NHS
West Norfolk Clinical Commissioning Group

Norfolk & Waveney Sustainability and Transformation Plan

Briefing Paper for

Environment & Community Panel

17th January 2017

This presentation provides:

1. The Norfolk and Waveney STP
2. A summary of the challenges facing The Norfolk and Waveney Health and Social Care System
3. An indication of the overall 'solutions' to the challenges
4. The next steps

Working together to tackle these challenges

Sustainability and Transformation Plans:

- A national policy initiative that are part of the delivery of the NHS **Five Year Forward View** (5YFV) - the shared vision for the future of the NHS, including the **new models of care.**
- 44 **place-based**, **system-wide** plans for **health and social care.**
- Aim to improve the health of the population, the quality of care for patients and the efficiency and productivity of the NHS by 2020/21.

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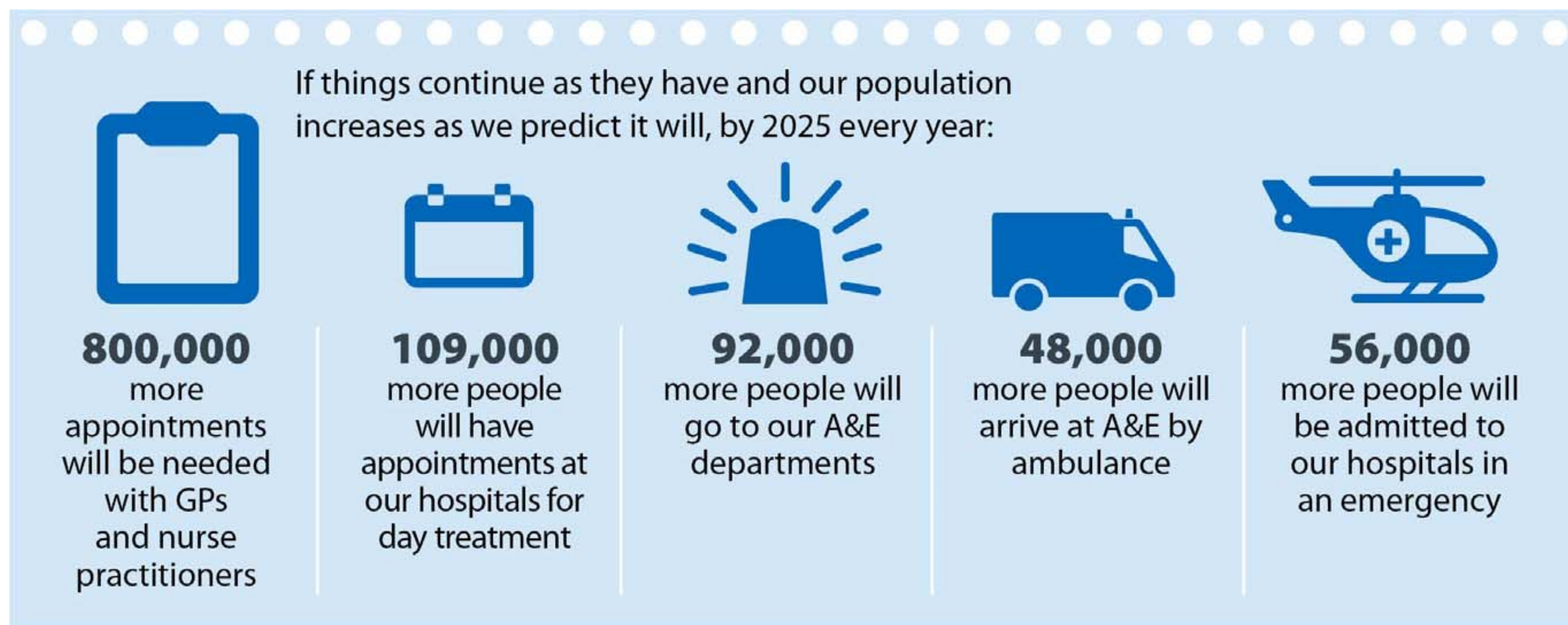
Norfolk and Waveney's STP

- NHS West Norfolk CCG
- NHS North Norfolk CCG
- NHS Norwich CCG
- NHS South Norfolk CCG
- NHS Great Yarmouth and Waveney CCG
- East of England Ambulance Service NHS Trust
- Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- James Paget University Hospitals NHS Foundation Trust
- Norfolk County Council
- Norfolk and Suffolk NHS Foundation Trust
- East Coast Community Healthcare CIC
- Norfolk Community Health and Care NHS Trust
- Norfolk Independent Care
- Norfolk and Waveney Local Medical Committee
- Healthwatch Norfolk
- IC24
- District, borough and city councils

Where we are now

- Our population is growing and changing
- The type of care that people need is changing
- We need to make our services more efficient
- Doing nothing is not an option. If we do nothing, in five years' time we would overspend by £409 million in just one year.


