based local need and opportunities for change. Alongside this we will document our detailed programme plans to deliver our LDG priorities for the next 3-5 years.
• To further our planned integration with Norfolk and Suffolk social services we will maintain this as a priority area focus through our Local Delivery Group. Early planning to design and evaluate future iterations of the Integrated Better Care Fund (IBCF) will take place, with specific consideration for the Great Yarmouth element of the Norfolk IBCF and Waveney element of the Suffolk IBCF (2019/20 onwards).

• Collaborative development of a common platform to allow universal access to information held within Liquid Logic (Suffolk Social Care practitioner system) and SystmOne databases (General Practice and Community clinical system) to facilitate joined up care across health and social care (2019/20 onwards).

Understanding the needs of our local population – improving health, tackling inequalities

Understanding the needs of our local population now, and in the future, is critical to ensuring we commission and deliver effective healthcare. We are working closely with public health experts in Norfolk County Council and Suffolk County Council, as well as analysts from Arden and Gem Commissioning Support Unit to develop an integrated, comprehensive data pack of information on disease prevalence and wider determinants of health to inform future commissioning and delivery for the locality. We are working together with partners from East Suffolk District Council and Great Yarmouth Borough Council to bring this information together to inform how we speak to the wider public and local communities about issues they face, and how we plan and commission services for the future.

A good example of this collaboration is our plans to participate in engagement events with local communities during Autumn 2019 with East Suffolk District Council through their Community Partnership programme to share data on health and wellbeing and inform future shared priorities.

A key priority for us in the locality is to embed a ‘population health approach’ into the way we design, plan and deliver healthcare. By this we mean ‘improving the health of our defined population through data driven planning and delivery of proactive care’. We will achieve this by improving physical and mental health outcomes and wellbeing and reducing health inequalities for patient groups through targeted action plans to reduce ill-health and address the wider determinants of health.

We are starting to use, and plan to build our usage of a range of IT systems and clinical tools to embed population health segmentation and risk stratification into both day to day clinical practice, and the way in which we plan and deliver services.

Our approach has a number of key features which can be seen to directly impact on clinical care and improved patient experience:

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**Population segmentation to target our care**
Drawing on an approach developed by the National Association of Primary Care (NAPC) we are segmenting data on our local population, looking at multi-morbidity prevalence as well as disease specific prevalence for those conditions such as diabetes, circulation and respiratory disorders where we have a relatively high prevalence when compared to national averages. This information has been presented to each Primary Care Network and local GP surgeries.

We will continue to work with Public Health commissioners, business intelligence analysts and partners to refine this data – in time combing a range of information to include not just population need and disease prevalence, but also information on health expenditure relating to patient cohorts and clinical workforce utilised in patient cohort care. This will enable us to consider whether we are using our valuable workforce and resources as effectively as possible to respond to the specific needs of individual patients. It is already leading to different conversations about the organisation of care within General Practice and with community teams, informing changes about best use of a range of clinical practitioner skills and maintaining continuity of care for those patients with the most complex needs.

We are using a range of IT systems and clinical tools across the ‘place’ to stratify our population; SystmOne as the local shared clinical system of primary and community care enables this, and is supplemented by the Eclipse system with functionality which includes alert generation for general practice for patients who may require more proactive clinical management. These technological solutions will be supplemented by the use of validated clinical tools to stratify need - for example the Electronic Frailty Index, alongside individual clinician knowledge of local patient needs.

Our new integrated model of clinical delivery provides dedicated community practitioner resource to each individual GP surgery. A key benefit of this is our ability to resource daily conversations at GP surgery level about the coordination of a multidisciplinary response to patient care. These practitioners will be able to draw on the population health data, segmentation and stratification information to highlight patients requiring a different response. This approach will be mirrored for more complex patients at Primary Care Network level. As part of our maturing Primary Care Networks we will also review population segmentation data by Network on a regular basis to inform service delivery and improvement.

We have described earlier that our integrated model of care in Great Yarmouth and Waveney has a workforce that has been designed by the number and type of staff to align to Primary Care Network population needs. This data will also inform our local relationships with community partners to make best use of wider community assets and infrastructure. We will ensure that through regular and active review of this data we will be able to commission and initiate more dynamic responses as new needs emerge. We will do this alongside information from other community partners to overlay other relevant intelligence – for example working with the district and borough councils on predictive tools which provide projections on future housing and benefits need.

**Engagement with local communities to shape care delivery**

A key part of understanding the needs of the Great Yarmouth and Waveney population is hearing from our local residents. As for the whole of Norfolk and Waveney there are some consistent themes that local people want us to focus on.
We will continue to engage with local people to embed a coproduction approach to how we design, shape and deliver services for Great Yarmouth and Waveney residents.

“What would you like to see in the local five-year plan for health and care services?”

You said….

Promotion of clinical pharmacists, more weekend appointments and social prescribing.

More GP hubs with wrap around services

All computer systems need to talk to each other

We are doing….

- Work with the Local Pharmacy Committee to promote the role of clinical pharmacists in the community and Primary Care Networks, supported by clinical protocols.
- An additional 128 hrs of evening and weekend appointments in GY&W each week.
- PCN Social Prescribers – aligned with East Suffolk District Council social prescribing activities.

- A Primary Care Network model of service delivery, integrating general practice and community services, with wrap around community, social care, mental health and specialist acute care.

- All Waveney GPs on SystmOne as the Community provider ECGH. Development work to improve SystmOne interoperability; population health searches. JPUH access to SystmOne as well as alignment of SystmOne with Liquid Logic, the Suffolk Social Care system.

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Primary Care: West Norfolk locality

Our key priorities as a West Norfolk ‘place’ partnership are:

- To ensure that we have the mechanisms in place to come together as local system partners, bringing together leaders from health, social care, voluntary sector, district councils and wider communities to shape the planning and delivery of health and care for the population of West Norfolk.
- To deliver an integrated model of care tailored for the local population, particularly that informed by the emergence of West Norfolk Primary Care Networks.
- To ensure we have a detailed understanding of our local population needs today and in the future, and the mechanisms in place by which this knowledge informs and shapes the services we commission and deliver.

About the West Norfolk population

West Norfolk covers a population of approximately 177,700 residents from Hunstanton and Burnham Market in the North to Feltwell in the South and from Swaffham in the East to Upwell and Emneth in the West. Just over half of the population (51%) are female, with 49% male. It has the eighth highest population of people over 65 of any CCG in England, 26% compared to 18% as the England average and with almost all population growth over the last five years being in this age group. There is a greater incidence of disease and lifestyle behaviours which increase health and care needs linked to the areas of deprivation. The life expectancy for men living in the most deprived areas is 5.8 years lower than for those living in the least deprived.

West Norfolk faces significant challenges in providing high quality health and social care which continues to meet the needs of its population. Health and social care organisations are working closely together to overcome these challenges and make sure that health and social care services are safe, sustainable and provided close to home.

Providers of healthcare

Within the geography there are a number of key health partners who are part of the Norfolk and Waveney Integrated Care System (ICS) and who play a leading role in delivering health and care:

<table>
<thead>
<tr>
<th>Care Sector</th>
<th>Main Provider(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary ‘Acute’ Care (e.g. Emergency Department, elective and non-elective services)</td>
<td>The Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust (QEH)</td>
</tr>
<tr>
<td>Community Healthcare (i.e. district nursing, physiotherapy, speech and language therapy, child health)</td>
<td>Norfolk Community Health and Care NHS Trust (NCHC)</td>
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<tr>
<td>Mental Health</td>
<td>Norfolk and Suffolk NHS Foundation Trust (NSFT)</td>
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<tr>
<td>Ambulance</td>
<td>East of England Ambulance Service NHS Trust (EEAST)</td>
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<tr>
<td>GP Out-of-Hours Service/111</td>
<td>IC24</td>
</tr>
<tr>
<td>Primary Care</td>
<td>General Practice (GP)/Doctors’ surgeries Dentists, Opticians, Pharmacists</td>
</tr>
</tbody>
</table>

These providers work closely with the local district councils (Borough Council of King’s Lynn and West Norfolk, Breckland District Council) and the voluntary and community sector.
West Norfolk Health is the GP provider organisation which represents the 21 GP surgeries and supports the development of the four PCNs within the area.

**Primary Care Networks (PCNs)**

In West Norfolk there are four PCNs; Coastal (circa 24,000 population), Swaffham and Downham (circa 44,000 population), Fens and Brecks (circa 37,000 population) and King’s Lynn (circa 72,000 population). Each PCN has a clinical director appointed; a named GP practising in that PCN area with responsibility for leadership of PCN development.

As groups of practices working together our PCNs are working with the partners to deliver improved care for patients. Collaboration in this way offers great potential benefit, particularly at a time when general practice is facing challenges with meeting population need and workforce sustainability. Working in networks can enable general practices to pool clinical and administrative resources, as well as making it easier to introduce truly multi-disciplinary teams. Ultimately it should help to free up GPs’ time to spend with patients in most need, and to improve access to more integrated services for our communities.

**What will the benefits of Primary Care Network and integrated community services be?**

Encouraging GP surgeries to come together around geographic localities, and clustering integrated health and care provision to these PCNs, is expected to benefit our local population by better tailoring services to local need, by integrated general practice and wider community care and by enhancing the accessibility and sustainability of services. We believe locality working supports our ambition for residents, regardless of their health needs, to play a central role in their own wellbeing. We believe the key tools for people being able to optimise their health and wellbeing are ones found within their local community, with primary care at its heart, and include:

- being able to access the services they need through primary care, the custodians of their story;
- ensuring the role of their family and carers is recognised and appropriately supported, through local support networks;
- having the opportunity to be part of their community and build personal resilience;
- pathways which are focused on the needs of the individual not based on organisational structures.

**West Norfolk – place based system as part of the wider Norfolk and Waveney ICS**

Working in partnership to deliver through our Local Delivery Group and local relationships

Our vision is that West Norfolk has a ‘place-based’ system of care, in which a range of partners work together to provide person-centred care in a proactive and integrated way. These systems of care work at the neighbourhood level through the four PCNs to wrap services and support around primary care. This means organisations working in close partnership, sharing information to fully understand the needs of the population, and collaborating to manage the common resources available.

The West Norfolk system is ideally positioned for integrated working as it operates within its own distinct system that allows partners to come together with a real identity to support the population of West Norfolk. It will be the local delivery mechanism for STP and national strategies. The delivery will be the West Norfolk operational response to the wider strategic planning that ensures the best outcomes are being delivered for the population of West Norfolk given the resources available. Working together we will deliver high value care.

**How will we deliver?**

The new, place-based system of care will be:
Person-centred

A person-centred approach means focusing care on the needs of the individual to ensure that people's preferences, needs and values guide clinical decisions. Person-centred care is much more than giving people whatever they want or providing information; it’s a way of working that considers the people who use health and care services as equal partners in planning, developing and monitoring their care and takes into account the desires, values, family situations, social circumstances and lifestyles of people using health and care services. It will mean better planning of care, more personal involvement for patients, and better transitions between services. It will also mean access to services in more appropriate settings that give patients easier access and a better experience.

Our model of care is being developed with the person at the centre, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means a move away from episodic and condition-based care where people may be expected to fit in with the routines and practices that health and social services feel are most appropriate, and is as much about the way professionals and patients think about care and their relationships as the actual services available.

Joined-up and consistent

In the new systems of care partners working together on a strategic level to understand the population and agree how resources can be shared to best achieve share objectives. This includes collaboration and integration in planning, commissioning and delivering services to develop and utilise system wide pathways and protocols that are used consistently across all partners.

We work together to take explicit collective responsibility for resources and outcomes. We aim to create a culture where systems will gain greater freedom and control over the operation of their local health system and how funding is deployed.

- We evolve new ways for providers to work together, in some cases coming together in a number of forms to deliver services where patient groups, populations or communities are best served by doing so.
- Commissioners and providers work together, blurring the lines of the traditional relationship, so that the workforce on the ground have a greater role in shaping services that brings experience, skills and passion to the forefront of service delivery.
- We operate as a single system using single system wide pathways and protocols to consistently identify and use proactive management and support for patients.

Providing proactive population focused care

The use of population health management approaches and tools allow us to work together to identify patients that will benefit from proactive care to prevent deterioration or adverse events that utilise much of the hospital based resources at present.

- Population health is an approach aimed at improving the health of an entire population. It is about improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health, and requires working with communities and partner agencies.
- Population health management improves population health by data driven planning and delivery of proactive care to achieve maximum impact. It includes segmentation, stratification and impactability modelling to identify local ‘at risk’ cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes. Within West Norfolk we have the NHS Pathways system that allows us to operationally deliver population health management approaches.

A culture of intelligence led, continual improvement
The system creates a culture where service redesign is ‘tried, tested, developed and rolled out’ through testing out integrated models at a small scale but with big scope. These test beds allow for the system to test out new models, adapt them and demonstrate generalisability across neighbourhoods. The leadership within the system will have a roll of enabling this change culture and freeing up the resources to make it happen.

**How we work differently**

Delivering this vision means a new approaches to how partners and wider stakeholders from across the West Norfolk Health and Care system work together to commission, design and deliver services. To achieve this, we are working to a new set of values. These are:

A new level of collaboration

Delivering this vision means new approaches to how PCN partners and wider stakeholders from across the care system work together to deliver services. To achieve this, we work to a new set of values - A New Level of Collaboration.

All partners recognise the shared problems facing health and care require shared solutions, and agree to work in collaboration to design services to address population need. This provides a foundation for collaboration with a wider range of organisations from different sectors. The basis for this collaboration is openness, trust and accountability.

This means designing shared solutions to shared problems, and where sharing risks means sharing gains. Resources are being allocated in a way that realises outcomes for all partners, not just the commissioning body.

The new way of working also has greater focus on recognising the wider implications on partners from redesigning systems, and working to find appropriate solutions. This means an end to commissioning and provision of services happening in isolation; no longer making unilateral decisions about services, pathways or budgets where the effects of those decisions will be felt by partner organisations. In cases where it is unavoidable for one partner to work in a way that another feels negatively impacts them, the Local Delivery Group is the forum to air, discuss and agree ways forward. The new model sees greater collaboration between providers, with organisations responsible for outcomes for the population rather than for delivering service activity. Partners work differently by co-producing and designing services around places, populations and people, not around conditions or service lines.

The LDG is inclusive in its approach and its constituent members:

**Embedding ‘Partnership Culture’ at all levels**

This new level of collaboration requires embedding partnership culture through management and operational levels of all partner organisations and across clinical boundaries.

Organisational leaders are being empowered to embed collaboration throughout their organisations, with delegated responsibility for collaboration and co-operation through the layers of management. This gives agency to integrate and freedom to work across organisational boundaries to staff at all levels.
For many organisations and departments, this is a significant shift and will take time and commitment, and will also involve sensitivities and governance arrangements that take careful planning. Strong, collective, relationship-based leadership is therefore necessary to achieve this culture change. This requires a real focus on leadership development at different levels across partner organisations, to ensure staff are empowered to collaborate to deliver services that deliver against patient need. We must also accept that things might change, and that the model of care must be responsive to changing demands and resilient enough to withstand external pressures on one or more of the partner organisations.

Retaining accountability and sovereignty

All partner organisations must remain faithful to their statutory obligations, governing bodies, charitable articles and legal requirements and losing accountability cannot be a by-product of collaboration. The development of integrated care is not a back-door for any one organisation to gain greater powers, shifting responsibility elsewhere or squeezing out smaller or less well-resourced organisations.

Our service improvement plans to deliver our ‘place’ based priorities

As with other ‘place’ localities in the Norfolk and Waveney system, the population of West Norfolk will benefit from the plans set out in this document relating to improving health and wellbeing, disease prevalence, treatment and outcomes. Overlaying this, and to deliver the priorities set out by the West Norfolk Local Delivery Group, there are a number of service improvement initiatives that are planned for the coming years that includes, but is not limited to the following:

Consultant Connect

The service aims to provide immediate clinician to clinician advice to support decision making regarding whether referral or admission is required. It is an app-based advice and guidance initiative that provides GPs with access to:

- Immediate phone-based advice from NHS consultants - currently covering 12 main specialty areas; and
- IG-compliant clinical photography – enabling GPs to make IG-compliant use of their smart phones (where they have one) to take clinical photos, leaving medical secretaries to download and save the photos to patient records

This service is being provided free of charge to GP surgeries.

Heart Failure and Cardiac Assessment

This is enabled through an increased investment into an existing heart failure and cardiac assessment liaison service capacity to work in dedicated PCNs and provide support and advice to GPs which will aid in reducing admissions. The service aims are to provide a patient-centred heart failure and cardiac assessment service across West Norfolk through the delivery of specialist support in home settings and community clinics that will:

- increase capacity for patient management by dedicated specialist staff rather than general physicians and support a reduction in the number of heart failure admissions locally
- Improved access for cardiac rehabilitation for post MI and by ad hoc agreement for patient cohort
- improve service consistency, delivery and access for patients with chronic heart failure in a cost-effective manner to meet the Norfolk and Waveney aims and objectives
- encourage patients to be actively involved in the management of their own condition
- increase the use of B-Type Natriuretic Peptide (BNP) and echocardiogram testing to support evidence-based diagnosis.

Respiratory Service
This is an increased investment to expand the COPD service capacity to a full Respiratory service. The new team are working in dedicated PCNs and providing support and advice to GPs which will aid in reducing admissions. They provide in-reach to the Emergency Department and assessment areas at the QEH to support early safe discharge with community follow up. The service aims are:

- prevent patients needing admission to acute settings wherever possible and support reduced length of stay
- improved oxygen assessment and accurate prescribing on hospital discharge with reduction in same day oxygen orders or inappropriate prescribing
- ensure patient medication reviews and education are carried out (including self-management plan, referrals to smoking cessation, pulmonary rehabilitation and oxygen alert cards)
- introduce the COPD Discharge bundle to facilitate discharges from Queen Elizabeth Hospital
- pilot the COPD app ‘My COPD app’ across community services with specific focus on pulmonary rehabilitation to reduce non-elective admissions and improve patient enablement and self-management.

Network Escalation Avoidance Team (NEAT)
This is development of the local approach to coordinating and unplanned care response, increasing the multidisciplinary practitioner capacity within the NEAT team, and the numbers of cases considered. Co-location of social care personnel with a single point of triage and MDT review.

High Intensity User Service
This is implementation of the High Intensity User service to provide an integrated and coordinated multiagency response for frequent attenders to hospital, putting in place sustainable preventative solutions for individuals with the greatest need.

As part of the development of the primary care networks the following projects were identified and are progressing:

Coastal PCN – Frailty Project
Coastal GP surgeries identified ‘frailty’ as a common problem amongst their PCN. They planned to undertake a pilot project on ‘frailty’ using a proactive care model approach. Initially the Coastal PCN population was segmented by Electronic Frailty Index (eFI) codes, however the coding varied considerably amongst practices, therefore an alternative approach to identify the cohort of patients was required. Using the PHM BI tool alongside clinical input the approach was reconsidered and a new cohort of patients identified. The PHM BI tool led the Coastal PCN frailty team to reset the parameters to identify the cohort as:

- Three or more chronic conditions in patients > 65 years
- The chronic conditions set as AF, Asthma, CKD, COPD, CVA, dementia, diabetes, IHD, PAD, heart failure, mental health / depression and rheumatoid arthritis.

Of these patients the clinical staff within the PCN wanted to raise alerts where set care processes and treatment targets were not being met, these were:

- Hospital admissions within last 3/12 Polypharmacy>5;
- Haemoglobin < 100g/L (If out of range or out of date, test within 12 months);
- Sodium<130;
- Fall within last 3/12 (Identified via Read codes);
- UTI within last 3/12;
- Low B12;
- HbA1c >75 (If out of range or out of date, test within 12 months).

The following measures of success were also set:
• 10% increase in annual chronic and polypharmacy reviews;
• Increase in dementia/frailty identification;
• Use of agreed patient related outcome tool;
• Improvement in levels of coding in Coastal PCN.

Data is currently being collected both automatically via systems and manually via clinical collection in order to evaluate the project. Findings will be shared and fed back to the MDT, these will be discussed and necessary changes can be made. It is planned to benchmark the cohort of patients against the last 12 months activity data to understand the impact the project has over the months still to come.

Swaffham and Downham PCN - Diabetes project

The Swaffham and Downham PCN has been formed by seven GP surgeries across a diverse population within West Norfolk. There are 41,178 patients of whom 3,430 patients have diabetes. Last year the region was average for diabetes monitoring and three treatment target attainment - National diabetes audit data.

The eight Key Care Processes which drive excellent diabetic patient care are:

• HbA1c
• Cholesterol
• U&E
• Blood Pressure
• Weight / BMI
• Foot check
• Urinary check: Albumin Creatinine Ratio (ACR)
• Smoking Status

Evidence suggests that multifactorial interventions aimed at improving the attainment of these metrics, reduces the risk of complications and improves life expectancy. Compliance with Best Practice Guidelines will be attained through three key actions:

1) Practices will be given accurate current data on the needs of their patients encouraging appropriate intervention.
2) Patients will be appropriately empowered with self-management plans to educate them of their specific needs and encourage improved engagement with their clinical team.
3) Outlying practices and non-engaging patient groups will be offered additional support and incentives to reduce variability and improve regional compliance with best practice monitoring.

It is vital that any such programme undertakes detailed analysis of the overall costs of healthcare and the overall patient outcomes within the region. This will be further broken down by monitoring and treatment target attainment. This will be measured as a quarterly measure of total cost, admitted patient care costs, accident and emergency costs, medication costs and referral costs. The impact for this project is being measured over a 12 month period.

Understanding the needs of our local population – improving health, tackling inequalities

West Norfolk CCG have engineered a Population Health Management (PHM) tool that provides an approach to delivering preventative care. It enables us to collect, understand and act on data at an individual patient level. The population health management database enables us to automatically collect data from all of our 21 GP surgeries’ systems, link it with data from our acute hospital and other health and social care partners and identify particular cohorts of patients that are relevant to local health and care challenges. Our model in West Norfolk has been recognised locally and regionally as an example of best practice.

The data provides commissioners with the information and context they need to make informed decisions and in turn this enables primary care teams to work proactively and focus on impactful care delivery by using a proactive care model.

Our current model of care is demand led which is inefficient, the majority of time, effort and resource is spent on the individuals who are already unwell. Population health management provides data and evidence to refocus resources on those individuals with potentially reversible conditions or those whose conditions can be stabilised. Moving
towards a proactive care model also enables the use of a stratified workforce model that ensures that the right patients are being seen by the right people at the right time.

**Engagement with local communities to shape care delivery**

We are keen to hear from local people and communities across west Norfolk in order to ensure that we can incorporate our stakeholders’ views and input into the design and delivery of our services and have demonstrated commitment to establishing and developing good working relationships with our stakeholders, including patients and local people, as well as partner organisations and healthcare professionals across our area. We have undertaken routine engagement activity with, for instance:

- Patient Participation Groups (PPGs)
- West Norfolk Patient Partnership Forum
- Community Action Norfolk (CAN)
- Patient Advice and Liaison Service (PALS)
- Maternity Voices Partnership (King’s Lynn and Wisbech)
- Healthwatch
- Health Overview and Scrutiny Committee (HOSC)
- Patient representatives on statutory groups
- Patient representatives on pathway development work

The approach to public engagement and consultation is to use a variety of mechanisms, methods and approaches to engage with as wide a range of people as possible.

Our future engagement priorities:

- We will continue to look at ways in which we can promote the patient voice and involve hard to reach groups in our work, using different and diverse mechanisms and ensuring that everyone’s voice is heard.
- We will look at developing our community engagement and explore new ways of working more closely with the VCSE community and consider different formats and approaches to this work.
• We will look at ways in which we can utilise new media, technologies, methods and approaches to ensure we reach hard to reach groups and encourage those who might not necessarily take part in our work to do so.

• We will continue to create public-facing materials and documents that are bright and visually appealing and in a variety of accessible formats for the community.

• We will look at new ways of engaging with patients and public, recognising the limits of a one-size-fits-all approach and striving for inclusivity and greater engagement in our work.

• We will work with our partners to promote the NHS Long Term Plan and the Norfolk and Waveney STP transformation initiatives, ensuring that local people are involved as this work develops and their voices are heard.

Patient and public representatives are involved in shaping our work as a place and we will continue to ensure they are engaged in development of our services in West Norfolk.
Primary Care: Norwich locality

Our key priorities as a Norwich ‘place’ partnership

The three priority work programmes as a Norwich ‘place’ partnership are:

1. Healthy Norwich - Prevention and health improvement with a focus on reducing health inequalities.
2. Your Norwich - our transformation programme to integrate local health and care services
3. Primary Care Network Development

About the Norwich locality

The current population of our Norwich locality is 238,000 and covers four local authorities – Norwich, Broadland and South Norfolk district councils and Norfolk County Council. Whilst comparatively younger than wider Norfolk, our ageing population will experience prevalence of chronic long term conditions which will require more care from general practice.

Norwich

A predominantly working age urban population, with pockets of deprivation and a greater mix of ethnicity, Norwich experiences particular characteristics of disease and ill-health; a higher than national average prevalence of alcohol related illness and self-harm, lower levels of healthy eating, pockets of income deprivation and relatively high acute hospital activity due to stroke and heart attack. Further detail by local authority footprint is provided below – this evidences the complex picture of Norwich ‘place’.

The health of our population in Norwich is varied compared with the England average. Norwich is one of the 20% most deprived districts/unitary authorities in England and 22.3% (5,335) of children live in low income families. Life expectancy for men in Norwich is lower than the England average. Life expectancy is 10.2 years lower for men and 8.4 years lower for women in the most deprived areas of Norwich than in the least deprived areas.

In Year 6, 18.7% (242) of children are classified as obese. Levels of teenage pregnancy, GSCE attainment and breastfeeding are worse than the England average.

The rate for alcohol related harm hospital admissions is 739 (per 100,000 population), worse than the average for England. This represent 901 admissions per year.

The rate for self-harm hospital admissions is 190 (per 100,000). This represents 288 admissions per year.

Estimated levels of excess weight in adults (aged 18+) are better than the England average.

The rate of new cases of tuberculosis is better than the England average.

The rate of new sexually transmitted infections is worse than the England average.

The rates of statutory homelessness and violent crime (hospital admissions for violence) are better than the England average. The rates of under 75 mortality rate from cardiovascular diseases and under 75 mortality rate from cancer are worse than the England average.


Broadland

The health of people living our Broadland district is generally better than the England average. Broadland is one of the 20% least deprived districts/unitary authorities in England, however 8.9% (1,755) of children live in low income families.

Life expectancy for both men and women is higher than the England average. Life expectancy is 4.0 years lower for men and 3.5 years lower for women in the most deprived areas of Broadland than in the least deprived areas.

In Year 6, 15.5% (196) of children are classified as obese, which is better than the average for England.
The rate for alcohol-specific hospital admissions among those under 18 is 35 – this represents eight admissions per year.

The rate for alcohol-related harm hospital admissions is 550 (per 100,000 population), better than the average for England. This represents 773 admissions per year.

The rate for self-harm hospital admissions is 138 (per 100,000), better than the average for England. This represents 161 admissions per year.

Levels of teenage pregnancy and GCSE attainment (average attainment 8 score) are better than the England average.

Estimated levels of smoking prevalence in adults (aged 18+) are better than the England average.

The rates of new sexually transmitted infections and new cases of tuberculosis are better than the England average.

The rates of violent crime (hospital admissions for violence), under 75 mortality rate from cardiovascular diseases, under 75 mortality rate from cancer and employment (aged 16-64) are better than the England average.


South Norfolk

The health of people in South Norfolk is generally better than the England average. 10.4% (2210) of children live in low income families and life expectancy for both men and women is higher than the England average.

Life expectancy is 4.4 years lower for men and 3.8 years lower for women in the most deprived areas of South Norfolk than in the least deprived areas.

In Year 6, 15.1% (180) of children are classified as obese, better than the average for England.

The rate for alcohol-specific hospital admissions among those under 18 is 21 (per 100,000 population). This represents six admissions per year.

Levels of teenage pregnancy and GCSE attainment (average attainment 8 score) are better than the England average.

The rate for alcohol-related harm hospital admissions is 565 (per 100,000 population), better than the average for England. This represents 811 admissions per year.

The rate for self-harm hospital admissions is 103 (per 100,000), better than the average for England. This represents 133 admissions per year.

Estimated levels of smoking prevalence in adults (aged 18+) and smoking prevalence (in routine and manual occupations) are better than the England average.

The rates of new sexually transmitted infections and new cases of tuberculosis are better than the England average.

The rate of killed and seriously injured on roads is worse than the England average.

The rates of violent crime (hospital admissions for violence), under 75 mortality rate from cardiovascular diseases and under 75 mortality rate from cancer are better than the England average.


Planned housing development in the greater Norwich area will significantly increase the population of the PCN over the next ten years. By 2020, it is estimated there will be an increase of population of 123,000. Up to at least 2036, there are expected to be an extra 2,000 new homes built per annum.

Providers of healthcare

Within the geography there are a number of key partners who are a part of the Norfolk and Waveney Health and Care Partnership, who play a leading role in delivery health and care to the population of Norwich and are members of the Local Delivery Group:

- The Norfolk and Norwich University Hospitals NHS Foundation Trust – delivering acute hospital care
• Norfolk Community Health and Care NHS Trust – who deliver community healthcare services
• Norfolk and Suffolk Foundation Trust (NSFT) – who delivery mental healthcare
• Norfolk County Council (NCC) – who deliver Adult Social Care services
• OneNorwich Practices – GP Provider Organisation which will come into being April 2020 following merger of Norwich Practices Limited and OneNorwich Executive members.

Primary Care Networks

Norwich has a single Primary Care Network, but this has been divided into four neighbourhoods (East Norwich, West Norwich, Norwich North and Central). There is one clinical director for the PCN and each neighbourhood has a clinical lead.

Norwich – place based system as part of the wider Norfolk and Waveney ICS

Working in partnership to deliver through our Local Delivery Group and local relationships

Since 2013, Norwich system partners have been working together to meet the needs of the local population through innovative solutions and initiatives. Building on these well-established collaborative working arrangements, the Norwich Local Delivery Group (LDG) brings together commissioners, cross sector provider organisations and key stakeholders across health, social care, service user forums, the not-for-profit sector and local authority to oversee the design and delivery of the New Model of Care (NMoC) for Norwich. The LDG is forward looking and values its workforce.

The LDG’s vision is “Promoting healthier lives by making local GP, health, social care, wellbeing and voluntary sector services work better for the people of Norwich.” This is underpinned by a commitment to shift our focus from the treatment of illness to the creation of health and wellbeing.

Our local ambitions are fully aligned with those of the Norfolk and Waveney Health and Care Partnership and support the development of an Integrated Care System (ICS) and supports the development of our local Primary Care Network (PCN).

We understand that, in order to deliver more sustainable and personalised care, General Practice, through PCNs, will be the driver for a transformational shift in care delivery. To further support and enable local partnership working at this level, the Local Delivery Group (LDG) is essential for bringing together a broad range of providers and stakeholders to progress transformative and innovative pieces of work supporting care closer to home and progressing the development of new relationships between all of our ‘out of hospital’ provision.

The LDG is committed to ensuring how healthy an individual is does not depend on where you live in Norfolk and Waveney. The initiatives within the Your Norwich work programme are supported by integrated and multi-disciplinary assessment and solution so the patient should receive one offer of care in response to them telling their story once.

Members of the Norwich Local Delivery Group are operationally accountable for the successful delivery of:

• Primary Care Network (PCN) Development
• Healthy Norwich Programme (Prevention, Health Improvement and Tackling Inequalities)
• YourNorwich Programme (Integration and Transformation of Services)
• Recently implemented initiatives developed as part of the New Model of Care, including
  o NEAT
  o HomeWard
  o Community FICS (Fully Integrated Care and Support)
• The design and implementation of new approaches, such as:
  o Embedding Physical Activity
  o Population Health Management
The Vulnerable Adults Offer

The LDG will also support and champion member organisation strategic ambitions including (but not limited to):

- Norfolk County Council’s Promoting Independence Programme
- Norfolk County Council’s Living Well Social Work Offer and Health Coaching
- Norwich 2040 City Vision

Our commitment to joint working

A Memorandum of Understanding (MOU) is being developed between members of the Norwich LDG to formalise these local partnership working arrangements and to safeguard the local initiatives outlined above which form part of the New Model of Care and have been designed to deliver improved patients outcomes, to facilitate working across organisational boundaries and to support a sustainable local health and care system.

As well as supporting existing projects, the MOU will also ensure that LDG members contribute to the design and delivery of new initiatives and priorities which include:

- Promoting physical activity and supporting positive behaviour change
- Population Health Management and the targeting of resources for people who are most at risk
- Improving outcomes for vulnerable adults and people with complex needs

Engagement

There is a ‘Place’ Community Involvement panel led by a Governing Body lay member. Membership includes individuals, Patient Participation Group representation and other interested representatives. The group is in the early stages of its formation and is finalising their Terms of Reference. Updates and feedback have been shared with the group on key Norwich initiatives such as NEAT and the Improving Access Service offer.

Governing Body clinicians and clinicians from all LDG members have led and contributed to design and implementation of the Your Norwich, Healthy Norwich and PCN Development work programmes. Clinical engagement has also been instrumental in finalising the LDG priorities for 2019/20 onwards. The following groups (either clinically led or with clinical membership) have influenced the direction of travel and decision making in Norwich ‘place’:

- Local Delivery Group – includes Primary Care Network Clinical Director as well as other clinical representation from other members
- Council of Members – representation from every GP surgery in Norwich – holding the Governing Body to account
- Primary Care Commissioning Committee – membership to be reviewed as currently does not include GP surgery membership – conflicts of interest will be managed appropriately
- Executive Committee - decision making with regards new commissioning proposals including business cases
- Clinical Reference Group – changing from Norwich ‘place’ based to central Norfolk Locality based but will be key clinical resource for input in shaping Norwich services
- All projects have clinical leads

How will we deliver?

The three priority work programmes as identified earlier at a Norwich ‘place’ partnership are:

1. Healthy Norwich - Prevention and health improvement with a focus on reducing health inequalities. Key projects to date have included:
   - The Daily Mile in schools - to tackle childhood obesity
   - Smoke Free Parks (85 Norwich Parks) and #Smokefreesidelines - used in the national Public Health England 2017 Stoptober Campaign
• #Sugarsmart animation – 14,500 student reached via a Facebook campaign (and school assemblies)
• Breastfeeding Friendly Practices – 31 champions (26 GPs) trained in 19 practices
• Social Prescribing Pilot - to link patients with non-medical needs to sources of community support. This helps to increase GP capacity and prevents the “medicalisation” of social issues
• Development of “heat maps” to identify and target those residents at risk of fuel poverty and excess winter deaths
• Holiday Hunger campaign targeting local primary school children (in association with Norfolk County Council and Norwich Food Banks)

2. Your Norwich - our transformation programme to integrate local health and care services which has seen the introduction of:
• HomeWard  - Our “Hospital at Home” service was a finalist in the HSJ Value in Healthcare Awards in 2017
• NEAT (Norwich Escalation Avoidance Team) is our integrated community response to urgent and unplanned health and care needs to keep people safe and well at home and prevent avoidable admissions to hospital or respite care. NEAT was a finalist in the HSJ Improved Partnerships between Health and Local Government Award in 2018 and the model is being rolled out across Norfolk and Waveney as an example of good practice
• Community FICS (Fully Integrated Care and Support) – our enhanced case management and community support model working with statutory and voluntary sector partners to support people holistically in a planned way and prevent them going into crisis

3. Primary Care Network Development

With our population set to increase, our ability to cater for our growing population requires increased capacity in Norwich general practice and extended primary care provision which is already under pressure and is an ageing workforce. 25% of Norwich GPs and 35% of nurses are over 54, and 18% of the Norwich GP workforce is projected to retire in the next five years.

A Norwich GP looks after approximately 2,100 patients compared to a Norfolk and Waveney average of 1,900 and a Norwich practice nurse looks after approximately 3,400 patients compared to a Norfolk and Waveney average of 2,000.

Responding to this challenge:
• The GP Alliance, OneNorwich, made up of all 22 practices continues to develop its capability, workforce capacity, and work closely with other local health and care providers towards an integrated, patient-centred system. To achieve this OneNorwich has developed a robust work programme which has grown significantly.
• Working at scale has helped to:
  o Identify what functions can be delivered together
  o Secure economies of scale
  o Enable them to deliver their own bespoke general practice styles which are suited to their individual practice clinicians and patient demographics

One core element of the activity is delivering support on the NHSE 10 High Impact Actions.

In addition, OneNorwich is the mechanism for practices to decide how to reinvest retained PMS resources into General Practice. Further to this, OneNorwich has provided support to the emerging Primary Care Network and Neighbourhoods. Through OneNorwich, the Network has a solid foundation and a united and cohesive vision for patients.

Service development workstreams
Aimed at service redesign and delivering a new model of care for Norwich as illustrated in the diagram below:

<table>
<thead>
<tr>
<th>Service development workstreams</th>
<th>Focus for 2019/20</th>
</tr>
</thead>
</table>
| 1. Primary care transformation   | • Transformation Leadership  
• Communication, engagement and collaboration  
• High Impact Change Actions: Productive General Practice, Learning in Action,  
• Workforce, Learning and Organisational development: Protected Learning Time, Active Signposting, Workflow Optimisation, Volunteers in Practice, Norfolk and Waveney Training Hub  
• Technological innovation: Ardens, MJOG, Centralised Dictation, Intranet, Online Consultations, Centralised website |
| 2. Extended primary care        | • Improved Access Service  
• Prescribing Protocol Model |
| 3. Integrated population based model of care | • Home Visiting Service  
• Mental Health Practitioners in General Practice  
• Engaging and supporting patients with multiple disadvantages (Complex needs) |

Enhanced Primary Care teams are essential to building necessary capacity and resilience within primary care, which is set out in the diagram below:
PCN enablers

In addition to the continuation and development of the work programme, and utilisation of PCN development support available, it is recognised that other enablers, in the form of the following need to be taken into account:

- PCN Leadership development – Clinical directors and other key stakeholders are able to access programmes to support their development
- Communication, engagement and collaboration – Continue to build on the relationships formed through networks, such as the Local Delivery Group to progress thinking and develop local solutions
- Workforce learning and organisational development – Opportunities to attract, retain, grow and utilise our workforce continue to evolve, as well as continuing to integrate other professionals and services in order to meet the needs of local people
- Estates and technological developments and innovation – Understanding, planning and responding to our primary care estates needs in the context of PCN developments and future ambitions. Ensuring that technological developments support the needs of the local population in the most appropriate means as well as enable extended teams to deliver better care, and can be accessed effectively

It is recognised that these enablers cannot be considered in isolation and greater value can be achieved through plans and actions that note these interdependencies. This again is a role that the Local Delivery Groups will continue to support as they mature further.

Prioritised Outcomes

In February 2019, a stakeholder meeting agreed the following outcomes to be delivered by Norwich LDG members for the Financial Year 2019-20. These outcomes were decided on following review of our health profiles and also in response to the Long Term Plan priorities of:

- transforming out of hospital care and moving to fully integrated community based care
- reducing pressure on emergency services including hospital
- giving more people control over their own health and more personalised care – OneNorwich PCN focus on ‘What Matters to Me’
- digitally enabling primary care and outpatient care
- improving outcomes for patients
  - with a cancer diagnosis
  - with mental health issues
  - reducing waiting times for elective procedures

<table>
<thead>
<tr>
<th>Priority area</th>
<th>Schemes / actions to deliver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in childhood obesity (child excess weight in 10-11 year olds)</td>
<td>• Healthy Norwich</td>
</tr>
<tr>
<td>Increased percentage of physically active adults</td>
<td>• Healthy Norwich</td>
</tr>
</tbody>
</table>
| Reduction in alcohol attributable hospital admissions | • Engaging and Supporting Patients with Severe and Multiple Disadvantage (SMD) within Primary Care  
• Vulnerable Adults redesign project                   |
| Injuries due to falls in people aged 65 and over | • High Intensity Users (formerly known as Frequent Attenders) service  
• Integrated Care - Community FICS  
• Physical Health Checks for Serious Mental Illness |
| Increase in the proportion of older people (65+) still at home 91 days after discharge from hospital into reablement/rehabilitation services | • Home Visiting Service  
• Integrated Care – Community FICS, NEAT, Enhanced Health in Care Homes |
| Increase the proportion of eligible referrals to improving access to psychological therapies treatment (IAPT) services that move to recovery | • Dementia Diagnosis and post diagnostic support  
• Integrated Care – HomeWard, Community FICS, NEAT |
| Reduction in unplanned hospitalisation for chronic ambulatory care sensitive conditions (diabetes; COPD; congestive heart failure; dehydration; bacterial pneumonia; urinary tract infections) | • Integrated Care – HomeWard, Community FICS, NEAT, Enhanced Health in Care Homes  
• Vulnerable Adults redesign project |
| Increased uptake of flu vaccinations in frontline staff by organisation | • Active Signposting  
• Community FICS  
• Mental Health PCN test and rollout |
| Emergency admissions rate per 100,000 population | • Integrated Care – HomeWard, NEAT, Enhanced Health in Care Homes  
• Home Visiting Service  
• Hospice at Home Pilot  
• Vulnerable Adults redesign project |
| Reduction in A&E attendances to NNUH | • Home Visiting Service  
• Hospice at Home Pilot  
• Integrated Care – HomeWard, NEAT, Enhanced Health in Care Homes  
• Physical Health Checks for Serious Mental Illness  
• Vulnerable Adults redesign project |
| Delayed transfers of care attributable to the NHS and Social Care per 100,000 population | • Integrated Care – HomeWard, Community FICS, NEAT |
| Reduction in the avoidable use of acute mental health beds. | • Engaging and Supporting Patients with Severe and Multiple Disadvantage (SMD) within Primary Care  
• Vulnerable Adults redesign project  
• Personality Disorder Service Development (NSFT)  
• Wellbeing Hub Service Development  
• Physical Health Checks for Serious Mental Illness  
• Integrated Care – HomeWard, NEAT  
• Mental Health – PCN test and rollout |

| Reduction in long-term support needs met by admission to residential and nursing care homes for:  
• people aged 18-64 years  
• people aged 65+ | • Promoting Independence Programme  
• Living Well  
• Integrated Care – NEAT and Community FICS  
• Home First |
Primary Care: North Norfolk locality

Our key priorities as a North Norfolk ‘place’ partnership

- Support people to get more control over their own health and more personalised care when they need it, keeping them in their own homes
- Better alignment of primary and community health services
- Reduce pressure on hospital services
- Drive forward the use of technology in care solutions
- Enable Primary Care Network to be able to deliver the national priorities
- Understand the local needs of our population through Population Health Management
- This chapter describes how we intend to work at North Norfolk ‘place’ and ‘neighbourhood’ level to improve health and wellbeing for the local population and to deliver Norfolk and Waveney Health and Care Partnership goals. It will describe how we will come together to organise and work in partnership at ‘place level’, how we have tailored our model of care to respond to population need and how we will work to understand the needs of our local population.

About North Norfolk

Place-based working involves NHS organisations (both commissioners and providers) working in partnership with local authorities and voluntary and community sector organisations to take collective responsibility for local resources and population health.

Within the North Norfolk ‘place’ we have four ‘neighbourhoods’ which are groups of practices that have come together to work as Primary Care Network (named NN1, NN2, NN3, and NN4).

North Norfolk covers approximately 174,540 patients and runs from Fakenham up to Wells, across the coast to Mundesley down to Acle in the south of the locality then back across the top of Norwich to Drayton.

Population Statistics

The North Norfolk ‘place’ covers a population of approximately 175,000 local residents across two district councils – North Norfolk and Broadland. It has an older population, with the highest number of patients over 75 years of age in the country and the second highest level of patients over 85 years of age. Correspondingly the services provided need to reflect the impact of increasing frailty and levels of chronic disease management required. This adds in another driver to the increasing demand for services on top of the anticipated population increase.
Within the North Norfolk district council area the population’s health is varied compared with the England average. Life expectancy for both men and women is higher than the England average, and is not significantly different between areas of lower and higher deprivation. 14.2% of children come from low-income families.

In the Broadland district council area health is generally better than the England average. The area is one of the 20% least deprived districts in England, with 8.9% of children in low income families.

Reflecting the older age profile, North Norfolk ‘place’ has a higher prevalence of long term conditions compared to the England average. Although North Norfolk has a lower smoking rate than the England average, there is a higher prevalence of obesity which can contribute to development of long term conditions such as diabetes and heart disease. North Norfolk is committed to a prevention agenda to support patients to make healthy lifestyle choices and reduce their risk of developing long term conditions.
North Norfolk geography and population growth

North Norfolk ‘place’ is largely rural with some coastal areas. There are many small towns and villages within the area, with issues concerning transport infrastructure and public transport which restricts travel options and makes it difficult to access services.

A number of housing developments are planned for North Norfolk with an additional 15,000 houses anticipated by 2036. Current services within North Norfolk are reaching or at capacity and plans are underway to meet the needs of the increasing and ageing population.

Providers of health and care

Within the North Norfolk geography there are a number of key partners who are part of the Norfolk and Waveney Health and Care Partnership, who play a leading role in delivering health and care:

- **Local hospital services** include the Norfolk and Norwich University Hospital (NNUH) or the Queen Elizabeth hospital in King’s Lynn. Some specialist services are provided elsewhere, such as at the James Paget University Hospital, Addenbrooke’s Hospital, or at Papworth Hospital.
- **Ambulance services** are provided by the East of England Ambulance service NHS Trust.
- **Community care** is provided chiefly by Norfolk Community Health and Care NHS Trust (NCH&C).
- **Urgent needs** can also be met by the Cromer Minor Injuries Unit, and urgent primary care needs can be met by the walk in service located within Norwich.
- **Most mental health services** are provided by the Norfolk and Suffolk NHS Foundation Trust. The adult Community Eating Disorders Service is provided by the Cambridge and Peterborough NHS Foundation Trust. Specialist learning disability beds are provided at Astley Court by Hertfordshire Partnership NHS Foundation Trust.
- **Out of Hours primary care** and **NHS 111 Services** are provided by IC24.
- The **Non-Emergency Patient Transport Service** is provided by ERS Medical.
- The CCG commissions **primary care services** from its member practices along with their overarching primary care at scale organisation – North Norfolk Primary Care.
- **Norfolk County Council** deliver **Adult Social Care Services**.
- **District council services** are provided by North Norfolk District Council and Broadland District Council, who also cover part of the Norwich ‘place’. Around the borders of this area some of the population will receive services from providers whose main cohort of work falls outside of North Norfolk.