If things continue as they have and our population increases as we predict it will, by 2025 every year:
800,000
more appointments will be needed with GPs and nurse practitioners
109,000
more people will have appointments at our hospitals for day treatment
92,000
more people will go to our A&E departments
48,000
more people will arrive at A&E by ambulance
56,000
more people will be admitted to our hospitals in an emergency

If trends in obesity continue then by 2020 we estimate that obesity will contribute to:

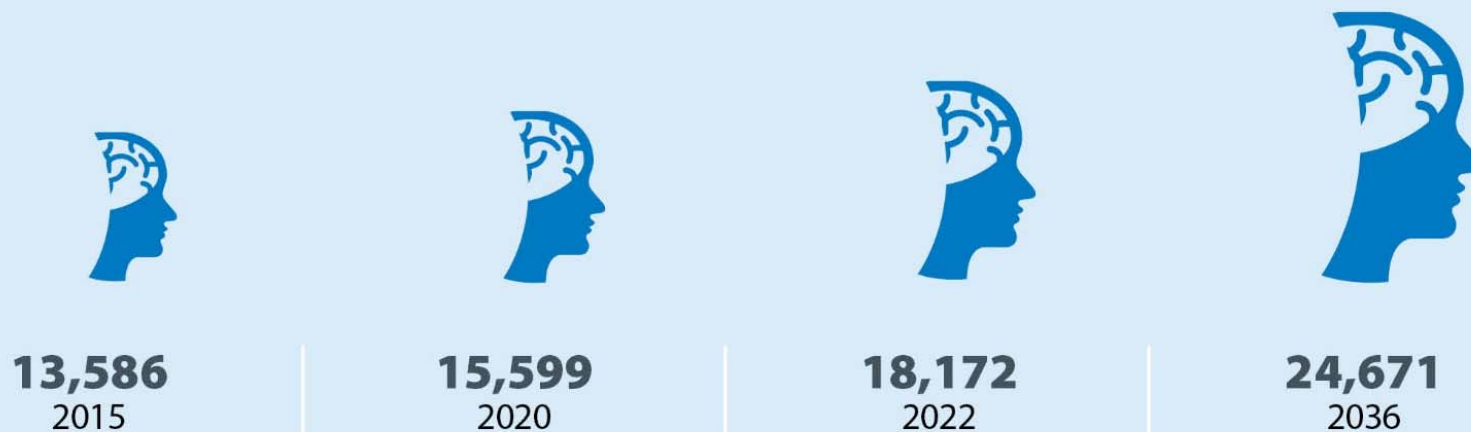
7,100
more people having coronary heart disease

2,100
more people suffering from a stroke

100,000
more people with hypertension

50,000
more people getting diabetes

If this happens then obesity will cost local health and social services more than £100 million per year by 2020.


Number of people with dementia in Norfolk and Waveney
13,586
2015
15,599
2020
18,172
2022
24,671
2036
Source POPPI and PANSI 2009

Case for Change – the 'do nothing' scenario

Population

4% increase 2015-2021

Elderly Population Growth vs 2016

	2021	2025
75+	18%	38%
85+	18%	38%

~1500 more people aged 85+ per year

plus chronic disease increases

Acute Activity by 2021

A&E Attendances 2015/16 - 232,000 2020/21 ⬆34,000

Emergency Admissions 2015/16 - 103,000 2020/21 ⬆22,000

Current acute models of care would require by 2021.....

- 315 additional General & Acute beds
- 101 additional Consultants
- 522 additional Nurses

....these are not feasible solutions

Out of Hospital Pressures

Social Care Impact (by 2025)

- 2x as much sheltered housing
- 7x as much housing with care
- 2x as many nursing beds
- 1.5x as many residential beds

Additional Primary Care Workforce (FTEs in 2021)

- 99 additional GPs
- 60 additional Nurses

Financial Impact in 2021 (Revenue)

£349m NHS Deficit + £93m Social Care Deficit = £442m Total

Key: = 20,000 = 5,000 = 2,000

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Guidance from NHS England

NHS England guidance says that STPs must set out how an area will:

- Strengthen and invest in primary care in line with the GP Forward View.
- Deliver the A&E and ambulance standards, simplify the urgent and emergency care system and make it more accessible to patients.
- Make tangible improvements to mental health and cancer services, and for people with learning disabilities.
- Prevent illness, empowering people to look after their own health and to prevent avoidable hospital stays.
- Improve the quality of hospital services, including maternity services, and deliver the RTT access standard.
- Create a financially sustainable health system for the future.