Primary Care Networks

Within North Norfolk there are four Primary Care Networks (PCNs); North Norfolk 1 (circa 41,500 population), North Norfolk 2 (circa 40,300 population), North Norfolk 3 (circa 45,600 population) and North Norfolk 4 (circa 46,800 population). Each PCN has a clinical director appointed; a named GP practising in that Primary Care Network area with responsibility for leadership and development.

Representatives from each practice in a PCN meet monthly to discuss issues both at a local and system level. It is also here that practices can raise concerns and have their say about system wide matters that the clinical director can then feed up into wider system debates.

Supporting and nurturing PCN development is essential to be able to deliver the best outcomes for the population with a health and care model that is fit for the future.

All PCNs in North Norfolk have completed an assessment of their current state of maturity, and identified key areas of development to help them take on their new role. Key areas identified include:

- Development of staff – including leadership programmes for clinical directors and emerging leaders from other staffing groups
• Estates development – there needs to be greater understanding of current estates capacity and likely need for growth of estates and support services to serve an increasing and more complex population. Demands on primary and community services include:
  ▪ projected housing growth
  ▪ an increasing and ageing population
  ▪ new staffing roles to be based at practices
  ▪ ambition to work with the hospital to move some services from a hospital setting into the community

• Population Health Management – tools and data to better understand the local population demographics and needs, so that services can be tailored to meet local health needs

**GP surgeries working at scale**

All 19 practices that make up the four PCNs within the North Norfolk ‘place’ are used to working at scale and prior to becoming PCNs had already established an overarching GP provider organisation; North Norfolk Primary Care (NNPC).

Current services provided by North Norfolk Primary Care:

• **Improved Access** – Provision of weekday evening and weekend GP and nursing appointments to the population of North Norfolk through four hub sites providing patients with access to 800 more appointments a week at a wider choice of times across general practices in North Norfolk. We will continue to build on this model to improve access for patients and increase the number of services available to patients in the community.

• **Enhanced Care Home Team** – A nursing team to support patients in care homes who have been identified by their GP as being at risk of admission and who may benefit from additional support. The service is reducing admissions to hospital and the number of GP visits by offering a more tailored and organised service for care homes.

NNPC were a crucial partner in the setting up of the PCNs, supporting practices to meet the requirements to apply. They have also provided support to recruit new staff roles including clinical pharmacists and social prescribing link workers.

In addition to this, NNPC have worked collaboratively with practices, commissioners and wider system partners to improve existing services. This has included a ‘100 day challenge’ project to improve working between community nursing and practices. The legacy of this is embedded in workstreams continuing to drive improvements.

NNPC are working with the four PCNs and commissioners to look at how we can transform existing mental health services to meet the needs of our population.

Key areas that NNPC will be supporting on delivering in the Primary Care Network:
North Norfolk – Our place-based system as part of the wider Norfolk and Waveney ICS

The NHS Long Term Plan enables us to build on a well-established history in North Norfolk of collaboratively developing services across health and social care providers to improve the health and care of the population.

A number of additional services are already commissioned from general practices to target our population needs including:

- **Atrial Fibrillation screening** – a screening service to identify those patients with undiagnosed atrial fibrillation and then provide the appropriate intervention and reduce the risk of stroke.
- **Anti-coagulation** – this thins the blood to help prevent strokes and heart attacks. This service provides community based monitoring and prescribing for patients on oral anti-coagulation treatment to enable patients to be tested and treated in a single general practice appointment.
- **Deep Vein Thrombosis (DVT)** - Early detection and intervention of DVTs.
- **Enhanced Chronic Disease Management** - Supporting and managing patients with chronic obstructive pulmonary disease, pre-diabetes symptoms and identifying and diagnosing patients with dementia to ensure they can access the appropriate support.
- **Prostate specific antigen (PSA) and Prostate Cancer Follow Up Service** – practices working collaboratively with the hospital to provide a monitoring and recall service for those men who require on-going measurement of their PSA levels within an accessible, safe, community setting.

Our community nursing services (provided by Norfolk Community Health and Care NHS Trust) have aligned their community nursing teams to Primary Care Network areas. There is a dedicated nursing team for each Primary Care Network, with the opportunity for link worker nurses to build relationships with individual practices, and for nurses to attend multidisciplinary team meetings within the practices to discuss complex patients and how the team can best holistically care for them.

Our main mental health provider, Norfolk and Suffolk NHS Foundation Trust (NSFT), are looking at how they can redesign their service in collaboration with Primary Care Network. Primary care network input will be via the Local Delivery Group, where system partners meet to discuss large scale changes. NSFT are proposing a phased approach to rollout of any changes, and will ensure that this will be at a primary care network level. New services will also wrap around the Primary Care Network, ensuring that teams meet the local needs of the primary care network that they align to.
Working in partnership to deliver through our Local Delivery Group and local relationships

The North Norfolk Local Delivery Group (LDG) is chaired by a North Norfolk GP and its membership includes representation from:

- Norfolk Community Health and Care
- Norfolk and Suffolk Foundation Trust (mental health services)
- Norfolk County Council
- Broadland and North Norfolk District Councils
- General Practice
- North Norfolk Primary Care (GP at scale provider organisation)
- Integrated Commissioning Team
- Clinical Commissioning Group
- Healthwatch
- Voluntary community and social enterprise sector
- Norfolk and Norwich University Hospital

General practice attendance includes the four clinical directors that lead the North Norfolk Primary Care Networks.

Further organisational development of the Local Delivery Group is taking place to support its growth and cohesion. Development work earlier this year brought group member’s together and strengthened cross-organisation working, along with developing a shared vision and purpose for the group:

<table>
<thead>
<tr>
<th>North Norfolk Local Delivery Group emerging vision and purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>To lead, develop, implement, support and monitor</td>
</tr>
<tr>
<td>• Delivery of transformational service change identified by the local delivery group as appropriate for managing the health and care of the population of North Norfolk.</td>
</tr>
<tr>
<td>• The roll out of national initiatives specifically including the NHS Long Term Plan and STP strategic direction.</td>
</tr>
<tr>
<td>• Evolution of primary care networks and progress relationships between providers.</td>
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<tr>
<td>• Coordination and management of the place level work plan.</td>
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Local Delivery Group Priorities

The LDG in North Norfolk has recently undertaken a further series of workshops to encourage stronger working relationships between organisations. This has helped to establish a set of priorities, as detailed at the start of this chapter, which reflect the needs of the North Norfolk place population as well as the key enablers required to progress the main workstream areas listed below.

It is important to note that PCNs are at the foundation stage of their evolution and as they mature they will develop a more detailed understanding of the needs of their specific population which will shape the work plan going forward.

The workstream areas are:

Boosting out of hospital care and reducing pressure on emergency hospital services

Within the North Norfolk ‘place’ we have commissioned schemes to support out of hospital care. Their evaluation and outcomes are reviewed at the Local Delivery Group where consideration is given as to how to develop them to increase the impact they are able to make. These schemes are:
- **A&E Frequent Attenders Support Service** – supports patients who frequently attend A&E but who may be supported within the community, to understand their choices and to reinforce self-care and alternative provider options.
- **Enhanced Care into Care Homes Service** – nursing team who will review, assess and support care home patients identified by GP surgeries as vulnerable and at risk of admission.
- **Supported Care Service** – a multi-agency service for patients at high risk of, or experiencing, a healthcare crisis who may otherwise be admitted to hospital, to enable them to remain supported within the community.
- **Hospice at Home Service** – supports patients identified at the latest stages of End of Life care to remain in their preferred place of care.
- **Network of Escalation Avoidance Teams (NEAT)** – The team acts as a single point of access for urgent, unplanned health and social care needs where an integrated immediate response is co-ordinated from across the health and care system to support the patient’s recovery from illness or crisis, or to maintain or regain independence in their own home.

Digitally enabled primary and outpatient care

There are a number of digital developments that are transforming services in the North Norfolk ‘place’ to utilise technology to deliver effective joined up care:

- **Online consultations within primary care** – The system has procured the ‘Footfall’ software to enable patients to interact online with their GP surgery. This system enables patients to use interactive features on the practice website to answer simple queries or submit information, or to send and receive messages to the practice via the online portal. Practices are going live with this system in a phased approach. The first practices have gone live in October 2019, and we expect the roll out to be complete by April 2020.
- **NHS App -** Norfolk and Waveney were one of the first areas to go live with the NHS App from April 2019. Patients can now download the app to their mobile device to access summaries of their records, to book and cancel appointments, and to order repeat medication. Uptake of the app has been increasing since go-live, and practices are promoting the app with patients to increase this uptake so that more patients can benefit.
- **Record sharing** - Patient records are already able to be shared within the North Norfolk Improved Access service. Patients are asked for permission to share records at the point of booking, which enables the patient to be seen at a hub site during weekends or weekday evenings. North Norfolk are looking at ways of sharing records across the North Norfolk ‘place’ for other services, and to improve collaborative working opportunities. We are in the early stages of this and will be communicating with a wide range of stakeholders to strike the balance between patient privacy of records, and sharing to improve access to services.

**Population Health Management**

Population health management aims to bring together the various data resources available within the system which can then be analysed to understand the state of health of a specified population. Once the needs of the population are understood, services can be tailored to ensure that local needs are met.

We look at population health data at ‘system’, ‘place’ and ‘neighbourhood’ levels which allows us to commission services that meet the needs of the individual groups, and where to focus existing services to ensure effective use of resources.

Our Population Health Management approach is constantly improving, and we continue to work to bring in new datasets to enrich our intelligence and look at new ways of using data to improve services for patients.

**Primary Care Network requirements**
From 2020/21 Primary Care Network will deliver a set of five new services – detailed below – to be confirmed in autumn 2019 by NHS England. From late 2019 the LDG will discuss the requirements of the new services and how the system could collaboratively meet these requirements.

In early 2020 the final five service specifications will be published by NHS England, and will then be discussed within the local PCNs and timelines for rollout will be discussed.

To note: there are a number of elements already being delivered that we anticipate will be encompassed in the service specifications which we will build on to ensure we deliver the outcomes needed to provide the following.

The five new services are:

- **Structured Medications Reviews and Optimisation**
  - Addressing overmedication and where appropriate withdrawing medicines no longer required
  - Supporting the national agenda for reducing inappropriate prescribing of antibiotics.

- **Enhanced Health in Care Homes**
  - Support the implementation of outcomes from the pilot vanguard models of enhanced care home support including; care homes to be supported by a multidisciplinary team of healthcare professionals and delivering proactive and reactive care.

- **Anticipatory Care**
  - Practices to collaborate within their PCNs to identify patients at high risk of poor health outcomes and offering proactive care collaboratively with other member practices.

- **Supporting Early Cancer Diagnosis**
  - Ensuring high and prompt uptake of cancer screening invites.

- **Personalised Care (as part of the NHS Comprehensive Model)**
  - Implement aspects of the Comprehensive Model of Personalised Care, which includes components promoting shared decision making, promoting choice, social prescribing, supporting self-management and promoting personal health budgets.

**Prevention**

Social prescribing aims to link patients with non-medical needs to sources of community support. This helps to increase GP capacity and prevents the ‘medicalisation’ of social issues.

The current social prescribing service in North Norfolk ‘place’ has been well received by patients and GP surgeries. An Integrated Community Coordinator (ICC) post already exist in each practice and have been fundamental in building a firm base for social prescribing to progress from. A pilot of housing support officers based in general practice led to improved outcomes for patients.

Recognising the impact that social prescribing can have on a patient’s wellbeing and with practical support for non-medical needs, NHS England are supporting systems to increase the number of social prescribing link workers in the community. It is our aim to have additional resource in place within North Norfolk by 31 March 2020.

**Patient engagement**

Within the North Norfolk ‘place’ there are a number of established routes for engagement to ensure that patients are at the heart of everything we do, and to gather opinions on existing services and proposed changes:

Patient Participation Groups
Each practice has set up a Patient Participation Group (PPG), which is a community of patients registered with the practice who meet to discuss local issues pertaining to their practice, and also wider system issues that may impact on their practice.

The PPG is an opportunity for practices to disseminate information to their patients, as well as for patients to provide feedback and views on service changes and how to improve the system.

PPG Events

The North Norfolk Clinical Commissioning Group has run several events for PPG members, aiming to bring together a wider group of engaged patients to share information across practices and to gather feedback directly from patients as a representative of their local population.

Recent topics for PPG group events have been:

- The NHS Long Term Plan, and a workshop on how we can address the challenges raised within it
- The National Primary Care Network plan and how we can implement this locally

Events are lively, with patients able to ask questions of commissioners and raise local concerns about their area, and to understand what changes are on the horizon and to help shape how these can be implemented locally.

Community Engagement Panel

North Norfolk has a bi-monthly Community Engagement Panel which is open to the public. The group has a wide range of attendance from 70 members including local patients to interest groups within the community to health and social care organisations and voluntary sector representatives.

The group is able to feedback on local plans and workstreams, and how they feel services are running in their area. They can raise concerns about local services or national plans, and the panel provides a regular platform and voice for patients to interact directly with the CCG.

Specific feedback

For large scale projects we have actively sought feedback from patients. For example when implementing Improved Access about additional primary care appointments in weekday evenings and at weekends, a survey was sent out to patients and this feedback helped shape the times and locations of the appointments.

When creating surveys and seeking out patient opinion, we try to ensure that our responses reflect the population demographics. The survey was available in electronic and paper format, with paper copies left at multiple sites and also handed out to housebound patients via community nurses. We engaged with local voluntary sectors to raise awareness with hard to reach groups that are typically under-represented. We completed a post-survey evaluation to match the respondent demographic with the North Norfolk demographic, and have identified actions that can be taken for future surveys to improve the representation of all patient groups even further.

Addressing inequalities

North Norfolk ‘place’ has a large amount of population health data available, which allows us to understand the demographics and needs of our patients. In addition to this we engage extensively with our patient groups (as described below), to ensure that we understand any issues they have with inequalities in services.

An Equality Impact Assessment is completed as standard for any projects that are undertaken, or services that are developed. This ensures that no patient group is disadvantaged, and that any reasonable adjustments have been made to ensure that services are accessible to all where practically possible.
When developing services transport is always considered, as we are aware of the poor transport infrastructure and public transport availability within the ‘place’.

To meet the needs of our patients, we have commissioned Improved Access that provide primary care services outside traditional core general practice hours on weekday evenings and at weekends. We are always looking at ways to develop these services to enable a wider range of choice for patients over time and location of services, improving their access ability.
Primary Care: South Norfolk locality

Our key priorities as a South Norfolk ‘place’ partnership

- Use population health management to identify where the key areas of work are to improve the health of the local population
- Primary Care Network (PCN) development working with GP surgeries, heath and care providers and the voluntary sector
- Social prescribing model to improve scope and alignment within PCNs
- Working with care homes to support and enable them to provide care for people with increasing care needs
- Community provider model to improve to patients by teams working in a more integrated way focusing on the needs of the population

In delivering these priorities, the South Norfolk LDG actively contributes directly or indirectly to all of our system goals – prevention and health inequalities, integration and workforce.

To deliver these we outline below how we work in partnership at three levels to commission and deliver health and care to our local population: at ‘System’ level (across Norfolk and Waveney), at ‘Place’ level (currently across five Clinical Commissioning Group areas), and at ‘Neighbourhood’ level (across 17 Primary Care Networks).

About South Norfolk

The area covered by the LDG serves a patient population of 230,414 (as at January 2019) with an average Practice list size of 9,600. This is higher than an average list size of 7,000 in the rest of the country. The CCG covers a predominantly rural area including the main towns Thetford, Dereham, Wymondham, Long Stratton, Attleborough, Watton, Loddon and Diss.

More than half the population of South Norfolk are of working age although there are higher numbers of children and older people than across Norfolk and Waveney. The South Norfolk area has a significant older people's population - 24% of the population are aged 65+ which is in line with the average across Norfolk (24%), but significantly higher than the national average for England (18%). The number of older people is set to rise further over the next 20 years.

People living in the South Norfolk CCG area generally report that their health is good or very good which is similar to the averages for Norfolk and England.

While deprivation is better than average and life expectancy is higher than average there are still areas which South Norfolk can target to improve health, such as adult and childhood obesity, physical activity and healthy diet. There is also some evidence that alcohol consumption levels in the more affluent and older section of the population are quite high.

Currently delivery of these key areas and the development of a forward plan to support the local population is via the South Norfolk LDG. Membership across the group is drawn from all areas of the local system: county and district.
councils (Norfolk County Council, Breckland District Council and South Norfolk District Council), Healthwatch, provider organisations such as the NNUH and NCH&C, alongside primary care and the voluntary sector.

In South Norfolk we have four locality PCNs; Ketts Oak, SNhIP, Mid Norfolk, Breckland covering 24 GP surgeries in the area.

The majority of acute hospital services for south Norfolk are provided by the Norfolk and Norwich University Hospital (NNUH) and community services provided by Norfolk Community Health and Care Trust. Some patients are also supported by West Suffolk Hospital and Suffolk community services. Norfolk and Suffolk Foundation Trust is the provider of mental health services to the south Norfolk patch.

Norfolk County Council is responsible for a range of services, including adult social care and services for children and young people. And we have are two district councils within the area; Breckland and South Norfolk.

The LDG will continue to evolve to meet the changing needs of the population and have committed to a series of development events to enable this to happen. The main focus will be to ensure close working relationships to support the future planning of services for the population and also to respond together when the services are under pressure. A key element of this will be to explore opportunities for the development of the workforce from recruitment to training and shared posts.

Extensive planned housing development in the south Norfolk area will significantly increase the population of the PCNs over the next ten years. The LDG will ensure a collective response on behalf of the population to ensure a robust plan is in place to enable the continuation of the delivery of high quality services to the increasing population.

How have we responded to the identified need in our LDG?

Examples of schemes already in place:

- We have commissioned an Enhanced Care service to increase clinical support to care, residential and nursing homes. The service aims to reduce avoidable hospital admissions and appointments with GPs, as well as to support integrated working between home providers, primary and secondary care; with the overall aim joining-up and improving the quality of care that people receive.

- We have established Norfolk Escalation Avoidance Teams (NEAT) which is a single point of access for urgent, unplanned health and social care needs where an integrated immediate response is co-ordinated from across the health and care system.

- We have commissioned a Hospice at Home service to provide short-term enhanced palliative care to patients and their families during periods of acute deterioration in health and the last few weeks of life; with the aim of enabling them to remain at home.

The LDG has also participated in partnership development activities which has led to improved relationships and a better understanding of the requirements of the group to meet identified priorities at ‘place level’

This has enabled identification of shared service delivery improvement projects for each of our PCNs and a commitment to a ‘place’ level improvement project for care homes.

Identified priorities and schemes to support PCN development over the next year 2020/21

Primary Care Network Requirements

From 2020/21 Primary Care Network will deliver a set of five new services – detailed below – to be confirmed in autumn 2019 by NHS England. From late 2019 the LDG will discuss the requirements of the new services and how the system could collaboratively meet these requirements.

In early 2020 the final five service specifications will be published by NHS England, and will then be discussed within the local PCNs and timelines for rollout will be discussed.

The five new services are:

- Structured Medications Reviews and Optimisation
  Addressing overmedication and where appropriate withdrawing medicines no longer required
Supporting the national agenda for reducing inappropriate prescribing of antibiotics.

- **Enhanced Health in Care Homes**
  Support the implementation of outcomes from the pilot vanguard models of enhanced care home support including; care homes to be supported by a multidisciplinary team of healthcare professionals and delivering proactive and reactive care.

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  Practices to collaborate within their PCNs to identify patients at high risk of poor health outcomes and offering proactive care collaboratively with other member practices.

- **Supporting Early Cancer Diagnosis**
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- **Personalised Care (as part of the NHS Comprehensive Model)**
  Implement aspects of the Comprehensive Model of Personalised Care, which includes components promoting shared decision making, promoting choice, social prescribing, supporting self-management and promoting personal health budgets.

**Prevention**

Social prescribing aims to link patients with non-medical needs to sources of community support. This helps to increase GP capacity and prevents the ‘medicalisation’ of social issues.

There are different models of social prescribing currently within South Norfolk and an evaluation is underway to ensure that future and additional provision considers the outcome of the evaluation.

**Addressing Inequalities**

Within South Norfolk we use the population health data available to us to better understand our population and the needs of our patients. The use of population data, aided by improved access to digital tools and the expertise within our administrative resource will help to identify areas of inequality and through engagement with the population and stakeholders solutions to improve services and access to them.

Understanding the equality impact of any new service introduced is essential and an equality impact assessment is completed as standard for any projects that are undertaken, or services that are developed. This process ensures that no patient group is unfairly disadvantaged, and that any reasonable adjustments have been made to ensure that services are accessible to all where practically possible.

Access to primary care services has been improved through the commissioning of an Improved Access service which provides more access to primary care appointments outside traditional core general practice hours on weekday evenings and at weekends. This service will continue to be developed utilising patient feedback to enable a wider range of choice for patients over time and location of services, improving their access ability.

**Patient engagement**

Engaging patients in conversation about current services and future plans is acknowledged as a key priority at place level. This is particularly true as we move into more integrated provision and location of services, and how the PCNs will deliver the new specifications in the future. Within the system there are organisations who will be able to support this function particularly Healthwatch but also voluntary sector organisations.

There are a number of established routes currently for engagement to ensure that patients are at the heart of everything we do, and to gather opinions on existing services and proposed changes.
Specific feedback
For large scale projects we have actively sought feedback from patients. For example when implementing new pathways or changes in services.

Patient Participation Groups
Each practice has set up a Patient Participation Group (PPG), which is a community of patients registered with the practice who meet to discuss local issues pertaining to their practice, and also wider system issues that may impact on their practice.

The PPG is an opportunity for practices to disseminate information to their patients, as well as for patients to provide feedback and views on service changes and how to improve the system.

Community Engagement Panel
South Norfolk has a Community Engagement Panel which is open to the public. The group has a wide range of attendance including local patients to interest groups within the community to health and social care organisations and voluntary sector representatives.

The group is able to feedback on local plans and workstreams, and how they feel services are running in their area. They can raise concerns about local services or National plans, and the panel provides a regular platform and voice for patients to interact directly with the CCG.
Our hospitals

Context

Norfolk and Waveney is served by three hospitals which together provide nearly all of the hospital (acute) services for our population of over one million people. To the west and based in King’s Lynn is the Queen Elizabeth hospital and to the east is the James Paget University Hospital in Gorleston. Both hospitals have around 500 beds and provide a broad range of specialist, emergency (A&E), maternity and community-based services. In addition, the Norfolk and Norwich University Hospital has around 1,100 beds and provides more specialist hospital services for the whole county, as well as serving its local population in central Norfolk.

The three hospitals already work closely with each other. There are a number of joint appointments and clinical staff work across the different sites in a number of specialties. There are also excellent referral links across the hospitals so patients can access the best care wherever this might be available. However, the hospitals remain separate organisations and it is recognised that greater collaboration and co-operation would offer more benefits to patients and help maintain strong local services. So in the future it is likely that the three hospitals will operate more and more as one overall hospital system to best serve our patients and meet some of the challenges - like recruiting specialist staff - which we are currently experiencing. There is a clear need for three hospitals serving the Norfolk and Waveney population but working in different ways in order to deliver sustainable services that communities need.

Working together brings other benefits as well. Recently a combined bid from the hospitals resulted in a £70m investment by the government in new diagnostic facilities and equipment at all three hospitals. This will see new facilities being built at all three hospitals which will offer patients a much quicker ‘one stop shop’ diagnosis for possible cancer and other conditions.

Within each of our hospitals, there are some excellent and nationally recognised services that we are proud of. These include examples at both front line delivery, and to make our system more sustainable. For example, the Norfolk and Norwich University Hospital has some of the best outcomes from surgery in the country and has recently won a national award for its pioneering use of robotic surgery. At the Queen Elizabeth Hospital, the Surgical Enhanced Recovery Unit (SERU) that supports elective flow in the hospital and reduces the reliance on inpatient beds has been recognised nationally as an example of best practice. At the James Paget Hospital, the nationally recognised Health Academy encourages young people into healthcare and gives individuals from the local area an opportunity to gain valuable insight into roles available in healthcare. This academy model is recognised by Health Education England, with the JPUH supporting the roll out across the whole region.

Together our hospitals employ around 15,000 staff and treat many hundreds of thousands of patients per year. For example, we see 300,000 A&E patients and about 1.3 million appointments per year.

Our hospitals also play a vital role in undertaking research and education, working with our main partner at the University of East Anglia. This helps us attract good quality staff as well as ensuring we are investing in the future workforce.

Our challenges

In common with most other health and care systems, our hospitals face a range of challenges. These include:

- Increasing demand across our system: a recent independent report concluded that an additional 520 hospital beds would be required by 2022/23 unless we act now. This demand is increasing from a growing and ageing population and population health forecasts show health needs are changing. More people are living with long-term conditions (e.g. diabetes, heart conditions and dementia) and unless there is appropriate support for them to manage their conditions effectively in the community then what we are seeing is that they become acutely ill and need admission to hospital.

- Difficulties recruiting and retaining appropriately qualified clinical staff. This is particularly the case for highly specialist staff, but there is also a challenge in recruiting and keeping sufficient numbers of support staff.
• Responding to the rapid advances in digital, technological and treatment pathways, which have the potential to transform the way in which care is delivered. For example, new digital technology offers some innovative ways to help people self-manage their conditions or disease, but this requires significant investment and change to how we currently deliver safe care. At the other end of the spectrum is the need to keep up to date with the introduction of new equipment and therapies.

• The extremely challenging financial climate for health and social care (and the wider public sector). This situation is exacerbated by those areas where investment is required in order to deliver national requirements (such as the workforce in midwifery to deliver the ‘continuity of carer’ models – see separate section) and the capacity to drive the programmes of work that support the acute sector to be more sustainable.

These are challenges faced by most hospitals in the NHS. However, in addition to these in Norfolk and Waveney we also have some particular local issues which we need to respond to. These include:

• Some of our services are, at present, not of the required quality and a number are increasingly fragile and unlikely to be sustainable in their present form

• Some of our hospitals have a financial deficit that is not reducing quickly enough

• Two of our hospitals are rated as ‘requiring improvement’ by the Care Quality Commission

• We cover a large geographic area with a poor transport infrastructure, resulting in sometimes long travel and transfer times

• Due to our relative geographical isolation, we have particular difficulties recruiting staff and as a result have a high number of vacancies in some areas

• We have significant physical capacity shortfalls at some of our acute sites, particularly in operating theatres and diagnostics

Overall the key issue is a mismatch between demand for hospital services and the capacity needed to meet this demand. The graph below shows the increase in activity at our three hospitals over the last five years.

Taking emergency admissions, the increase over the last five years has resulted in an additional 122,000 bed days (assuming an average length of stay in hospital for each patient of five days).
The increase in emergency demand in particular is a major challenge and if it is not addressed the hospitals will find it increasingly difficult to undertake planned care (e.g. scheduled operations). The growth in waiting lists over the last five years illustrates the growing problem.

In March 2019 there were 68,000 patients on the hospitals’ waiting lists which is an increase of 18% over the last five years. As a result, the Norfolk and Waveney system is struggling to meet the national target whereby 92% of patients on a waiting list do not have to wait more than 18 weeks for their treatment to start.

Working together as one hospital system

We believe that by working more closely together the three hospitals can deliver a wide range of benefits. These include:

- **Ensuring the sustainability of key services** – by integrating some services we can ensure that we have sufficient critical mass to continue to deliver high quality services, for example by ensuring we have sustainable rotas
- **Better use of physical capacity** – by ensuring that as a system we make maximum use of all available capacity, rather than operating as separate silos
- **Addressing current quality and patient safety challenges** – we know that in parts of our area existing services are not of an adequate standard; closer collaboration will help us to address these challenges more rapidly
- **Improving clinical outcomes for patients** – we will be more effective in narrowing the current variation in outcomes in some specialties (and between hospitals) by making better use of scarce clinical expertise, establishing centres of excellence that concentrate skills and experience in a single location, developing consistent high-quality pathways and reducing unwarranted variations in care
- **Recruiting and developing our workforce** – by creating future roles that are attractive to leading clinicians, for example by building in strong research and academic components and providing clearer career paths, and through the delivery of better training and development
- **Financial benefits** – including potential economies of scale and reduced running costs by doing things once.

The acute services integration programme

Greater collaboration between the three hospitals has already commenced. For the last two years, our clinicians have been working together on the acute services integration programme; well over 100 staff from across the three hospitals have contributed to the work. This programme has identified a series of services that will be more sustainable and of higher quality if we integrate the teams and deliver them in partnership rather than in isolation.

In June 2019, the Boards of each of our hospitals looked at the conclusions of the programme and took a series of landmark decisions. They agreed that we should move quickly to implement a first wave of integration:

- A single, pan Norfolk and Waveney urology service will go live in early 2020, bringing together the clinical teams from across the patch to develop a single, consistent model of service delivery
- At the same time, ENT services at the Norfolk and Norwich and James Paget hospitals are being brought together into a single, integrated clinical team
- In spring 2020 we will bring together the clinical teams for haematology and oncology at the Norwich and Norfolk and James Paget hospitals

The Boards of the three trusts each recognise that forming integrated clinical teams in this way will help to ensure that there are consistently high standards across the whole of Norfolk and Waveney, as well as help to address immediate challenges, for example by introducing single rotas to help address staffing gaps in some areas.
A single Hospital Services Strategy for the three hospitals

Building on the experience and learning from the acute services integration programme, we have now resolved to work together to develop a Norfolk and Waveney hospital services strategy. This will be driven and shaped by our clinicians, and we will support and enable clinical leaders from all three trusts to contribute. Our medical and nursing leaders all strongly support this direction of travel and view it as a positive development.

Whilst we have undertaken reviews of a number of services in recent years and – as set out above – have agreed to integrate several specialties, we have not developed an ‘umbrella’ hospital services strategy that looks ahead to the next three to five years. We want to develop a strategy that will specifically aim to reduce the time it takes for patients to get the surgery and other planned care they need, to make sure services are more consistent and of the same high quality across Norfolk and Waveney. We feel that having a single plan that sets out the overall acute vision for Norfolk and Waveney is a fundamental priority.

The Boards of the three hospitals considered a common paper at their meetings in September/October 2019 that recommended developing a pan-Norfolk and Waveney strategy. All three strongly endorsed this direction of travel.

The hospital services strategy will, we believe, help us to achieve the following objectives:

1. To agree where enhanced collaborative working could lead to a significant improvement in the quality of care patients receive e.g. standardising clinical practice, maximising of expertise

2. To identify opportunities for increased capacity and how this could be realised for the benefit of the whole system through increased collaborative working

3. To identify opportunities to improve efficiency and reduce cost in the delivery of services (e.g. reduction in temporary staff, joint on-call) and how this can be best achieved

4. To ensure the clinical dependencies of any changes to models of care are clearly understood and accounted for (e.g. out of hours support, radiology input)

5. To ensure that our three hospitals offer a sustainable portfolio of clinical services

We have already convened a group of senior clinical and managerial leaders from across our system to plan and agree how we develop our Hospital Services Strategy. We recognise that this is a complex piece of work, and know that we will need to balance several factors, including a desire to move at pace whilst ensuring all stakeholders are involved, and ensuring we keep our focus on hospital services whilst recognising the vital contribution of partners in the community. Whilst this is foremost about providing sustainable, high quality and consistent services across Norfolk and Waveney, such approaches could drive out efficiency savings such as a reduced reliance on more costly agency and locum costs.

Our initial thinking is that having made good progress by working more collaboratively, in the first phase of the development of our Hospital Services Strategy we will identify a small number of speciality areas to work on together. We are identifying these at present by looking at those services that are particularly challenged, and the extent to which increased collaboration across the three hospitals is likely to provide a lasting solution.

The development of our strategy will be clinically led. We will be asking doctors, nurses and other practitioners from each of the three hospitals to lead and contribute to each of the speciality groups, and we are planning to establish a senior clinical leadership group to oversee and coordinate the work.

We will involve the public and patients as well as key partners - such as primary, community and social care - in this work. We are about to start work on a comprehensive engagement and communications plan to ensure that we have we fully involve local people and partners from the outset.

As the development of a Hospital Services Strategy is a single Norfolk and Waveney wide process (and not led by any one organisation), we are establishing a dedicated team to progress and support this work, drawing together our best people from across the system and beyond. We have already made a start on assembling this team, including
securing external input from a former medical director with extensive experience developing a hospital services strategy that encompasses multiple trusts.

We plan to launch the reviews of priority speciality areas in late 2019, and aim to have all the workstreams established by early 2020. We anticipate that the work will conclude in late 2020. By that point, we want to have a clear assessment of both the options for change across the whole of Norfolk and Waveney, as well as a vision for the future for our hospitals.

Organisational form

Alongside collaborating to improve service delivery, we have considered whether it makes sense to look again at organisational form and, in particularly, whether we should continue to have three legally separate hospital trusts. These discussions have revealed a broad consensus across our system that in the medium term (3-5 years) there is likely to be one approach to managing and delivering acute services across Norfolk and Waveney. It is recognised that the needs of our population and the geography we service, three hospitals will be needed, with key services being provided at all. It is about how we deliver the best quality services, in a sustainable way, to meet the changing needs of the population we are focusing on.

Exactly what form this might take has not yet been determined. Our agreed approach is to focus on the development of the Hospital Services Strategy outlined above, and to use the tripartite sub-group of our Boards to further develop thinking on potential organisational solutions.

We remain open minded about making changes to our governance and organisational form in the near future, but in our view it is paramount that this supports any improvements we want to make to clinical services across the three hospitals and promotes collaboration.
Our system demand and capacity

Where we started

In 2018, we conducted a review of demand and capacity for local health and care services. The review analysed the expected demand for our services against the expected capacity within those services over the following five years. The report was published in early 2019.

Whilst the challenges were not unknown to us, the review helped to quantify the scale of the challenges facing us, the cause and some potential solutions. For example, the review stated that if we do not implement the many schemes already in the pipeline and if we do not develop more, the mismatch in demand for services and our capacity to care for those people would result in a deficit of 500 beds by 2023.

In summary the report concluded that our system had significant challenges and requirements in a ‘do nothing’ scenario:

- Circa 500 beds shortfall by 2023 (and in the short term a shortfall of 200 beds)
- A shortfall of 900,000 GP appointments by 2023 (and in short term 500,000)
- Demand will increase by 75,000 emergency department attendances by 2023 (50,000 in 2019/20)

The report was also clear that the issues we face cannot be addressed by any single organisation, and only collective interventions will create a sustainable position. Hence, together, with improving outcomes for patients, we are focused on developing more integrated services for people before they need hospital treatment. The suggestions were consistent with the work our partnership has been doing over the past two years to integrate services, provide care closer to home and to develop primary care networks and teams of different professionals.

System Case for Review

While much of the system is in balance, there is little spare capacity in areas such as A&E and in-patient beds, allowing for the inevitable variability of demand that comes with delivering healthcare. When a surge occurs, for example during winter, there are significant capacity challenges across the system. The report highlighted that we already have a significant problem in primary care appointments with a shortfall of around 500,000 (9%) appointments compared to the demand we expect.

The report then analysed the system over the following five years and found that by 2022/23 the situation deteriorates significantly if no action is taken:
This shows that in a ‘do nothing’ scenario, the Norfolk and Waveney system would face intolerable issues impacting healthcare delivery, with insufficient capacity in primary care, insufficient capacity in our emergency departments and too few beds across both our acute and community services.

The review demonstrated the importance of the actions set out in this long term plan and the need to transform and refresh our service across the Norfolk and Waveney system to ensure they are fit for our future needs.

In summary the review concluded the following challenges:

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

**Critical Objectives**

The critical objectives for our system based on the review are as follows:

- Reduce acute length of stay through optimisation
- Shift medically fit for discharge (MFFD) patients from acute to community care (virtual wards, reablement packages etc.): 43,500 bed days. This requires a significant shift in terms of commissioning.
- Implement locality-based model to support primary care (improved mental health provision, improved cancer care, improved diabetes care)
- Improve access to primary care with alternative workforce models (ANPs, Therapists etc)
- Reduce primary care demand with nurse-led triage, self-care tools, digital consultations, correct signposting, social prescribing
- Agree and deliver acute integration opportunities
- Improve end of life care
- Improve outpatient referral systems
- Deliver Outpatient Transformation objectives within the NHS Long Term Plan
- Deliver improved data and information sharing: key to efficient working across the STP
- Assess the system-working opportunities: workforce, estates, digital
- Future QIPP years plans to be developed including, central trackers to summarise how much activity saving for each QIPP project now a requirement for the Demand Management Report for NHS England
- Further review of clinical variation with available tools such as Rightcare
- Quantification of benefits to be achieved through the Acute Services Integration Program
- Consider other initiatives

### How we are addressing the gaps

The Demand and Capacity workstream was established in February 2019 to take forward the findings from the review. The workstream commenced a review of our workstreams’ existing plans, and the coordination / development of short, medium and long term plans to tackle these challenges. Whilst much work has been done in recent years to address the capacity shortfalls, there was a need to think more about the longer-term and so a significant part of the group’s work is to focus on the longer term strategy.

The workstream has considered all the recommendations within the review and brought together key sector specific representatives including from acute, community and primary care, as it was acknowledged, ongoing STP workstreams were already progressing activities which contribute outcomes to this work. The Demand and Capacity workstream has worked with existing groups and key stakeholders although this is still work in progress and a renewed focus on this work commences in November 2019.

A model was created which looked across primary care appointments, ED attendances, elective and emergency admissions, day case, outpatients, community beds, 111 calls and ambulance conveyances.

The model revealed for 2019/20 the combined impact of the existing QIPP schemes:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Savings in Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing avoidable admission</td>
<td>10 beds</td>
</tr>
<tr>
<td>Hospice at home</td>
<td>21 beds</td>
</tr>
<tr>
<td>Frailty program</td>
<td>7 beds</td>
</tr>
<tr>
<td>Care home work</td>
<td>6 beds</td>
</tr>
<tr>
<td>Primary care variation reduction in elective referrals</td>
<td>11 beds</td>
</tr>
<tr>
<td>Frequent attender reduction</td>
<td>3,500 ED attendances and 5 beds</td>
</tr>
<tr>
<td>IC24 clinical assessment service</td>
<td>2,700 ED attendances</td>
</tr>
</tbody>
</table>

In total 90 beds saved if all schemes deliver
The 2019/20 Primary Care schemes focus on delivering improved GP access and lower Emergency Department attendances:

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Quantification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved access</td>
<td>100k more appointments</td>
</tr>
<tr>
<td>Extended hours</td>
<td>55k more appointments</td>
</tr>
<tr>
<td>Population health management/Patient stratification</td>
<td>Not yet quantified</td>
</tr>
<tr>
<td>Primary Care Networks and Local Delivery Group</td>
<td>Not yet quantified</td>
</tr>
</tbody>
</table>

The 2019/20 acute schemes include:

- ‘Prudent’ assessment of 95 beds saved by bringing length of stay across the acutes equal to the best in Norfolk
- NNUH plans to open an additional 120 beds by January 2020 (not included in model as implementation plan being developed)

The realistic working assumption is 23 emergency beds and 72 elective beds can be realised through sharing of best practice through the acute hospitals.

Here is an extract from the review showing the variance between our acute hospitals:

Community 2019/20 schemes include:

- Norfolk Community Health and Care Trust:
  - Ongoing use of operations centre - delivering length of stay reduction of two days (or five beds) per year
  - Schemes in discussion with commissioners – full plans would save 26 beds
    - Home care
    - Discharge support
    - NEAT
    - EEAST collaboration

- East Coast Community Health Trust - (Schemes not yet quantified)

- Norfolk County Council Schemes include (schemes not yet quantified):
Immediate next steps

Further plans needed to mitigate risks and ‘fill the gap’ include:

- Primary care task and finish group to continue to generate more ideas for primary care
- Engagement with other groups to generate and act upon innovative ideas
- Potential to develop digital schemes to support capacity
- Recent Urgent and Emergency Care schemes regarding Emergency Department performance to be reviewed
- Opportunities to be generated through Model Hospital comparisons
- East Coast Community Healthcare schemes being quantified
- Norfolk Community Healthcare Trust commissioning decisions to be resolved
- Norfolk County Council work being quantified
- Outpatient transformation program to proceed at pace
- Other smaller schemes such as frequent attenders being quantified
- Review of diagnostics.

Future

The review outlined a number of actions to help align our systems demand and capacity in the future and these have been integrated in the other sections of our LTP explaining the service developments that need to take place. These developments can be broadly placed within three categories:

1. Primary care is required to develop its locality based models. As the model matures more patients will be able to be seen in primary care which will mean less patients attend emergency departments as either their condition worsens or as a first point of contact.

2. Community care is to increase capacity so patients can be moved from the acute sector into community care at an earlier point. This will both improve the patient’s rehabilitation prospects and increase capacity within the acute sector.

3. The hospitals are required to improve their processes to reduce the length of stay of patients where there is variation across the system. There are also significant benefits to be gained by further integration of the acute hospitals.

These three categories form part of this long term plan and further detail is included in this document around how the demand and capacity challenges are being met in the specific sections through the report.

As the Local Delivery Groups develop further oversight of their specific areas, they have the potential to own the demand and capacity problems and solutions from within each area as we progress forward with all our initiatives. The overall direction of the Demand and Capacity work is being refreshed during November 2019 to ensure the required robust focus is in place.
Norfolk Community Health and Care and Norfolk and Suffolk Foundation Trust – a collaborative approach

Context
Within Norfolk and Waveney we have two NHS trusts providing the majority of care within community settings – Norfolk Community Health and Care (NCH&C) alongside a specialist mental health provider, Norfolk and Suffolk Foundation Trust (NSFT). In addition we also have a community interest company East Coast Community Health (ECCH) providing services predominantly to Great Yarmouth and Waveney. Cambridgeshire Community Services NHS Trust deliver the Healthy Child Pathway and School Immunisations programme and sexual health services.

NCH&C and NSFT – collaborative working
NSFT was subject to a CQC inspection in July 2017 and was rated as “inadequate”, and placed in quality special measures. The organisation has already been in special measures and then exited in October 2016. In September 2018 NFST was re-inspected by the CQC, and the CQC continued to have serious concerns about the quality and safety of services. NCH&C was rated ‘Outstanding’ in June 2018.

Both organisations deliver care across large geographical areas from a dispersed and old estate. This creates logistical problems for staff and patients as well as financial challenges and opportunities for efficiency. Both organisations want to participate actively in their multiple Primary Care Networks. Both organisations have an overlap of service users who would benefit from enhanced collaboration and input. For example a common cohort of frail elderly service users has both physical and mental health needs and patients with long term conditions would benefit from mental health support.

In July 2019 the respective trust boards approved a formal basis for collaboration and co-operation. This prioritised a number of objectives:

- To share best practice across both organisations with an aspiration of achieving high quality care for the patients, service users and carers of Norfolk and Waveney
- To develop specific pathways of care, drawing on shared Quality Improvement methodologies and research best practices, to deliver agreed outcome measures
- To ensure readiness for and development of the Norfolk and Waveney Integrated Care System
- To contribute to the Sustainability and Transformation Partnership review into mental health provision
- To create and co-ordinate a community response (single voice) to commissioning intentions and the emerging Integrated Care System
- To consider the most appropriate governance and form for the relevant stage of our development
- To consider options for more effective organisational function and form

Initial activity has been to focus on:
- Back office integration including shared functions such as procurement
- Clinical pathway re-design
- Estates management / Utilisation

The focus of the clinical pathway re-design work-stream will be the development of an integrated service model, most likely services provided to frail elderly patients, many of whom are seen by both organisations. The ambition is to provide higher quality services that are also cost-efficient.

Organisational form
As this work progresses, both organisations will keep under review their respective structural form and re-evaluate whether there are benefits to more formal transactions of some kind longer term. Firstly in order to enable NSFT to focus more fully on exiting special measures and secondly in order to lay the groundwork of effective collaboration which in turn is important for sustainable benefits realisation post any merger or acquisition. Re-evaluation of options relating to structural change will take place over the course of 2020/21 and 2021/22.
Our Children and Young People – an alliance model of working

Context
As discussed in the chapter entitled ‘Better care for people – integrating ways of working – Children and Young People’ we are currently transforming the way we provide services for our children and young people. The iTHRIVE concept is a fundamental shift in the way the system views the mental health and emotional wellbeing of children and young people, underpinned by the following principles:

- 0—25 years
- A focus on Thriving
- Working as a single system
- Clear access routes
- Community Based
- Relationship focused
- Multi-agency multi-disciplinary teams

To further develop iTHRIVE our system has endorsed the adoption of an alliance contracting approach, thereby enabling providers to continue to collaborate and develop the iTHRIVE approach over the course of 2020. Not only does this allow considerable flexibility to strengthen links with wider children’s services (such as the Healthy Child Programme) but it is fully in keeping with our progression towards becoming an ICS. It also aligns with developments in neighbouring Suffolk thereby ensuring minimal impact and disruption for providers who currently span multiple systems.

The intention currently is for a shadow year (12 months) of operation as an alliance to commence late 2019 - allowing for evolution and learning - with full rollout thereafter.

Governance
A lack of clarity over governance and decision making has been a major issue for Child and Adolescent Mental Health Services and overall for Children and Young Peoples (CYP) services respectively. Such confusion clouds accountability and makes it difficult for stakeholders and the public alike to understand how and where decisions are made.

To directly address these issues, and to facilitate the move towards iTHRIVE, a single whole system Children and Young People’s Alliance Board (‘the Board’) has been established from November 2019. The role of the Board is to bring together senior commissioners and providers across Norfolk and Waveney in keeping with the ‘one system’ approach to the transformation of services, and the wider development of Norfolk and Waveney as an ICS.

Specifically, in relation to children and young people, the Board will:
- Set strategic direction and ensure delivery of system plans
- Lead service transformation
- Develop and agree system-wide outcome measures
- Collectively assess and improve operational delivery
- Act as the Executive Group for the Section 75 agreement (see below)
- Develop the alliance agreement and an alliance model of contracting
- Ensure, encourage and promote co-production and engagement

Membership includes commissioners, provider organisations, education, the third sector, family networks and young persons’ representation. The membership is not exclusive and as the iTHRIVE model gains in confidence so too will the organisations and services it covers. This in turn will allow for the membership of the Board to grow.

Section 75 agreement
In order for the Alliance Board to act as the system focal point for decision making on Children and Young People’s services there needs to be an accompanying Section 75 agreement between affected parties. There is currently in place an existing Section 75 between the five CCGs and NCC capturing expenditure across a relatively small set of services (CAMHS tier 2). This is being expanded to capture ‘core’ CAMHS provision (tier 2 and tier 3) in the first instance. Ultimately, and in keeping with the ambition of iTHRIVE, additional expenditure beyond CYP mental health services will also be captured over the course of 2019/20 and beyond.

Alliance agreement
The development of the alliance approach to commissioning and contracting is being taken forward by a sub-group of the Alliance Board. The role of the group is ultimately to progress and recommend to the Alliance Board an Alliance Agreement between Providers, and Providers and Commissioners respectively. This may or may not be underpinned by a Memorandum of Understanding between all parties outlining the principles by which all are engaged in this process.

The group is reviewing existing models of best practice, available model-templates or toolkits and any legal or regional/national advice. Discussions over risk share, shared priorities, management structures, right of veto, voting rights are all being taken forward with a view to having a signed set of Alliance Agreements in place for late 2020.
Our finances

The NHS in England spends around £134billion in 2019/20 of which Norfolk and Waveney receives approximately £1.5bn. As spenders of public money we have a responsibility to ensure we spend this money wisely and to the best effect for all our patients, staff, carers and families. We have a statutory duty to at least break even and if we improve on break even then we can invest this money on new buildings and equipment to offer the best possible care.

In recent years there have been huge demands on the NHS budget: demand for health care is increasing as we live longer and advances in technology are found,

Whilst the NHS in overall terms has managed to live within its overall budget many provider organisations (our hospitals) have failed to balance their books, with shortfalls being managed at national level through nationally held reserves and through national support funding (Provider Sustainability Funding and Financial Recovery Funding).

Throughout the next four years the NHS must achieve financial balance and become financially sustainable across all its organisations, working together across health and social care, being inclusive and making decisions about how we provide health care in the future.

Norfolk and Waveney STP reflects the national position. In 2018/19 our financial position across our NHS organisations was a deficit of £97.6m compared to a planned deficit of £63.3m. The target set for us over the next five years through to 2023/24 will improve this position.

Summary financial position for the next five years

The table below shows the targets we have been given for our NHS organisations in Norfolk and Waveney. Whilst Norfolk and Suffolk NHS Foundation Trust, our mental health provider, works across two STPs/ICS the financial position for the organisation is shown in full below.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Financial Recovery Trajectory Pre Central Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2019/20</td>
</tr>
<tr>
<td>James Paget University Hospitals NHS Foundation Trust</td>
<td>(2.4)</td>
</tr>
<tr>
<td>Norfolk And Norwich University Hospitals NHS Foundation Trust</td>
<td>(46.2)</td>
</tr>
<tr>
<td>Norfolk And Suffolk NHS Foundation Trust</td>
<td>(3.5)</td>
</tr>
<tr>
<td>Norfolk Community Health and Care NHS Trust</td>
<td>(2.8)</td>
</tr>
<tr>
<td>Queen Elizabeth Hospital King's Lynn NHS Foundation Trust</td>
<td>(22.4)</td>
</tr>
<tr>
<td>NHS Great Yarmouth and Waveney CCG</td>
<td>2.2</td>
</tr>
<tr>
<td>NHS North Norfolk CCG</td>
<td>-</td>
</tr>
<tr>
<td>NHS Norwich CCG</td>
<td>-</td>
</tr>
<tr>
<td>NHS South Norfolk CCG</td>
<td>2.1</td>
</tr>
<tr>
<td>NHS West Norfolk CCG</td>
<td>1.0</td>
</tr>
<tr>
<td>SYSTEM TOTAL</td>
<td>(72.0)</td>
</tr>
</tbody>
</table>

Financial recovery

The Norfolk and Waveney system has worked collectively to develop plans to deliver its financial targets. The targets set by NHS England / Improvement are extremely challenging for our system, in light of:

- Distance from target funding is 2.2% below what we should receive for our population, equating to £32m in 2019/20 to £37m by 2023/24.
- An expensive PFI hospital, the Norfolk and Norwich University Hospital, one of the first in the country, agreed in 1998.
- Three of our trusts are in ‘special measures’ following Care Quality Commission reviews of services.
The financial targets lead to the following levels of cost improvement across our organisations:

<table>
<thead>
<tr>
<th>Efficiency as % turnover/allocation</th>
<th>2019/20 Forecast</th>
<th>2020/21 Plan</th>
<th>2021/22 Plan</th>
<th>2022/23 Plan</th>
<th>2023/24 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>JPUH</td>
<td>4.5%</td>
<td>4.3%</td>
<td>4.1%</td>
<td>4.0%</td>
<td>4.0%</td>
</tr>
<tr>
<td>N&amp;NUH</td>
<td>4.1%</td>
<td>5.1%</td>
<td>5.0%</td>
<td>5.3%</td>
<td>5.6%</td>
</tr>
<tr>
<td>NSFT</td>
<td>4.1%</td>
<td>3.5%</td>
<td>3.0%</td>
<td>2.1%</td>
<td>1.8%</td>
</tr>
<tr>
<td>NCH&amp;C</td>
<td>3.4%</td>
<td>4.6%</td>
<td>3.9%</td>
<td>3.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>QEH</td>
<td>2.7%</td>
<td>4.3%</td>
<td>3.8%</td>
<td>2.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td>CCG</td>
<td>3.7%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td><strong>System Wide % of Provider CIPs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3.8%</td>
<td>4.4%</td>
<td>4.0%</td>
<td>3.4%</td>
<td>3.1%</td>
</tr>
</tbody>
</table>

Our STP and its partner organisations recognise the scale of the challenge and have agreed to work together to deliver transformation across our health and social care system. This will include:

(i) Outpatient transformation, a pillar of the NHS Long Term Plan, which will focus on a more digitally-enabled service and reduce the need to attend our hospitals for outpatient care

(ii) A focus on improving our digital maturity across all our organisations, linking our systems and implementing an electronic patient record system in our acute hospitals

(iii) Rolling out our approach to population health management to improve what we do for our patients who are most at risk of ill health

(iv) Working across our acute hospitals to ensure we maximise the bed, theatre and clinic capacity available to treat and care for our patients

(v) Ensure best use of the Better Care Fund across our health and social care system

(vi) Ensure our staff at the front line have the opportunity to develop their own ideas on improving the care we deliver, to avoid waste and to make our services more efficient.

We have committed to deliver the overall health system financial target of a deficit of £51.8m in 2020/21 through to a deficit of £25.0m in 2023/24. However as our plans develop individual organisation targets may change whilst the overall position will be maintained.
How do we spend the money?

### Commissioner planned expenditure 2019/20

- **Acute** - £795.2m
- **Community Healthcare** - £146.5m
- **Primary Care** - £212.6m
- **Other Programme Services** - £33.1m
- **Mental Health** - £160.1m
- **Continuing Care** - £70.5m
- **Primary Care (Co-Commissioned)** - £155.8m
- **Running Costs** - £24.7m

### Planned Operating Expenditure 2019/20

- **Workforce** - £941m
- **Supplies and services** - £200m
- **Drugs costs** - £124m
- **Premises** - £42m
- **Capital** - £37m
- **Purchase of healthcare** - £26m
- **Charges to op expenditure** - £27m
- **Establishment** - £14m
- **Other** - £37m

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**Five financial tests**
NHS England/Improvement have identified five financial tests to be achieved.

<table>
<thead>
<tr>
<th>Financial test</th>
<th>Norfolk and Waveney position</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan must show how organisations return to financial balance</td>
<td>Financial recovery schemes are being established. Backdrop of ‘distance from target’ funding shortfall of circa £32m-£37m. Large PFI scheme with no national funding support.</td>
</tr>
<tr>
<td>The plan must achieve cash-releasing savings of at least 1.1% per year (1.6% for those organisations in financial deficit)</td>
<td>System plans show a significantly higher level of cash-releasing savings are required to achieve the financial targets.</td>
</tr>
<tr>
<td>The plan must reduce the growth in demand for care through better integration and prevention</td>
<td>The plan reflects a number of work programmes to reduce or manage demand.</td>
</tr>
<tr>
<td>The plan must reduce unjustified variation in performance</td>
<td>Population health management will support this work, alongside Model Hospital reviews and other benchmarking work.</td>
</tr>
<tr>
<td>The plan must make better use of capital investment and its existing assets to drive transformation</td>
<td>Improved capital planning across our system in place to use the funding available to the best effect.</td>
</tr>
</tbody>
</table>

Our actions

The following key actions are required to ensure delivery of the financial elements of the Plan.

1. Development of detailed financial recovery schemes to deliver the overall system-wide financial position.
2. Establish capital planning across our system to ensure we use our assets efficiently and to the best effect.
3. Review our monitoring mechanism to allow fast identification of issues and trends in time to allow action to resolve problems.
4. Review our approach to reporting and assurance in order that we can be self-governing, deliver credible plans and that we own and address problems without regulator intervention.
Our workforce

Staffing has been described as the make-or-break issue for the NHS in England. Across NHS trusts there is a shortage of more than 100,000 staff. Many of the same issues are affecting the social care workforce: for example, vacancies in adult social care are rising, currently totaling 110,000 with around 1 in 10 social workers and 1 in 11 care worker roles unfilled. We have chosen to use this chapter not only to highlight the current workforce issues we are facing from both a national and a local perspective but to also capture and include our response to the interim People Plan themes at high level.

Our wider Norfolk and Waveney (Norfolk and Waveney) People Plan (five year workforce strategy) is currently in development and is built on the principle of integration with all parts of the health and care system in our geography. Delivering better care for our people will only be possible by integrating with the full range of partners in care which will in turn enable us to achieve the aspirations set out in national policy documents and our local ambitions.

‘Our Workforce’ is the term that will be used to describe the totality of people in Norfolk and Waveney working in health and care, both paid and unpaid, e.g. professional staff across traditional organisations, private/independent sector and unpaid carers and volunteers.

Our local priorities for workforce

Over the last two years our Norfolk and Waveney Local Workforce Action Board (LWAB) has developed four ambitions to address our key workforce issues. There are a number of actions aligned to these ambitions already in progress and these mirror the NHS People Plan. The four ambitions are listed as follows:

- **Ambition 1** – Implement new roles and new ways of working
- **Ambition 2** – Leadership Development
- **Ambition 3** – Up-skill the workforce
- **Ambition 4** – Increase/improve supply and retention

Our priorities contribute to our system goals in the following ways:

Delivery of the workforce strategy in its entirety and the associated priority areas will directly address our system goal ‘To make Norfolk and Waveney the best place to work in health and care’.

We also feel strongly that integration and collaboration of the workforce is essential to achieve greater consistency of care to our patients and better use of limited resources reducing duplication of effort. And we are committed to delivering a ‘digitally-enabled’ workforce as outlined below by delivering on these ambitions we will also contribute significantly to another of our goals: ‘To make sure you only have to tell your story once.’

Our local system - workforce initiatives and areas of excellence

Within Norfolk and Waveney we have a diverse range of providers of health and care services, approximately 100,000 unpaid carers and around 50,000 paid workforce across health and care. Our areas of excellence include:

- **Training Nursing Associate (TNA) Partnership** recognised as HEE exemplar
- **#WeCareTogether** online conversation which is open to 50,000 members of workforce allowing people to share their hopes, wants and future needs for working locally
- Development of joint roles and rotations supporting retention of staff, increasing collaboration, and promoting integrated working
- Launch of a programme of support aligned to the national General Practice Forward View to retain GP workforce – now being extended to GPN and wider workforce
- System ambition to align principles and delivery of health coaching, Quality Improvement, and growing our own workforce
- Collaboration and strong networks with health, social care, local authority, and VCSE to co-design our future workforce
• Strategic Workforce Planning Steering group established; system workshop on 7 October 2019 (to review and ratify our e-workforce submissions and agree the ambitions for transformation required by organisations to meet system priorities); and development of workforce dashboard to monitor our progress.

• #WeCareTogether People Plan – Norfolk and Waveney’s Five Year People Plan – launching for consultation in the Autumn of 2019.

• The establishment of sites of excellence for education and training, including the Norwich Radiology Academy, Medical School at University of East Anglia, the James Paget Health Academy for school pupils and more in the pipeline.

• Growth of a core STP Workforce Team providing expertise, guidance and strategic leadership for the delivery of our workforce ambition.

Our local system – workforce areas of challenge

Our ambition for our Patients/Service Users – Chronic shortages in the workforce have led to longer waiting times for some services and sometimes poor experience of care. By addressing our workforce needs and delivering on the People Plan we will deliver the following outcomes for our patients and service users:

• higher standards of care
• more information about their treatment
• more involvement in decisions about their care
• access to the latest treatments providing work based learning and development opportunities for more people
• more empowered patients/service users and carers

Our strategy needs to address our greatest risks, with the top six risks highlighted below:

• Retention and health and wellbeing of our workforce
• Gaps in Registrants across all professions
• Supply timelines and education quality e.g. Clinical Psychologists and Medical
• Accountability and confidence in new roles
• Capacity to support learning in practice
• Level of system transformation and resources required to meet the aims in the LTP

To address our local issues we will see significant growth in new roles such as Registered Nursing Associates, increases in healthcare assistant roles with greater band width, new psychology roles, Physicians Associates, Advanced Care Practitioners, joint posts and rotational roles.

The Registered Nursing Associate roles will enable us to grow our pipeline of first level nurses over time in addition to increasing the two year Nursing Degree programme, international recruitment and our academy approach.

These roles will be underpinned by comprehensive education programmes delivered in a multi-professional training environment, and they will work across all health and care boundaries to meet the requirements of our local workforce needs and ambitions set out in the LTP.

We will also do more to proactively prevent ill health and prevent wellbeing to ensure our workforce is able to deliver care to the highest standards.

Our local system - our unpaid workforce

We have approximately 100,000 unpaid carers across Norfolk and Waveney providing vital caring roles looking after a family member or friend.
Norfolk County Council (NCC) offers a range of services to support carers and is focused on working with partners, such as the Carers Council and Carers Matters, to deliver outcomes for carers, designed by carers to improve their experience.

Carers Matters Norfolk is a county-wide organisation, supporting unpaid carers aged 16-plus who care for someone aged 18-plus. They provide advice, training and education, counselling, carers voice and community support.

NCC is a key partner at the Norfolk and Waveney LWAB and both Carers Matters and the Carers Council have been fully engaged as part of the development of our people plan. We will be delivering joint training and education sessions for carers on a range of topics identified by carers such as dementia and other long term conditions in partnership Carers Matters and the Carers Council as part of the support strategy.

Developing bespoke training for carers and enabling access to multiagency training is one of our LWAB ambitions to up-skill our workforce both paid and unpaid in order to empower patients and their families to have greater independence. We will also develop opportunities for carers to deliver training to professionals in health and care in recognition of their expertise in caring. Carers Matters will continue to provide awareness raising sessions to patient facing services to ensure that staff across health and care promote the ‘self-help hub’ for carers which is available online and provides training, information and signposting for carers.

The national priorities we must deliver

A number of policies reviewed show that the workforce challenges in the NHS in England now present a greater threat to health services than the funding challenges.

Current shortages are due to a number of factors, including the fragmentation of responsibility for workforce issues at a national level; poor workforce planning; cuts in funding for training places; restrictive immigration policies exacerbated by Brexit; and worryingly high numbers of doctors and nurses leaving their jobs early.

Current workforce shortages are taking a significant toll on the health and wellbeing of staff. Reviews also highlight that work patterns are changing; demand for highly skilled individuals is growing while automation threatens the jobs of the less skilled.

Information technology is blurring the boundaries between work and home, facilitating part-time and remote working; and we are seeing generational differences in peoples’ expectations from employers and ways of working.

Changes to pension provision mean that people can expect to work for longer.

Finally, sources of informal care are shrinking while future demand from older people expands; the ‘care gap’ could place additional pressure on formal health and social care services.

The NHS Interim People Plan was launched in June 2019 with clear direction on how to tackle the range of workforce challenges in the NHS with a particular focus on the actions for this year. Although the interim People Plan refers mainly to the NHS, the themes will be used in our Norfolk and Waveney workforce strategy and applied across all partners as they are considered best practice, relevant and essential in ensuring consistency of the offer to our wider workforce.

The five People Plan themes are:

- Making the NHS the best place to work
- Improving NHS leadership culture
- Addressing workforce shortages
- Delivering 21st century care
- Developing a new operating model for workforce

How will we deliver?
Our future Integrated Care System Workforce Model

Delivery of our local priorities is as follows:

<table>
<thead>
<tr>
<th>November 2019 to April 2020</th>
<th>Year 1 2020/21</th>
<th>Year 2 2021/22</th>
<th>Year 3 2022/23</th>
<th>Year 4 and 5 2024/25</th>
</tr>
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<tbody>
<tr>
<td>Standardisation of agency and bank (Phase 1)</td>
<td>Deliver health coaching training to 500 staff</td>
<td>Increase care ambassadors and health ambassadors by 10%</td>
<td>Nursing career development pathway</td>
<td>Achieve total of 1,000 Nursing Associates and TNAs in workforce</td>
</tr>
<tr>
<td>Adopt and spread best practice on sickness reduction to achieve 1% decrease by end of 2020</td>
<td>Recruit 300 more TNAs across health and social care</td>
<td>Commissioning infrastructure change to move resources to primary care/community</td>
<td>Personalised care initiatives</td>
<td>Digital transformation; systems aligned, digital enablement and shared patient record</td>
</tr>
<tr>
<td>Agree skill mix changes for staffing escalation/‘specialising’</td>
<td>Improve retention rate by 2%</td>
<td>Roll out of new discharge pathways to speed the flow out of hospital</td>
<td>Patient marketing campaign and engagement</td>
<td>Secondary care Trust integration</td>
</tr>
<tr>
<td>Accelerate expansion of NEAT teams to slow the flow at front door</td>
<td>Reduce student and trainee attrition by 1%</td>
<td>Hub and spoke model for clinical/subject matter experts and non-clinical services</td>
<td>System wide flexible, agile working initiative</td>
<td>STP wide skills (passport) and transfer</td>
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<tr>
<td>Launch Norfolk and Waveney Health Academy</td>
<td>System wide Health and Wellbeing offer</td>
<td>Increase skill mix changes across more pathways within health and care providers</td>
<td>New mental health staff (CAP, RTT, EMHP) and additional Clinical Psychologists in post and service redesign</td>
<td>Grow your own initiatives have delivered reduction in vacancy rates by 10%</td>
</tr>
<tr>
<td>Launch workforce strategy</td>
<td>System wide Quality Improvement infrastructure – 1st conference</td>
<td>Roll out health and care supervision model system wide</td>
<td></td>
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</tbody>
</table>
On 10 April 2019 we launched the development of our workforce strategy and our online conversation #WeCareTogether to engage with our system wide workforce to further test and expand our workforce ambitions. Early outcomes of this engagement show that empowering people and promoting autonomy and better health is the foundation for our strategy.

In addition, we will focus on the use of local community assets such as community groups, clubs, faith groups and charities to support better health, wellbeing, and information to people about the most appropriate services available.

Our focus for nursing across all branches will be to grow our own through academies and apprenticeship routes, which will be extended to other professions such as Allied Health professionals. The profile of our population lends itself to local people getting into health and care through supported work-based learning, and we are developing a robust plan to develop our academy working with education providers; job centre plus and other recruiters; charities; and other sectors to offer an innovative and exciting pathways.

We aim to create better work places to increase well-being of staff and enhance care with use of new technologies and new models of care which will also increase productivity and efficiency.

Integration of the workforce across care pathways is essential to achieve greater consistency and better use of limited resources reducing duplication of effort.

Finally our strategy will focus on strengthening primary and community care to ensure alternatives and better access to care is provided closer to home.

Our LWAB members are fully representative of our system and agreed unanimously to commit £480K of Learning Beyond Registration (LBR) funds to support delivery of these ambitions. LWAB are also providing leadership to ensure our workforce plans are realistic and ambitious in relation to transformation.

We held a system wide workforce event on 7 October 2019 which had multi-professional senior representation from all health and care providers and we agreed the guiding principles that underpin our ambition for workforce transformation as follows:

- To create a workforce model based around our local population so that we achieve the best outcomes for them.
- Challenge the status quo of how services are delivered and how workforce planning takes place across Norfolk and Waveney.
- Listen and engage with our workforce to ensure the model supports their health and well-being; lifestyle; and career aspirations.
- Develop a system wide workforce planning model that all providers are committed to deliver, taking into consideration the local and regional challenges.
Transformation initiatives were identified at the event ranging from immediate changes to those that will be implemented over a five year period. Five immediate key system transformation recommendations were agreed at the event and they are:

- agency and bank standardisation
- sickness initiatives
- slowing the flow by preventing people coming into hospital
- speeding up the flow of people out of hospital
- rotational posts.

Alignment of the Interim NHS People Plan with our developing Workforce Strategy

**People Plan theme 1: Making the NHS the best place to work** – This theme is about paying greater attention to why staff leave the NHS and taking action to retain existing staff and attract more people to join. This requires the development of a new offer for all people working in the NHS. This theme links to LWAB Ambition 4 (Supply and retention) and our promise is to make Norfolk and Waveney an employer of choice by working together locally and with relevant regional and national public bodies to create attractive local employment offers, support staff mobility, improve recruitment, retention and succession planning across the system. Development of a Norfolk and Waveney Academy will be a focal point for recruitment of people to health and care pathways.

**Key risks**

- Norfolk and Waveney has an ageing workforce – imminent retirements and loss of experienced staff and clinical leadership as staff retire with no clear succession planning
- General practices have difficulties recruiting GPs due to high retirements and low local training fill rates, especially in West Norfolk and Great Yarmouth and Waveney Retention/avoidable losses (non-medical) are linked to work/life balance, and lack of development opportunities
- Future demand and capacity shows that Norfolk and Waveney has an ageing population with a growing burden of chronic disease, and our 0-14 year olds requiring mental health support will increase significantly over the next 10 years.

**Actions in place**

Development of our local five year workforce strategy is key in identifying how we can make things better for our people so that we focus on what’s important in Norfolk and Waveney. We will set out how we will value, support and invest in our staff to improve recruitment and retention as part of the strategy and this will be ready for launch in early 2020. Other strands of work already underway include:

- Commenced an exciting innovation with EEAST to develop a range of rotation opportunities across our system
- General Practice Primary Care Workforce Strategy approved by NHSE
- Improved Access to Psychological Therapy (IAPT) outreach to primary care and an expansion programme being developed as part of the mental health strategy implementation plan
- Development of a system plan to increase capacity in our mental health workforce through new roles and new ways of working, including an expansion of Clinical Psychology programmes and the introduction of new roles such as Clinical Associate Psychologists and Educational Mental Health Practitioner roles based in schools
- System focus on staff rostering, early escalation and resilience of workforce
- Partnership working with other systems in the East of England to address agency and locum caps collectively
- Pilots for joint roles/rotations in place for example: Advanced Nurse Practitioners across primary care/community
- Establishment of the Health Academy model at James Paget Hospital, and ambition to scale this up across the system
On-going use of our on-line platform to engage with staff continuously

Leadership development programmes for staff across a number of settings

People Plan theme 2: Improving NHS leadership culture – This means addressing how we need to develop and spread a positive inclusive person-centred leadership culture across the NHS, with a clear focus on improvement and advancing equality of opportunity. This theme links to our LWAB Ambition 2 which promises that we will develop a new culture of continuous improvement, facilitate the shift in staff behaviours from organisation focus and encourage sharing of talent across the system to improve the local population’s health and social care experience.

Key risks

- Three trusts are in special measures
- If leaders are not connected then the development of relationships, trust and shared goals which are essential for system change will be unachievable

Actions in place

The development of a Norfolk and Waveney Leadership Forum is underway and is essential for the successful delivery of integrated care and population health management across our system. Other strands of work already underway include:

- Design and delivery of a digital platform to engage staff across Norfolk and Waveney to create the culture for a successful ICS
- Developing a cultural baseline to measure improvement using our #WeCareTogether campaign
- Extensive leadership development offer for Strategic and Cross Cutting workstreams in place
- OD Leads Network in place
- Coaching and Mentoring support facility in place to support GP’s within Primary Care
- First report on #WeCareTogether has been produced and will inform the future actions on all People Plan themes
- Director Development programme to support people to consider their role as strategic systems leaders launching Autumn 2019

People Plan theme 3: Addressing workforce shortages – Although there are shortages of many registered professionals, this theme prioritises the biggest shortfall which is registered nurses. We need action to support and retain existing nurses while attracting nurses from abroad and ensuring we make the most of the nurses we already have within our NHS and wider system. This links to the LWAB Ambitions 1 and 4 (New roles and new ways of working and Supply and retention).

Key risks

- Social care is facing significant recruitment and retention problems, especially in domiciliary care
- Nursing and medical workforce supply shortages are predicted to continue over the next five years based on current service and supply models
- Our workforce is aging and we are seeing increases in stress related illness

Actions in Place

We are working closely with Directors of Nursing to assess organisational readiness and provide targeted support and resource to develop the infrastructure required to increase placement capacity.

Our immediate focus is to set ourselves ambitious recruitment numbers to implement three key roles: nursing associate, advanced care practitioner and physicians associates.
We are also implementing a number of flexible entry routes to create opportunities to ‘grow our own’ workforce. These new entry routes are designed for both school leavers/mature entrants with low educational attainment to take up apprenticeship pathways, and for staff who have degree level attainment wishing to advance their careers.

LWAB members and system wide education leads have focused on building capacity and capability in a number of new and existing roles. These are described as follows:

**Trainee Nursing Associates (TNA)** – This new role sits between a healthcare assistant and a registered nurse. This role will be implemented across health, social care and primary care therefore enabling existing registrants to advance their practice. The Norfolk and Waveney TNA Partnership is recognised by HEE as an exemplar. We will expand this programme at pace over the next 2-5 years.

- 162 TNA’s started in 2018
- 120 TNA’s started in 2019
- 106 TNA’s due to start in February 20

We are part of a regional group of the National RePair programme which is sharing best practice on Reducing Pre-registration Attrition and Improving Retention of our healthcare students.

Other key pieces of work include:

- We developed our TNA programme with successful procurement of an education provider in 2018
- We supported access to Levy for non-levy paying organisations (e.g. care homes)
- We are working with NMC to align system need to new NMC revalidation for programmes locally
- Five year growth plan in development and will be aligned to our Strategic Workforce Planning Process

**Advanced Care Practitioners (ACP)** – This role enables practitioners to work at the top of their license in-between a clinical specialist and a medical practitioner.

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

A baseline assessment of ACP capacity across Norfolk and Waveney (including nursing, pharmacy, paramedics and occupational therapy) is underway.

Alignment to the national definition and framework for Advanced Clinical Practice and the requirements for entry is clear.

Finally, we are developing joint educational commissioning in 19/20 and a growth plan for the future of ACPs across Norfolk and Waveney.

**Physicians Associates (PA)** – We were the first system in the region to commission PA training posts and we aim to expand the numbers of PAs across acute trusts and primary care, further expansion of the PA role will increase to two per Primary Care Network (PCN) by March 2024.

We will expand our training places with our universities and offer robust practice placements across acute/community pathways to ensure we have the capacity and capability we require.

We are also piloting a new primary care assistant role to provide a higher level of administrative support to the new primary care teams.

**Nursing Degree Apprenticeships** (Two year NDA courses) – We have developed clear information for flexible entry routes into nursing including a system wide approach to attracting people onto programmes through coordinated recruitment.

**Clinical Pharmacists** – We are expanding the number of clinical pharmacists to one per PCN across Norfolk and Waveney by March 2020. Further expansion of the clinical pharmacist role within primary care networks will increase to an estimated one per practice, subject to PCN population size.
Social Prescribers (SP) – We will expand the number of SP to one per PCN by March 2020. Further expansion of the SP role within primary care networks will increase to three SPs per primary care network by March 2022.

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

People Plan theme 4: Delivering 21st century care – This theme centres on developing a multi-professional and integrated workforce to deliver primary and community healthcare services while ensuring we have a flexible and adaptive workforce that has more time to provide care. In order to achieve this we are using all options to improve the development of the workforce, this includes students on placements, LBR, apprenticeships, education for patients and their carers, volunteers and staff across social care e.g. care homes. We will also focus on transforming models of care so that care is co-ordinated, personalised and proactive for better health outcomes. We will implement innovations highlighted by Topol by better use of technology investing LBR to increase digital skills in existing workforce and redesigning opportunities to manage admin functions across system.

Key Risks
- Effective utilisation of post registration funding
- Lack of placement capacity and supervision
- Hard to recruit to areas for nursing, particularly in the West

Actions in place
We have worked with LWAB members to maximise our LBR funding for staff across NHS provider and primary care organisations, this has included an increase in the numbers of training places for independent prescribers and support for projects to test new models of care and workforce roles.

Work is also on-going to develop further apprenticeship levy options to develop both new and existing staff. This will continue to be marketed heavily across schools, colleges and job centre plus this year, with business cases developed to support organisations in maximising funding for staff development.

We have established an approach to develop systems and processes that support the implementation of population health management (PHM).

We continue to work with our PCNs to align their workforce development needs to the delivery of care at scale. This will include the introduction of new roles but considering how rotational arrangements, shared posts, and developing new skills and competencies for workforce will support delivery of 21st century care.

Models such as Buurtzorg should be developed for hard to recruit to areas to maximise integrated team working and skill mix.

We have a number of successful volunteering models in our system, particularly within hospitals and now the community and primary care. We want to build on this momentum. Volunteer roles are a means of enhancing the experience and support available to our population working alongside an appropriate compliment of paid staff roles. New volunteer roles are developed in line with the likely areas of interest, capacity and skills of potential participants and are effectively supported through training and management.

We have employed a strategic Coaching Lead to deliver coaching training to as many of our staff across health and care as possible. Coaching skills will enable our workforce to empower people to take greater control of their health and this is also linked to our prevention agenda.

Other actions in place include:
- Cohort of 40 general practice assistants are being tested across Norfolk and Waveney
- Pilot rotational paramedic programme in place
• Development of flexible working arrangements to allow staff to have more opportunities for shadowing, secondments and change in roles amongst organisations

• A review of volunteering across the system, undertaking a baseline or current capacity, and developing a plan to expand and enhance the roles of volunteers across the system

**People Plan theme 5: Developing the workforce model** – We are putting workforce planning at the centre of our planning processes. We will develop a system wide workforce plan using priorities and opportunities identified in our staff engagement, by using key targets in the LTP and People Plan and by using other productivity tools. This theme is underpinned by all LWAB ambitions and is a key strand of our developing workforce strategy.

**Key Risk**

• Level of system transformation required to meet the aims in the LTP

**Actions in place**

Themes from workforce strategy engagement activities, research and local priorities has enabled us to develop some assumptions and principles that will enable LWAB members to identify areas for transformation in the short, medium and long term.

The assumptions will embrace a future vision of integration across health and care. The main actions in place are to work together to develop a system wide workforce plan that is underpinned by robust local data, learning from new models of care, and senior clinical leadership to both agree the plan and to implement it.

**Key activities in place to achieve this are as follows:**

• Circulate pre-populated workforce templates to each organisation for completion by 23 September 2019

• System workshop held on 7 October 2019 to bring together system workforce leads to review individual Provider workforce returns in line with modelling assumptions and financial savings requirements

• Continued engagement with East of England Regional Workforce Focus Group weekly/monthly during September/October 2019

**In addition our local People Plan will include theme 6: Developing a digitally-enabled workforce** – Our STP plan outlines the importance of utilising digital capability to meet the needs of our population, and deliver efficiencies and improvements in care that new technology and information can provide.

In order to harness this delivery and in turn the Long Term Plan we will need to invest in our people and their digital skills. Our STP Digital Strategy outlines in ‘Connect’, ‘Together’ and ‘Innovate’ the importance of building our digital capability – not just in traditional technology and informatics but more importantly have our entire workforce have confidence and skills in the new digital-NHS.

We will develop a system wide digital workforce plan using priorities and opportunities identified in our staff engagement, by using the framework outlined in Health Education England’s Building a Digital Ready Workforce. We are beginning with leadership, then building on improving the profession of clinical informatics. We understand that this culture change will take new skills in transformation, user-design, education and training to be effective and get the benefit of our planned investment in digital care.

**Key Risks**

• Barriers to the implementation of equipment and tech

• Fear of change from staff

**Actions in place**

The main actions in place are to work together to develop a system wide digital workforce plan that is underpinned by learning from new models of care, and senior informatics and clinical leadership to both agree the plan and to implement it. Key activities in place to achieve this are as follows:

• Chief Information Officer in place and on STP Executive
- Addition of STP Medical Director to have Chief Clinical Information Officer responsibilities in role.
- Addition of either Chief Clinical/Nurse/AHP Officer as a role in each of our provider organisations by end of 19/20.
- Develop further roles for clinical staff to take leadership and delivery roles in digital e.g. GP Informatics Lead, and Nursing Informatics Officer.
- Develop new digital roles to lead development of digital workforce to mirror our investment in digital care of the coming years. We will have in place by December 2019, STP Digital User Experience Lead, Digital Solutions Architect and Data Sciences and Data Architect Leads which along with CIO and STP Director of Workforce will create new digital roles.
- We will develop stronger links with local further education in shaping the digital skills to support our transformation in future.
- Continued engagement with HEE for developing a digitally enabled workforce
Working with the voluntary, community and social enterprise sector

In March 2017 Community Action Norfolk, in partnership with colleagues from the local clinical commissioning groups and Norfolk County Council, ran a series of three engagement workshops to seek input from the VCSE sector into the STP; the Norfolk and Waveney Health and Care Partnership.

Other VCSE forums such as the Voluntary Sector Forum (young people and family services) and the Older People’s Partnership Board will also have discussed and viewed the work of the partnership.

The narrative below gives an idea of some of the issues raised by our VCSE partners, grounding them within the current context, as well as providing a degree of focus on what our local VCSE sector colleagues believe are current priorities to inform our system plan:

1. The focus on prevention as a priority continues to be broadly welcomed by the sector. The feeling is, however, that there has been a limited system level shift towards a prevention approach in terms of resourcing. Previous commitments to increase funding for prevention have been reduced due to the increased costs within acute services. A commitment to specify and then allocate ring-fenced funding into long-term prevention activity would be welcomed. By which we mean non-clinical interventions that target the wider determinants of health.

2. Meaningful engagement with VCSE partners is a priority as part of a true whole system approach. It is also vital that such engagement enables the many and varied voices of the VCSE sector to be heard. VCSE organisations wish to be part of the conversation early as ideas are shaped and developed, with a meaningful ability to influence the outcomes of discussions. To facilitate this we would seek to have the VCSE an integrated part of the most senior decision making level.

3. The place-based planning model within the NHS long-term plan is broadly welcomed. The majority of VCSE organisations see themselves as place based so this approach supports them in more easily aligning activity. In addition, a place-based approach is more compatible with a person-centred approach core to many VCSE organisation’s values. As new structures emerge, most notably Primary Care Networks and Local Development Groups, robust transparency together with VCSE involvement should be included. The relevant chapters of the plan should acknowledge this, as well as the risks posed by the absence of these in a rapidly developing environment, and commit to their development.

4. Any successful system transformation is always wholly dependent on cultural transformation. One observation might be that the medical-model of delivery favoured in part by the NHS, together with, at times, a perceived distrust on both sides across NHS, other-statutory and non-statutory sectors can be a barrier to genuine integration.

   If we may acknowledge the research that identifies health care as representing around 20% of health outcomes and the wider determinants of health the latter; we would hope that a significant cultural development programme might be prioritised in the plan.

5. Our five year plan should make clear the distinction between NHS organisations and the system. The NHS is only one part of the Norfolk and Waveney system. Although this distinction is often highlighted in narrative, data about capacity, challenges and resources often only reflects the NHS and at times social care. We should both make clear these distinctions and commit to reducing gaps in understanding total system resources including NHS, public sector and VCSE.

6. The transition to a more integrated system requires organisational development. A large number of VCSE organisations often do not have the management capacity to support such transformational processes and we would hope future organisational development plans and investment are fully inclusive of non-NHS partners.

7. Since the initial report by Community Action Norfolk, social prescribing has significantly developed with both a countywide pilot and a NHS commitment to investment in one social prescriber for each Primary Care Network. Beyond this social prescribing is often used as short-hand for connecting patients with non-medical support. We feel this is part of a continuing general trend of the transfer of demand onto the VCSE sector. If a new pathway design includes an expectation around VCSE services we would seek for a resourcing, impact and capacity
assessment to be undertaken prior to the service going live. We would seek to look at how any resource gap can be addressed.

8. We support efforts to enhance the use of digital technology. We also agree with partners that in many areas Norfolk and Waveney is currently in a digital deficit. However, to be effective, future development plans must be inclusive of VCSE sector organisations and recognise they may need additional support to develop the necessary infrastructure and skills.

9. Many VCSE sector organisations report challenges in working with NHS organisations due to the level of bureaucracy involved, particularly attitudes to risk, quality and governance that are not appropriate to activity being undertaken. This acts as a barrier to effectively leveraging the value of the services provided by VCSE sector organisations. We wish to see a commitment and an ambition to co-developing new quality, governance and risk management systems that are proportionate and able to function across sectors and outside clinical models.

10. Data sharing remains a particular challenge. We recognise from work with NHS colleagues that this is often as a substantive barrier to them as it is to VCSE sector organisation. Our five year plan should be ambitious in its desire to address this, but also ensure such a commitment is inclusive of sharing appropriate information with non-NHS partners.

11. We must ensure a strategic commitment to population health management that is focused on addressing the wider determinants of health. It is important this is seen as separate to risk management approaches needed to target high resource intensity patients. The focus on wider determinants is critical in generating alignment with VCSE sector priorities that will enable VCSE sector organisations to support activity.

12. It is important that we develop an inclusive and motivating vision that partners can align behind. Moving beyond that vision a greater focus in strategic documents should be made on establishing clearly defined, measurable objectives. This allows all partners to clearly understand both the intended end point of a strategic process and track progress towards this.

13. We have seen a greater recognition in workforce discussions with partners of both the importance of inclusion of the VCSE sectors workforce and the role of volunteers. We welcome this. This need to continue and translate into meaningful interventions. As part of this we feel it is important that our system recognises:
   a. The distinction between VCSE paid and unpaid workforce
   b. The volunteers roles exist inside and outside of the NHS
   c. That volunteer recruitment has been consistently flagged by VCSE organisation as a key challenge
   d. That volunteer roles are a means of enhancing the experience and support available to residents and patients, working alongside an appropriate compliment of paid staff roles
   e. That new volunteer roles are developed in line with the likely areas of interest, capacity and skills of potential participants and are effectively supported through training and management.

Moving forward

To plan together for the future, the VCSE sector infrastructure organisations in Norfolk and Waveney, in partnership with the STP, organised a series of four workshops in October 2019. These were held across Norfolk and Waveney in Norwich, Great Yarmouth, Lowestoft and King’s Lynn. Over 100 representatives of VCSE organisations attended.

The events were designed to build on the discussions at the workshops in 2017. We discussed with attendees their thoughts and ideas about what should go in our five year plan, as well as a their views on a proposal to develop a Voluntary Sector Health and Social Care Assembly and Memorandum of Understanding, based on the Greater Manchester model.
We have made changes to our plan as a result of what VCSE colleagues told us at the events. Notably, we amended two of our three goals:

- One of the key themes from the events was that there needs to be a greater focus on prevention and the wider determinants of health. This is consistent with feedback from local government colleagues too. As a result we have changed our first goal, so that it encompasses prevention and tackling the root causes of poor health, as well as addressing health inequalities in Norfolk and Waveney.
- We are also changing our third goal to better reflect our whole workforce and everyone who provides health and care in Norfolk and Waveney. VCSE colleagues told us that, understandably, not all volunteers and carers identify as health and care professionals. As a result, we have changed our third goal to say: “To make Norfolk and Waveney the best place to work in health and care”.

Overall there was broad support from VCSE colleagues at the events for the proposal to develop an assembly and a Memorandum of Understanding. However, there was a clear feeling that the assembly must deliver meaningful change and some frustration of the lack of progress or outcomes from previous engagement. We have a steering group set-up to take this forward, made-up of the VCSE sector infrastructure organisations in Norfolk and Waveney, the STP and an independent chairperson.

The aims of the assembly will be to:

- Strengthen the relationships between the sectors and improve joint working and communication.
- Provide an interface with health and social care and encourage shared decision making.
- Complement existing VCSE forums across localities and systems across Norfolk and Waveney.

The design of how the assembly will operate will be developed by the VCSE sector itself, with wide ranging elected representation so that it can ensure it represents and meets the wide ranging needs of communities and the voluntary sector, and that the voices of smaller groups are heard. Developing a clear mandate and support from the VCSE sector therefore at all levels within the STP/ICS at local, place and system level. It is expected the Assembly would be a key part of Norfolk and Waveney’s current STP governance, and development of the ICS.

The Memorandum of Understanding will provide us with a set of shared outcomes that we will work together to deliver. The outcomes will be based on the key themes that come out of the engagement we have done with VCSE organisations over the past two years, such as contracting, data sharing and workforce planning.

Over next six months we will develop and finalise what the assembly will look like and how it will work, as well as the Memorandum of Understanding. So by April 2020 we will have a set of shared outcomes that we will work together to deliver that will help to improve the health and wellbeing of people locally, as well as help to address some of the challenges facing both the statutory and VCSE organisations in Norfolk and Waveney.

There was a wealth of rich data and ideas generated at the events which we will use to help us with the implementation of our plan, as well as the development of our assembly and Memorandum of Understanding. A full report from the events can be found on our website: www.norfolkandwaveneypartnership.org.uk.
New technology

National Context

For the first time, digital health is an integral part of the Government’s NHS plan, being both a supporter or enabler of success. The plan discusses ‘wide spread digital services’, a plan for a ‘digital first’ model of care in primary and community sectors and sets out an aim to give ‘our hospitals the most advanced IT in the world’. Its objectives are to:

1. Empower People
2. Support Health and Care Professionals
3. Support Clinical Care
4. Improve Population Health
5. Improve Clinical Effectiveness and Safety

Current Digital Landscape

As previously discussed our Norfolk and Waveney health and care system has a large physical geography, based mainly across the county of Norfolk and part of North Eastern Suffolk. It is mainly rural with some urban areas. Our population has a more aging population than most systems, and has both some of the highest and lowest levels of social deprivation in the country. This rural nature is both a challenge and an opportunity with respect to utilising digital services now and in the future – infrastructure can be a barrier to place-based care but, if available, addresses the challenges of time and cost of care for both patients, carers and our staff.

Primary care providers have been largely digitised for many years, and national primary care digital programmes are being delivered in line with or ahead of national timeframes. The ability to share information amongst providers and across care settings is still at the beginning of the maturity curve, as is secondary and especially, hospital provider digitisation.

From both NHS Improvement Model Hospital data (2018), and from a recent (2019) benchmark utilising the Healthcare Information Management Systems Society, Norfolk and Waveney is the least digitally mature system in the NHS. The NHS average score for hospital trusts is 2.5 out of 7. Our three hospitals are at 0.05. Thus, one of the priorities for the digital agenda for Norfolk and Waveney must be to progress with acute digitisation and associated programmes (Electronic Patient Record, infrastructure, cyber security, interoperability etc).

Digital Maturity

According to latest NHSI figures (2018) Norfolk and Waveney STP is the least digitally mature STP in the country. Hospitals are 0.05 / 7.00 and STP system is 1.00 / 7.00.

This has massive implications for the health of our population and the sustainability of our system.

In 2019, the STP has undergone a HIMSS review. Our aim is to be a HIMSS Stage 6 STP by 2024.

This supports the NHS Long Term Plan aim of a core level of digitisation by 2024.
**Investment**

Investment is required in order to address the current digital landscape and ‘leapfrog’ other systems so that Norfolk and Waveney is at the forefront in using digital tools and digital care to meet our ambition and deliver the NHS Long Term Plan. We currently spend on average 1.2% of our STP turnover on digital services. In some cases for our secondary care providers, according to NHSE/I Model Hospital (2019), we are spending just 20% of the average for similar cohorts of organisations. We will need to increase this to a minimum of 2.5% and a significant capital investment to digitise our acute providers. Without capital support, we will need an investment of 4.0% of system turnover to meet the LTP requirements.

**Our Plan – the Norfolk and Waveney STP Digital Strategy**

The Norfolk and Waveney STP Executive approved our digital strategy in April 2019. This document outlines our ambition to deliver care in new and innovative ways for our patients. It sets out our plan over the next five years to transform the way we deliver care in a sustainable, efficient and effective way utilising technology, infrastructure, devices and information. The challenges we face in the health and care services are well known to us and whilst we strive to improve our clinical quality, operational performance and financial management, we realise we will need to think in a different way to deliver our ambition.

People living in Norfolk and Waveney expect technology and information systems to be part of how health and care services are delivered, they are enthused about how we could embrace the opportunity to make people’s experience of services more straightforward, personalised and interactive, as they expect in other areas of their lives.

**Strategic Objectives**

Our ambition is to “Create a Norfolk and Waveney care system where digital health and care actively supports the best clinical outcomes and experiences for our patients, staff and public.” This will be achieved through our values:

- **Collaborate** - Working together with our partners, staff and public for the best health outcomes for the region.
- **Activate** - Working with passion to activate digital tools and experience for all.
- **Innovate** - Embracing new ways of thinking and doing.

In order for us to achieve this, our STP has a Chief Information Officer in place and each of our partners also has their own digital agenda aligned to our overarching Digital Strategy.

Our digital strategy has been created to align with the LTP priorities; delivering specific digital elements and to enable the LTP in general.
**LTP Connections**

<table>
<thead>
<tr>
<th>LTP Key Concepts</th>
<th>Norfolk and Waveney Plans in Action</th>
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</thead>
<tbody>
<tr>
<td><strong>Digital technology should underpin wider local system transformation plans</strong></td>
<td>STP Digital Strategy steps out as per above how each STP Focus area maps to and is supported by digital. Each STP workstream has CIO on board, and functional areas to deliver transformation, such as Population Health have CIO and other technology and informatics professionals in place.</td>
</tr>
<tr>
<td><strong>Comply with cyber security standards by summer 2021</strong></td>
<td>Cyber Awareness for Boards is being delivered. Internal and external penetration testing on regular intervals. Benchmarking against Cyber Essentials and NIS Directive have taken place. Further investment will be required to be fully compliant.</td>
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<tr>
<td><strong>Digitise secondary care providers and establish locally shared health and care records to support integrated care by 2024</strong></td>
<td>Three Hospital Trust Boards have agreed to move forward with single EPR system. Programme in place and currently at OBS and Outline Business Case stages. Norfolk and Waveney Connected Care Record is now in test with pilot care pathway go-live set for this year.</td>
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<tr>
<td><strong>Put user need, both staff and patient, at the heart of technology decisions and design</strong></td>
<td>CCIO, CNIO and clinical informatics roles are being developed across the STP. The STP has created a Digital User Design and Transformation role which will focus specifically at user design – which is at the forefront of STP Digital resource across the NHS. We have built in patient engagement across our work-streams and large programmes.</td>
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</table>
Drive faster update of citizen facing digital tools, including use of the NHS App
NHS App programme is in place and supporting uptake and use of NHS app. GP Online uptake has been successful and is continuing to be supported. Strategy outlines need for patient portal once investment is available.

Cultivate the right workforce to enable change and exploit technology
We are creating a single digital team across the STP to leverage both capability and address capacity allowing us to learn and build both together.

Our Digital Strategy

Our digital strategy has five key strategic pillars: Together, Connect, Activate, Understand and Innovate. Each of these pillars has strategic initiatives – programmes and projects to deliver the STP Digital Strategy and in turn, the NHS Long Term Plan and its LTP digital priorities.

Considering the low baseline of digital maturity of the STP – we will look for strategic investment in order to support and deliver the digital strategy and thus meet the aims of the LTP.

Our strategic priorities are outline below

Strategic Priority 1

1. Together

Our focus in this area is to create a shared, STP digital capability that supports the best possible care and sustainability for Norfolk and Waveney. A central resource that creates a single digital voice for our region and its relationships with key partners and national bodies.

Nationally, NHS England are looking to create Integrated Care Systems (ICS) and sees digital as a core part in an ICS’ success.

A shared digital capability would not only support better, integrated working, it would provide economies of scale, commercial rationalisation, opportunities to improve capabilities and support quality, regional collaboration.

Currently, While local IT teams have good working relationships, we do not maximise our opportunities for economies of scale, shared capability and region wide improvement. Our digital system remains fragmented with ongoing duplication of effort. We are addressing this by creating a single digital function across the STP, with providers and commissioner organisations support.

1.1 - STP Digital Team

1. Create an ICS Digital team to action strategy – leverage each organisations capability and capacity and provide single leadership team across STP.
2. Address changing digital skills gaps and specialist, difficult to recruit areas such as integration, architecture, cyber security, UX.
3. Develop team to change from purely IT and IM to digital transformation function.

1.2 - System-wide, Leveraged Infrastructure
1. Develop an STP-wide Warranted Environment Specification – rules to support interoperability, supportability, service-design and security.
2. Set out ICS infrastructure strategy.
3. Move to shared data and network infrastructure.

1.3 - Commercial Alignment
1. Baseline current contract and suppliers, managing them across the STP away from organisation silos.
2. Develop Commercial, legal and ITSLM capability.
3. Harmonise similar contracts and procure collectively.

1.4 – Common technology
1. Mobility, voice recognition and user-designed for ease of use.
2. Standardise devices for value and supportability.

2. Connect

Our focus in this strategic pillar is to connect our region so that we have one clear picture about our citizens, patients - the people we look after and the care we provide.

Nationally, there is a real drive to connect systems, people and processes, to increase safety and effectiveness, create economies of scale and deliver secure open standards across the health care system.

Locally, we will work across the STP to be digitally connected; to share, to collaborate and to provide our staff and citizens with the information they need to provide effective care in the right location.

Due to the region’s digital immaturity it remains difficult to work together to share information and create one view of our care needs and pathways. We have large scale duplication, and therefore wasted effort in our attempts to deliver joined up care in our region.

2.1 - Regional System Data Repository
1. Develop data strategy and have an STP data architect.
2. Hybrid data lake – there will be a need to exploit public cloud, and ‘high-spin’, local storage for critical clinical applications – we will do this in conjunction with local government.
3. Exploit public cloud.

2.2 - System Interoperability
1. Open APIs to support clinical systems data flow.
2. Systems redeveloped, procured to ensure interoperability – defined by a solutions architect for the STP.
3. Meet national guidelines on Transfers of Care.

2.3 - Privacy, Security and Governance
1. Establish an ICS IG/data security function and strategy.
3. Encrypted networks and data systems designed for security.

2.4 - Standardised Clinical Terminology

1. Baseline assessment of current adherence to guidelines.
2. Set standard of SNOMED CT – and make it part of our Warranted Environment Specification.

3. Activate

Our Focus for Activate is to utilise digital tools to support, enhance and enable our staff and citizens to create exceptional care and healthier futures.

Nationally, digital services, built around the needs of the user, has become key enabler to healthcare delivery. National focus is on inclusive design and access with control, but not complexity, shared with the user.

Locally, key to success will be consideration and inclusion of all age, socio-economic status, rurality etc. Engagement, conversations and co-production will be key as we build digital culture and develop the digital skills of our staff and citizens.

Currently, we are building our capability to engage with our citizens and staff in relation to digital, it is a key area for development. Historically, we have decided and implemented digital technology in isolation and thus not leveraged its full potential.

3.1 - Clinical Applications

1. Deliver consolidated EPR system – a key and significant strategic programme and also enhance primary and social care systems. Support Mental Health EPR review.
2. Move towards mobile app and/or interoperable clinical applications.
3. Harmonise clinical applications across the system.
4. Deliver a Norfolk and Waveney Connected Care Record.

3.2 - Non-Clinical Applications

1. Consolidate back-office and productivity tools.
2. Further develop and support business intelligence platforms including self-service and insights.

3.3 - Citizen/ Patient Digital Tools

1. Continue to develop Norfolk and Waveney Clinical Record – including a Personalised Health Record (PHM) for our patients and citizens.
2. Develop a citizen portal, built to integrate with regional and national portals.
4. Understand

Our focus in Understand is to create exceptional, secure and accessible data so our region can effectively, plan, prevent and take action to positively influence the health and care of our citizens.

Nationally, data has become an increasingly vital part of healthcare delivery. It supports the insight that lead to better decisions and therefore better outcomes. Driven by new, national data standards, the aim is to simplify the ability to connect and aggregate.

Locally, our dependence on paper has hindered our ability to access data to maximum effect. It is vital to our care provision and sustainability that we create regional, accurate, timely data when and where people need it.

In some areas we do not have aggregated, real time or even timely data. Initial pilot projects in place to create regional views of data.

We do have some areas of excellence however, with our locally-developed NHS Pathways/Eclipse product which is used across the NHS.

4.1 - Clinical Decision Support and Reduction of Clinical Variation

1. Support Acute Services Integration.
2. Standardise clinical pathway tools.
3. Evidence-based machine learning and clinical decision support tools integrated with clinical applications.

4.2 - Research

1. Active role in the Academic Health Science Network.
2. Data systems and architecture that is ‘research ready’.
3. Forge strong working relationships with academic partners such as UEA and private health science partners.

4.3 - Insights and Population Health

1. Develop a data sciences function.
2. System-wide dashboards and insights – predictive and advanced analytics.
3. Aggregated data at population-level.

4.4 - Hybrid Data Lake

1. Develop data strategy and standards.
2. Vendor agnostic data exchange.
3. Seamless integration with organisational systems to provide a joined-up data experience.

5. Innovate
Our Focus in the Innovate strategic pillar is to create the space and capability to build modern, timely approaches to digital services. Continually improving health and care by working with partners from industry and academia. This transformation will be supported by a new ethos and team that will blend technology and informatics professions with clinical, operational and support functions in partnership.

Nationally the NHS recognises that it needs to do more to leverage the health tech industry and innovation that exists in the UK. The NHS recognises it has to do better to exploit current and future innovation and to be able to deploy it at scale across the health service. This includes areas such as artificial intelligence, machine learning and robotics – which we will look to support a specific team to exploit the opportunity that these innovations can unlock for the health and care system of Norfolk and Waveney.

Locally, we have access to a number of brilliant partners such as the Norwich Research Park and University of East Anglia, local government and private partners. Part of the future will be to build more formal partnerships with these organisations to enable our own innovative practices and team.

Currently we have little capacity or capability to give modern or innovative technologies the focus required. Pockets of innovative thinking is taking place but translation to reality remains minimal.

5.1 - Innovation Team

1. Create a Norfolk Care Innovation Hub.
2. Leverage talent through an Innovation Community and existing groups for PPP, Hack-days, Education links.
3. Second operational, commissioning and clinical staff to work in partnership with technology and informatics.

5.2 - Digital Transformation

1. Prescribing and supporting care apps including the NHS App.
2. Erode separation from traditional contracts, technology, performance, clinical practice, QIPP, PMO.
3. Digital first policy.

5.3 - Machine Learning, Robotics and Artificial Intelligence

1. Expand use and maturity of Clinical Decision Support across all sectors of health and care applications and SOPs.
2. Expand use of robotics for clinical practice and expand into administration functions.

Focus – Population Health

Throughout our LTP response, we have outlined how we look to use the power of Population Health Management in order to meet the Quintuple Aim of Health and Care:

- Reduce per capita cost of health care and improve productivity
- Improve the health and wellbeing of the population
- Enhance experience of care
- Address health and care inequalities
• Increase the well-being and engagement of the workforce

Key Enablers

Norfolk and Waveney are building the key enablers for successful Population Health Management:

Infrastructure

• **Organisational Factors** such as dedicated system leadership and decision making on PHM – we have joint-SROs in the STP Director of Workforce and CIO and have and PHM steering group with representatives from each organisation across the STP and a second group which focusses on Primary Care PHM.

• **Digitised health and care providers** and **common health and care record** – The main focus for digitisation is the acute EPR programme, which is now in specification and Outline Business Case phase. Our Norfolk and Waveney Connected Care Record project is in flight and expect our first pilot to be live in December 2019.

• **Integrated data architecture** and a single version of the truth - Our STP digital strategy will deliver a virtual data lake through interoperable clinical systems, real-time data feeds – led by a Data Architect who will be in place in December 2019.

• **Information Governance** that ensures data is shared safely, securely and legally – We are building on existing information governance agreements – DPIAs and DSAs, led by an STP Information Governance Group.

Intelligence

• **Supporting capabilities** such as advanced analytical tools and software and system wide multi-disciplinary analytical teams, supplemented by specialist skills – We have a STP BI and Data Group which looks to create an increased system-wide capability and capacity in analytics and data sciences. We will have an STP Head of Insights and Analytics in place for December 2019.

• **Analyses** to understand health and wellbeing needs of the population, opportunities to improve care, and manage risk – As well as building increased analytics capability we also understand the importance of building confidence across our entire workforce, including clinicians as we indicated in our Workforce Plan.

• **Interpretation** of the data and analyses, to work with and advise providers and clinical teams.

Interventions

• **Care model design** and delivery through integrated personalised interventions tailored to population needs – We already have toolsets in place and are using it to deliver care in new and proactive models through MDTs in GP surgeries. We have supported the development of a PHM tool that is being used across the country – Eclipse / NHS Pathways. This has been developed by a GP in the West Norfolk area of our STP. We are also using the foundation of this excellent tool for our Connected Care Record.
• **Community wellbeing** asset based approach, social prescribing and social value projects – Our Primary and Social Care PHM group, supported by our CSU, County Council, PCNs and Public Health England are already beginning to develop models and interventions a PCN level.

• **Workforce development**, upskilling teams, realigning and creating new roles – As described, our Workforce Workstream 5 – Building a Digitally Enabled Workforce sets out our ambition and plan to develop these skills in order to support the benefit that PHM can provide to our population and the STP aims.

**Case Study – PHM in West Norfolk**

**Process for Delivery of the West Norfolk Proactive Care Model**

1. **WHO?**
   - Population cohort analysis and segmentation

2. **STANDARDISE THE WHAT?**
   - Agreed key health and social care indicators for identification, management and monitoring of at risk patients

3. **FIND & DELIVER CARE**
   - Case finding
   - Deliver Proactive care based on protocol driven primary care management

4. **WORK TOGETHER SMARTER**
   - Develop MDT model for specialist health support at PCN level
   - Using integrated datasets

5. **Support from system partners to provide targeted interventions to address the wider determinants of health**
   - Crisis management – admission avoidance and proactive discharge planning

**HOLISTIC CARE FOR THE CITIZEN**

Everything we do is focussed on the right hand side of the image above. We spend huge sums of money sending out rapid response vehicles, crisis support teams, we focus the majority of our attention on the individuals who are already unwell.

PHM allows through the use of data and evidence to refocus resources on those individuals who would benefit most where there is reversible risk.
Our buildings and estate

Our current buildings – both within the NHS and local government – are made-up of a mixture of property some of which is high-end, modern and well equipped. Some, however, is ageing and carries significant backlog maintenance, which results in high running costs and requires considerable ongoing maintenance. In addition to this we also have properties no longer fit for purpose, not well utilised and/or not providing flexible use.

Our local estates strategy aims to ensure that we have the right properties in the right locations to meet the needs of our patients and public. It ensures the maximum use of our public sector estate, seeks to integrate health and social care within primary care premises, and support the relocation of appropriate acute (hospital) services into the community.

Our future estate will be fit for purpose, and any investment will seek to address backlogs in current maintenance across our system, in particular any maintenance considered high-risk such as the safety of our care environments and ensuring they remain compliant to clinical and legislative requirements. Expanding and opening up access to our NHS property and prioritising resources toward improving patient experience are other key components of our plan.

Where an existing property is considered too expensive to modernise or is surplus to requirements a decision will be made as to their future. If appropriate they may be sold and the revenue re-invested into schemes deemed a priority. One such example of a priority area is our commitment to invest in supported affordable housing for our staff.

Sustainably, innovation and investment in energy reductions, environmental impacts and enhancing social value through developing accessible community green spaces are other priority areas for our local estates plan.

Leadership and Transformation

Individually our local providers oversee a significant spend and resource that serves our population. We recognise the opportunity that collaboration brings and, to facilitate this, our estate leaders have teamed up across our system to share expertise, resource and effort with the aim of streamlining and improving our services.

We have developed an estates leadership programme bringing together into one overarching estates strategy the priorities and needs or our individual organisations. The programme is focused on:

- A workforce strategy – supporting the development and growth of our estates and facilities staff, through the use of apprenticeships and internal secondments, thereby sustaining and growing our system expertise.
- A programme of shared procurement to reduce costs and bring service solutions and contracts together.
- A shared information strategy to maximise our production of estate data and assessment of performance at provider and system level.
- Shared policy and strategy developed through common processes, training and service objectives. Acting and behaving ‘together’.
- Planning and investment jointly developed through aligned programmes supporting agreed service priorities and reducing significant back log maintenance.
- Adaptability to climate change impact and impact on evolving demography.

Primary care

The viability and suitability of our primary care buildings is essential if we are to provide the integration required to deliver patient centred care closer to home. For example we must:

- Meet our increasing population growth and subsequent capacity required for the provision of services
- Integrate service provision across primary, community, mental health and hospital services in accordance with national direction
- Be more efficient through the better use of high quality shared buildings and location.
With 17 Primary Care Networks in place across Norfolk and Waveney our estates strategy for primary care plans to provide the capacity required in the most effective way to enable the delivery of high quality services. We are investing in estates expertise and individual pieces of work so as to have a clear view of the current state of our general practice buildings. This will allow our system to make informed decisions and prioritise new builds or refurbishment of existing premises. We are participating in national pilots to establish a common understanding and data capture of primary care estate as a basis for strategic planning and development.

**Our priority programmes**

We have four overarching programmes of work that we are focusing on over the next five years:

- **Transformation through leadership** - the achievement of a single virtual estates function across our system, underpinned by key programme areas: workforce, procurement, finance, informatics, strategy and policy, planning and investment.

- **Redevelopment of Emergency Department facilities in North West Norfolk** - to ensure patients receive emergency care in the right place and at the right time, in modern facilities that are fit for purpose. We will invest in redevelopment of the Emergency Department at The Queen Elizabeth Hospital to aid transformation of the emergency care pathway.

- **Integration of health and social care in localities** - focusing on primary and secondary prevention, facilitated through the growing of our out of hospital capacity and networks.

- **Consolidating our acute (hospital) services** - including re-location of appropriate acute services into the community to free up capacity in our hospitals to focus on what they do best; providing care to our most sick patients. A further aim of the programme is to utilise our buildings to improve the consistency in children and adult mental health provision.

**Our priority projects**

Under the umbrella of these overarching work programmes are a number of projects central to creating a clinically and financially sustainable system and delivering excellent patient care. Our investment planning aims to deliver these programmes over the next five years. Investment will be phased where applicable and linked to planned growth in housing and therefore demand for health services. Our priority projects are:

- **Developing ‘Diagnostic and Assessment Centres’ (DAC’s)** at each of the three acute hospital sites to improve referral to treatment times, deliver better clinical outcomes and reduce hospital visits. The DAC is a collaboration to respond to the acknowledged lack of diagnostic capacity in Norfolk and Waveney. DACs in Norwich, Great Yarmouth and King’s Lynn will establish diagnostic radiology capacity more aligned to future demand, incorporate outpatient accommodation to support more ‘one stop’ clinics delivering shorter patient pathways, underpinned by the Radiology Academy with an expanded remit to train a wider cohort of radiology professionals.

- **Re-developing our community and mental health hospital estate** will enable us to create modern facilities that provide integrated care to patients and are deemed good places to work. We will invest in development of Norwich community hospital, and the provision of modern in-patient facilities at Hellesdon Hospital.

- **Co-locating services together in community health hubs** will help us to make integrated care a reality. Our aim is to bring physical and mental health care together, with social services, wrapped around clusters of GP surgeries. This will reduce referrals and admissions to our acute hospitals. Bringing together different professionals, including colleagues from the voluntary sector, will result in people getting coordinated and seamless care from an integrated team in their neighbourhood, enabling us to provide care closer to home.

**Our opportunities**
<table>
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<tr>
<th>Opportunity</th>
<th>Action</th>
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<tbody>
<tr>
<td>Leadership – Partnership working and resourcing (Acting and Delivering Together)</td>
<td>Our estates leadership team is collaborating to create a streamlined, cost effective estates and facilities function. Our collective spend and services activities across the health system are aligned to attain a maximum synergy in key program areas, releasing efficiency in process, financial, and other factors such as sustainability, freeing up revenue for reinvestment in patient services.</td>
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<td>Aligning the STP estates strategy to STP clinical strategy</td>
<td>We are working together, enabling opportunities to dispose of surplus estate, reconfigure and invest in core estate to meet service requirements. We continue to identify strategy impacts requiring infrastructure investment, ensuring prioritization and alignment to core strategy.</td>
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<td>Developing operational metrics (Carter/Naylor)</td>
<td>We are working together to create common investment programmes between all providers. We have established a program of work to reduce estates running costs by 20% by 2022/23. The plan includes reduction of non-clinical floor space/unused floor space in line with NHS performance targets and alignment of disposal and housing figures within the strategy.</td>
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<td>Acute service reconfiguration</td>
<td>The program for acute services reconfiguration is appropriately re-sourced with each trust implementing or developing its estates strategy. Our Acute Service Integration programme is now beginning to yield positive results. There is a single Pathology service across the STP and advanced collaborative working in radiology through the Norfolk Imaging Alliance. Plans are advancing to create single clinical teams within pathfinder specialities including urology under a lead provider model. Site development at NNUH is based around a programme of service configuration, integrating the Trust within the wider research and learning campus.</td>
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<td>Out of hospital facilities and estates data</td>
<td>Our estates leadership team continues integrated working across public sector to advancing a programme for out of hospital facilities. We are focused in key areas:</td>
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<td>• Supporting workforce development, understanding and advancing management of key worker accommodation and enabling affordable housing for NHS Employees.</td>
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<td>• Integration of health and care service delivery, focusing around key hub service locations.</td>
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<td>• Leveraging the increasing availability of mobile working amongst administrative service teams, to access estate on a flexible, bookable basis. Developing estate strategy alignment with digital strategies to identify and develop complementary investment priorities.</td>
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<td>• Operating a shared procurement programme which collaborates on development and delivery of flexible procurements at scale.</td>
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<td>• Our estate team are participating in national pilot scheme to establish common primary care data sets for the basis of PCN and wider estate strategy planning.</td>
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| Funding and delivery models | Our estates team have identified the development of a capital financing strategy laying out funding sources and how they are going to be applied to specific planned developments is essential to ensure the estate plan remains on target.  
Example funding strategies include:  
- Working alongside local authorities to increase cross public sector collaborations.  
- Matching known funding sources to infrastructure pipeline throughout investment planning cycles.  
- Management of CIL/S106 funding opportunity through strategic conduct of Health: Planning relationships (member of all local planning forum meetings).  
- Alignment of funded investment programmes to support and maximize investment gain e.g. prioritised reduction in backlog.  
- Alignment of planned expenditure and investment priorities at system level is planned to move toward a collective planning round during the LTP period. |

| Prioritisation of investment pipeline | Our investment emphasis is placed on advancing our understanding and completion of disposal planning, and use of receipts to re-invest where required in front line service developments.  
Capital funding has been secured to implement prioritised schemes for:  
- £76m – Diagnostic service centres  
- £25.7m – phase one primary care hub development  
- £40m – replacement Mental Health wards |
Research and innovation

Norfolk and Waveney is a high performing area for research with all five CCGs consistently falling in the top 50 CCGs for recruitment to research studies relative to population size. Since 2001, over 29,000 patients have taken part in 173 NIHR Portfolio studies, with around 50 (49%) of our practices regularly hosting research studies, exceeding the national target of 45% of practices to be involved in research. Each Primary Care Network (PCN) in the Norfolk and Waveney region includes at least one research active practice.

Both Norfolk and Suffolk Healthwatch respectively has established research teams with links to Memorandum’s of Understanding in place, research projects in train, and good links into key education institutes such as Essex University, the University of Suffolk, and the University of East Anglia.

Our local priorities for research and innovation

To inform the development of our 2019-2023 research strategy for Norfolk and Waveney we undertook a stakeholder engagement exercise, to explore the key strengths and weaknesses of the current system and to look at what a good research system might look like, building on existing strengths and expertise.

These plans for research and evidence are centred around four key themes (leadership; collaboration; communication; capacity and capability – see table below) to deliver our ambition to:

“Embed a culture that enhances the health and wellbeing of our population through involvement in research and translation into practice”; …

...building on existing expertise to:

- Offer increasing opportunities for managers, clinicians and patients to participate in research.
- Support commissioners to use best evidence to commission services and translate evidence into practice.
- Work to support and embed research and build research collaborations across the STP footprint and within emerging structures such as Primary Care Networks.

These themes will be underpinned by the development of a robust research infrastructure to support the design, delivery and adoption of high quality, nationally relevant research and evidence, addressing the needs of patients and commissioners.

Priority areas

For research to have the best impact on patients, health and social care practitioners and service, it needs to be collaborative, to be focussed on the most important questions and challenges, and meet the needs of our population. Together with our stakeholders, and with input from the CCG Clinical Executive Committees we collectively identified the Research and Evidence Priorities which are reflected in our strategy. These priorities focus on:

- **Best start in life and reduction of inequalities**
  Supporting research into children and young people’s mental health; working in partnership to improve prevention, diagnosis, intervention and treatment; improving birth chances for mother and child, empowering individuals to manage their own health and lifestyle factors

- **World class prevention and care for major health problems**
  Early diagnosis of disease through screening services and early detection in primary care; prevention and detection of Stroke and Coronary Heart Disease; prevention and detection of dementia, including biomarkers and development of interventions; healthy living, achieving good mental health, disease prevention and management of chronic conditions particularly in the working age population

- **Supporting People to age well and targeting inequalities**
  The impact of increasing integrated working by professional groups; helping people live independently at home longer and avoid hospital admissions including home based monitoring and new ways of providing care; empowering individuals to manage their own healthcare particularly those with long term conditions
• **Supporting the Transformation of Services and Development of the ICS**
  Creation of an evidence and evaluation hub to undertake critical system evaluations; undertake a programme of evidence briefings; and develop and lead staff training and development programmes around use of evidence and evaluation.

**Local Leadership and partner arrangements in relation to Research**

The Research and Development (R&D) team sit within the Office of Strategic Commissioning within the new Norfolk and Waveney CCG single management structure, reporting into the Executive Management Team via the Director of Strategic Commissioning. This ensures research sits firmly within the core business of the CCG.

System-wide leadership is via our Research Steering Group, which includes representation from all Norfolk and Waveney CCGs together with our academic partners at the University of East Anglia (UEA), the Clinical Research Network (CRN: Eastern), the NIHR Applied Research Collaborative (ARC), Public Health and Heathwatch.

Our recently developed five year Strategy for Research and Evidence aims to ensure research leadership is fully aligned with new CCG structures, meeting the needs of the changing local health system, and that we are best placed to drive forward the ambitions in the Long Term Plan for our local population. Following development of this strategy our accountability arrangements are being reviewed in line with these aims.

**NHS Partners**

We work closely with our partners across the local health system to support the set-up and delivery of studies across primary and community care. This includes working alongside mental health, community and acute providers and the local clinical research network (CRN: Eastern). With the CRN Division 5 Manager and the Primary Care Delivery teams we help facilitate rapid set up of studies in Primary and Community Care, supporting patient and public access to and participation in research, and delivery of CRN targets.

More than 100 studies are active at any one time across Primary and Community Care in Norfolk and Waveney of which approximately 75% are network supported. We work in collaboration with the R&D Team in Cambridgeshire and Peterborough CCG to support Primary Care research across the whole of the CRN: Eastern region, and receive £164k funding from CRN: Eastern to support this activity on behalf of the Norfolk, Suffolk and North East Essex CCGs.

The Research Team also act, on behalf of South Norfolk CCG as the lead CCG for the 15 CCGs that make up the CRN: Eastern network for the new Excess Treatment Costs in Research process introduced by NHS England in 2018.

**Academic Partners**

The R&D team have strong relationships with our academic partners at UEA, including the Norwich Medical School, the School of Health Sciences, and the School of Pharmacy. The team work with these partners to fund calls for research and to develop research ideas that meet the needs and priorities of the local population. Our Research Design Lead sits on the UEA NIHR Review panel, which appraises NIHR grant applications prior to funding submission, and chaired the East of England Research Design Service for five years. Close working with the School of Pharmacy resulted in the award of a £2m NIHR Programme Grant to look at pharmacist management of medicines for care home residents, one of very few awarded to CCGs at the time.

The team also work closely with the Quadram Institute, especially the gut health group to develop research ideas and support roll out in primary care.

The Norfolk and Waveney CCGs are members of the new UEA Health and Social Care Partners (UEAHSCP), which brings together NHS, social care and academic partners to enhance health and care research and innovation for the region. This partnership champions the needs of its combined workforce and the local population, aiming to bring better outcomes for service users and health and care professionals through:

- increasing the level of research and innovation in the local health and care sector
- developing a shared and improved research infrastructure
- engagement with service users and healthcare professionals to improve their experience and identify areas for innovation
- developing a mature innovation culture across partners, creating projects which impact on service user care and leading thinking on workforce development and innovation of healthcare professions
The Norfolk and Waveney CCGs are represented by the Chief Officer for the Norfolk and Waveney CCGs / STP Lead Norfolk and Waveney and a GP / Chair of North Norfolk CCG on the Executive Committee, the Associate Director of Research on the Management Group and the Research Design Lead on the Medicines Optimisation Group.

The Norfolk and Waveney CCGs also contribute to the Clinical Academic Reserve (approx. £1m) which funds research and service time for clinical academics, we share the research findings from this programme to ensure that CCG clinical leads are up to date with the latest evidence.

NIHR Partners

We also have close links with the local NIHR infrastructure such as the NIHR Applied Research Collaboration (ARC – formerly CLAHRc), and the local Academic Health Science Networks (AHSN).

We were actively involved in the bid development workshop for the ARC, and representatives from the ARC sit on our Steering Group. Our Research Design Lead is also a member of the ARC capacity building committee.

We work with the AHSN to support adoption and spread of innovations helping to strengthen the research and innovation climate. We are a member of our local innovation hub Health Enterprise East (HEE), and promote innovation schemes led by HEE though our bulletins and newsletters. We have also helped develop local innovations through our research bursary scheme.

Clinical Leadership

The steering group has clinical quality leads on its membership to provide oversight and strategic input to the duty to promote research and innovation.

Clinical input from the Norfolk and Waveney CCG Clinical Executive Committees was invaluable in the development and refinement of our strategy for Research and Evidence helping us to focus on the main clinical and research priorities for the CCGs.

Clinical leadership for study delivery is through the CRN: Eastern Clinical Leadership team and the CRN: Eastern Primary Care Specialty Lead, a GP who is expert at generating and delivering research in general practice across Eastern.

Local leadership and engagement with GPs at local level is undertaken via attendance at GP research forums – enabling us to address operational issues around research, develop research capability and capacity and support good patient uptake into studies.

Patient and Public Involvement

The R&D Team host a 50 strong panel of lay volunteers who are able to give a lay perspective the development and delivery of locally designed research proposals across all sectors. They support research teams to design studies that really work for patients and meet the needs of the local population. Our patient volunteers also provided valuable input into the development of our research strategy and achievement of the LTP priorities.

We are working with local stakeholders and academic partners to look at alignment of PPI systems across research and education and ran a local stakeholder event to lead thinking on how this might be done.

Current Position

Performance

Norfolk and Waveney continues to be a high performing area for research with CCGs using its research infrastructure to:

- Host four NIHR grants with a total value of £2.8m in the following areas:
  - Pharmacist based medicines Management in Care Homes
  - Learning about breathlessness
  - Increasing physical activity after hip / knee replacement
  - Behavioural support for smoking cessation
- Supported 62 people to develop research ideas through our RCF or bursary schemes since 2013 in areas including:
  - Hospital associated deconditioning
- Post stroke rehabilitation
- Carer support in COPD

- Supported development of 106 grants over the last five years
- Received £248k Research Capability Funding in 2018/19 based on grant income (1 CCG) and recruitment performance (4 CCGs) which is used to drive the development of research grants in areas of importance to the CCGs and local population
- Delivered Service Evaluation Training to over 90 staff over the past two years and supported evaluations of:
  - Central Norfolk Admiral Nurse Service
  - Musculoskeletal First Contact Practitioner Service
  - Cancer Alliance Transformation Programme
  - High Intensity User Support Service
- Delivered 21 evidence briefings for CCGs since 2014 in areas including:
  - Effectiveness of Community Development
  - Recent research evidence on treatments and interventions for ME/CFS and alignment of local ME/CFS Service with NICE guidance and service provision across the NHS in England
  - Musculoskeletal First Contact Practitioner
  - Co-location of community nurses in general practice
  - THRIVE programme to inform CAMHS redesign
  - Reducing antibiotic prescribing in primary care
- Supported the set-up of around 180 studies in primary care and 100 in community care across Norfolk and Waveney since 2013

Challenges

Our five year strategy aims to address the following challenges:

- Development of capacity and a sustainable infrastructure for the adoption and translation of evidence and evaluation of services to support evidence based commissioning and transformation of services.
- To address the fundamental mismatch between commissioning vs research timescales for generation and adoption of evidence and support the development of research that is meaningful to all parties.
- To consider ways to support research getting to the population that needs it; to ensure those participating part in research are representative of the population as a whole, and hence the findings are applicable to this same population. This includes supporting research in areas of deprivation and populations most in need, and expanding scope into social care.

Communication and Promotion

We have regular bulletins to highlight research and innovation activities including findings relating to health service design and implementation, study progress as well as support promotion of research and research related events more widely.

We share our evidence briefings and make these available on our website.

We produce a comprehensive annual report to champion Norfolk and Suffolk as a place to do research. This is presented at Governing Body and circulated widely to our stakeholders supporting the CCG Duty to Promote.

Over the last few years we have also collected research impacts and stories to help demonstrate the local impact research has on patients, services and staff and have identified improvements in clinical practice and outcome which resulted directly from involvement in research.
**Future Plans**

**Strategic themes**

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Collaboration</th>
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<tbody>
<tr>
<td>• Review research accountability structures to ensure these meet the needs of the changing healthcare landscape</td>
<td>• Build system-wide partnerships to enhance research design and development to address local need and to support broader access to research opportunities for the local population, this will include working to embed research within Primary Care Networks, building on the excellent foundation of research in Primary Care in Norfolk and Waveney</td>
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<tr>
<td>• Align research activity with STP and CCG priorities where possible</td>
<td>• Work with commissioners to support implementation and adoption of innovation coming via the local Academic Health Science Network</td>
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<td>• Develop a business case for an evidence and evaluation hub to help support and foster a culture of innovation and evidence appraisal in strategic commissioning. This will help generate a culture of innovation and will identify gaps in the evidence which can feed into the local research pipeline, helping to support research that is relevant to the needs of the local population.</td>
<td>• Work with CRN: Eastern to attract externally developed studies from Universities across the UK that address the health needs of our population, increasing opportunities for our patients to get involved</td>
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<td>• Work with the local Clinical Research Network to identify and support opportunities to increase patient and public participation in research</td>
<td>• Work with partners to develop and support systems for patient and public engagement in research, building on best practice to ensure research meets the needs of the local population and has the best chance of funding.</td>
</tr>
<tr>
<td>• Use national networks and contacts to influence national profile and raise profile of Norfolk and Waveney as a “go to” area for research</td>
<td>• Build on and develop CCG collaborations to share and adopt best practice at a local, regional and national level.</td>
</tr>
<tr>
<td>• Promote and champion Patient and Public Involvement in Research</td>
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<thead>
<tr>
<th>Communication</th>
<th>Capacity and Capability</th>
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<tr>
<td>• Develop a comprehensive communication plan for research to support promotion and engagement of research across a broad spectrum of stakeholders including patients; managers and clinicians.</td>
<td>• Develop capacity and capability of commissioners to best use evidence in commissioning and support evaluation of new services via investment in an evidence and evaluation hub with a view to building evaluation into all service reviews and specifications and for the ability to use evidence to commission services to be recognised as a core skill for all managers and clinicians.</td>
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<tr>
<td>• Engage with CCG colleagues and STP partners to identify where research can support CCG and STP initiatives</td>
<td>• Promote and support both local and national career development opportunities in research (e.g. NIHR Fellowships) and explore establishment of research portfolio careers.</td>
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<tr>
<td>• Continue to support dissemination of research findings and national and local derived research evidence ensuring these are accessible to a variety of audiences. A programme of evidence briefings that reflect national work will be developed to fit with STP and ICS priorities</td>
<td>• Create “communities of practice” to enhance study design and development and establish a pipeline of research ideas and priorities</td>
</tr>
<tr>
<td>• Build on existing work to understand the impact research has on local systems, patients and services.</td>
<td>• Explore cross working opportunities between commissioning and academia</td>
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</table>
Research infrastructure

Building on existing expertise to support PPI, research design and development, and study management; to create an evidence and evaluation hub; and to grow dissemination and communication activities and assessment of impact.

Adding value – going beyond national requirements

The R&D team for the Norfolk and Waveney CCGs is one of few CCG hosted research teams which includes the research teams at Cambridge and Peterborough CCG; Bristol, North Somerset and South Gloucestershire CCG, Greater Nottingham Clinical Commissioning Partnership and North of England Commissioning Support (NECS) supporting the CCG ‘Duty to Promote’ research, and are one of eight CCGs that regularly receive grant related Research Capability Funding (RCF), compared to many areas with very limited research support outside the clinical research networks. We have a track record of working collaboratively across sectors to deliver research that benefits the wider population.

Our Patient and Public Involvement in Research (PPIRes) project is seen as a national model of good practice, and we are working achieve cross system PPI arrangements for health and education.

We work closely with our CRN colleagues to support research across the region and are planning on submitting a collaborative bid for central funding with the CRN and Cambridge and Peterborough CCG to look at governance arrangements for social care research, if successful this will ensure national arrangements for support of research in social care reflects local priorities, support the wider CCG and commissioning agendas and maximising opportunities for our population to gain access to research.

We will link into national initiatives including those to get research out to the populations that need it and will work with the local CRN to identify solutions to these challenges in the best interests of our population. This will include supporting use of digital interventions where appropriate to increase accessibility of research to specific groups (e.g. working population; children and young adults).

We will work with the AHSNs and ARCs to support spread of innovation and will link these with existing systems for dissemination of research and adoption of evidence, and will promote opportunities for the promotion of innovation that come via Health Enterprise East.

National Partnerships

The CCG R&D team have well established partnerships at national levels enabling early sight of, and input into national and local research and innovation policy, via participation in the following research groups:

- The Associate Director of Research, alongside the Associate Director of Clinical Outcomes and Population Health at Cambridgeshire & Peterborough CCG, sits on the local CRN: Eastern Partnership Board representing Primary Care interests within the CRN.
- The Associate Director of Research is the only CCG representative on the national UKRD Research Leaders Group which champions research at a national level.
- The Research Management and Finance Lead chairs the NHS R&D Forum Primary Care and Commissioning Working Group.
- The Research Design Lead is a member for the NHS R&D Forum Evidence for Commissioning Working Group.
### Glossary of terms

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<tr>
<td>ADHD</td>
<td>Attention deficit hyperactivity disorder</td>
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<td>AF</td>
<td>Atrial fibrillation</td>
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<td>AHP</td>
<td>Allied health professional</td>
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<td>AHSN</td>
<td>Academic Health Science Network</td>
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<td>AI</td>
<td>Artificial intelligence</td>
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<td>AMR</td>
<td>Antimicrobial resistance</td>
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<tr>
<td>BAME</td>
<td>Black, Asian and Minority Ethnic</td>
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<td>BCF</td>
<td>Better Care Fund</td>
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<tr>
<td>BI</td>
<td>Business Intelligence</td>
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<td>BMI</td>
<td>Body mass index</td>
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<tr>
<td>CAS</td>
<td>Clinical Assessment Service</td>
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<tr>
<td>CCG</td>
<td>Clinical commissioning group</td>
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<tr>
<td>CCTG</td>
<td>Clinical and Care Transformation Group</td>
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<tr>
<td>CCIO</td>
<td>Chief Clinical Information Officer</td>
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<tr>
<td>CIN</td>
<td>Child In Need</td>
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<td>CIO</td>
<td>Chief Information Officer</td>
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<tr>
<td>CoC</td>
<td>Continuity of Care</td>
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<tr>
<td>COPD</td>
<td>Chronic obstructive pulmonary disease</td>
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<tr>
<td>CPD</td>
<td>Continuing professional development</td>
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<tr>
<td>CPP</td>
<td>Child Protection Plan</td>
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<tr>
<td>CQC</td>
<td>Care Quality Commission</td>
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<tr>
<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
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<td>CSTR</td>
<td>Community Service Treatment Requirement</td>
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<tr>
<td>CT</td>
<td>Computerised tomography</td>
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<td>CVD</td>
<td>Cardiovascular disease</td>
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<td>CWP</td>
<td>Children’s Wellbeing Practitioner</td>
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<td>CYP</td>
<td>Children and young people</td>
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<td>DES</td>
<td>Directed Enhanced Service</td>
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<tr>
<td>DHSC</td>
<td>Department of Health and Social Care</td>
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<td>DTOC</td>
<td>Delayed transfer of care</td>
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<td>ECCH</td>
<td>East Coast Community Healthcare CIC</td>
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<td>ECDS</td>
<td>Emergency Care Data Set</td>
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<td>EHCH</td>
<td>Enhanced Health in Care Homes</td>
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<td>EHCP</td>
<td>Education, Health and Care Plan</td>
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<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>EPR</td>
<td>Electronic patient record</td>
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<tr>
<td>EPS</td>
<td>Electronic Prescription Service</td>
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<tr>
<td>ESCAPE</td>
<td>Enabling Self-management and Coping with Arthritic Pain through Exercise</td>
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<tr>
<td>FCP</td>
<td>First Contact Practitioners</td>
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<tr>
<td>JPUH</td>
<td>James Paget University Hospitals NHS Foundation Trust</td>
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<tr>
<td>RF</td>
<td>Financial Recovery Fund</td>
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<tr>
<td>FTE</td>
<td>Full-time equivalent</td>
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<tr>
<td>GIRFT</td>
<td>Getting It Right First Time</td>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
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<td>GP</td>
<td>General practitioner</td>
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<td>GPPO</td>
<td>General Practice Provider Organisation</td>
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<td>HCP</td>
<td>Healthy Child Programme</td>
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<td>HEE</td>
<td>Health Education England</td>
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<td>HPV</td>
<td>Human papilloma virus</td>
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<td>HWB</td>
<td>Health and wellbeing board</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>IC24</td>
<td>Integrated Care 24</td>
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<td>ICC</td>
<td>Integrated Care Coordinator</td>
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<td>ICES</td>
<td>Integrated Community Equipment Services</td>
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<td>ICP</td>
<td>Integrated Care Provider</td>
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<td>ICS</td>
<td>Integrated Care System</td>
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<td>IPS</td>
<td>Individual Placement and Support</td>
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<td>JSNA</td>
<td>Joint Strategic Needs Assessment</td>
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<tr>
<td>LAC</td>
<td>Looked After Child</td>
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<td>LD</td>
<td>Learning Disability</td>
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<td>LDG</td>
<td>Local Delivery Group</td>
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<tr>
<td>LeDeR</td>
<td>Learning Disabilities Mortality Review Programme</td>
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<tr>
<td>LGBT+</td>
<td>Lesbian, Gay, Bisexual, Transgender</td>
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<tr>
<td>LHCR</td>
<td>Local Health and Care Records</td>
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<tr>
<td>LoS</td>
<td>Length of stay</td>
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<tr>
<td>LTC</td>
<td>Long-term condition</td>
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<tr>
<td>LTP</td>
<td>Long Term Plan</td>
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<td>MCP</td>
<td>Multispeciality community provider</td>
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<td>MDT</td>
<td>Multidisciplinary team</td>
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<tr>
<td>MHST</td>
<td>Mental Health Support Team</td>
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<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
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<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MSK</td>
<td>Musculoskeletal</td>
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<tr>
<td>NCC</td>
<td>Norfolk County Council</td>
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<td>NCH&amp;C</td>
<td>Norfolk Community Health and Care NHS Trust</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHSE</td>
<td>NHS England</td>
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<td>NHSI</td>
<td>NHS Improvement</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
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<tr>
<td>NMC</td>
<td>Nursing and Midwifery Council</td>
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<tr>
<td>NNUH</td>
<td>Norfolk and Norwich University Hospitals NHS Foundation Trust</td>
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<tr>
<td>NSFT</td>
<td>Norfolk and Suffolk NHS Foundation Trust</td>
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<tr>
<td>OT</td>
<td>Occupational therapy / Occupational therapist</td>
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<tr>
<td>PACS</td>
<td>Primary Acute Care Systems</td>
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<tr>
<td>PCN</td>
<td>Primary Care Network</td>
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<tr>
<td>PHB</td>
<td>Personal health budget</td>
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<tr>
<td>PHE</td>
<td>Public Health England</td>
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<tr>
<td>PHR</td>
<td>Personal health record</td>
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<tr>
<td>QEH</td>
<td>Queen Elizabeth Hospital King’s Lynn NHS Foundation Trust</td>
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<tr>
<td>QI</td>
<td>Quality Improvement</td>
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<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework</td>
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<tr>
<td>R&amp;D</td>
<td>Research and development</td>
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<tr>
<td>RDC</td>
<td>Rapid Diagnostic Centre</td>
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<td>RTT</td>
<td>Referral to treatment</td>
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<tr>
<td>SaLT</td>
<td>Speech and Language Therapy</td>
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<tr>
<td>SBLCB</td>
<td>Saving Babies Lives Care Bundle</td>
</tr>
<tr>
<td>SCC</td>
<td>Suffolk County Council</td>
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<tr>
<td>SDEC</td>
<td>Same Day Emergency Care</td>
</tr>
<tr>
<td>SEND</td>
<td>Special Educational Needs and / or Disabilities</td>
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<tr>
<td>SMI</td>
<td>Serious Mental Illness</td>
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<tr>
<td>SSNAP</td>
<td>Sentinel Stroke National Audit Programme</td>
</tr>
<tr>
<td>STAMP</td>
<td>Supporting Treatment and Appropriate Medication in Paediatrics</td>
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<tr>
<td>STOMP</td>
<td>Stopping over medication of people with a learning disability autism or both</td>
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<tr>
<td>STP</td>
<td>Sustainability and Transformation Partnership</td>
</tr>
<tr>
<td>UEA</td>
<td>University of East Anglia</td>
</tr>
<tr>
<td>UTC</td>
<td>Urgent Treatment Centre</td>
</tr>
<tr>
<td>VCSE</td>
<td>Voluntary, Community and Social Enterprise</td>
</tr>
</tbody>
</table>