Source: NHS Operational Planning and Contracting Guidance 2017-2019 (September 2016)

The STP timetable

- June 30 – initial submission to NHS England
- August 15 – KPMG engaged
- October 7 – Publication of “In Good Health” and June submission
- October 17 to 21 – Council, all Trust Boards, HWB and CCG Governing Body meetings
- October 21 – Submission to NHS England
- November to December – Wider engagement and detailed planning
- November 24 – Submission of full draft 2017/18 to 2018/19 Operating Plans
- December 23 – Submission of final 2017/18 to 2018/19 Operating Plans and signed contracts

- January to March 2017
  - Detailed Planning for each Delivery Workstream
  - Revised governance arrangements agreed and established
  - Recruitment and mobilisation of core team to include additional capacity for Programme Management, Communications & Engagement, Finance and Business Intelligence
- April 2017 onwards – Design and implementation including formal consultation on service changes

The Financial Assumptions

If the system "does nothing" there will be a big financial gap by 2020/21 because:

- Demand for services exceeds the income available
- Many NHS organisations are currently running a deficit

Financial gap in "do nothing" scenario	2015/16 £m	2016/17 £m
CCGs	16	148
NHS Providers	57	144
Specialist Commissioning	0	25
Social Care	18	99
Total	90	416

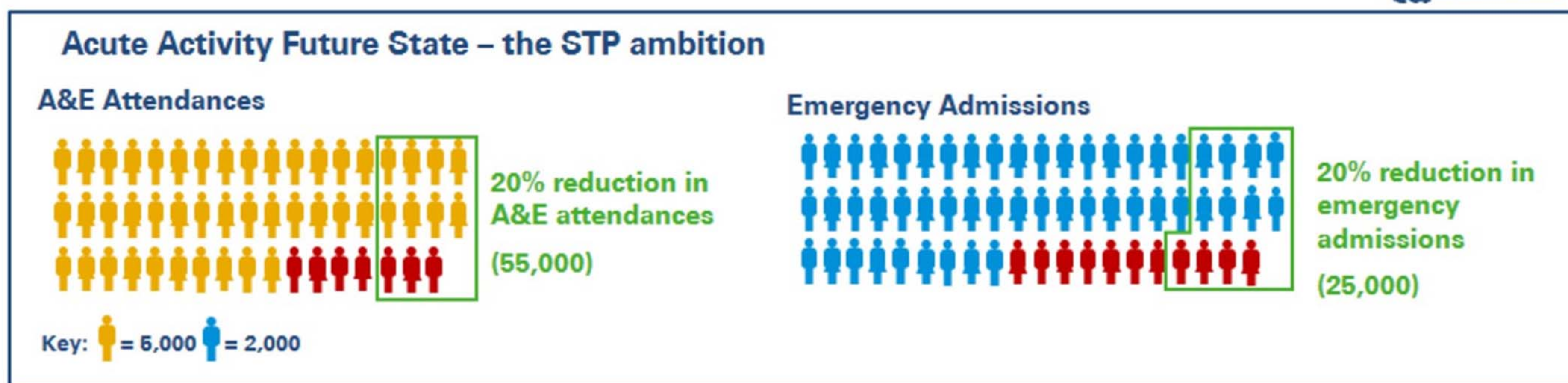
Filling the Gap

- The plan is to fill the gap through:

- “Productivity” = Provider (eg: doing the same activity for a lower cost) and CCG Savings (eg: paying less for providers doing the same activity)
- “Transformation” = Achieving the same outcomes for patients (or better ones) by changing the pathways and doing activity in better and cheaper settings (eg: supporting people at home rather than in expensive hospital beds; taking out unnecessary steps in a pathway)

Neither of the above are “cuts” as such but doing a lot more with the same or slightly more funding.

Reducing Acute Activity – Demand management



Solutions

Primary, Community & Social Care	Target cohort of 0-1 day LoS • Residential/care home telehealth (Airedale model) • 111 with GP input • Clinical Hub to reduce ambulance conveyance	Target cohort of >1 day LoS • Out of Hospital Teams supporting complex patients
	• Other solutions e.g. Primary care structure/access (Workshop II), Out of Hospital teams (see later)	

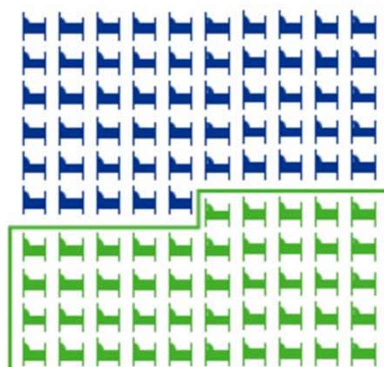
Acutes	• Solutions in development	Mental Health & Prevention	• Solutions in development (Workshop II)

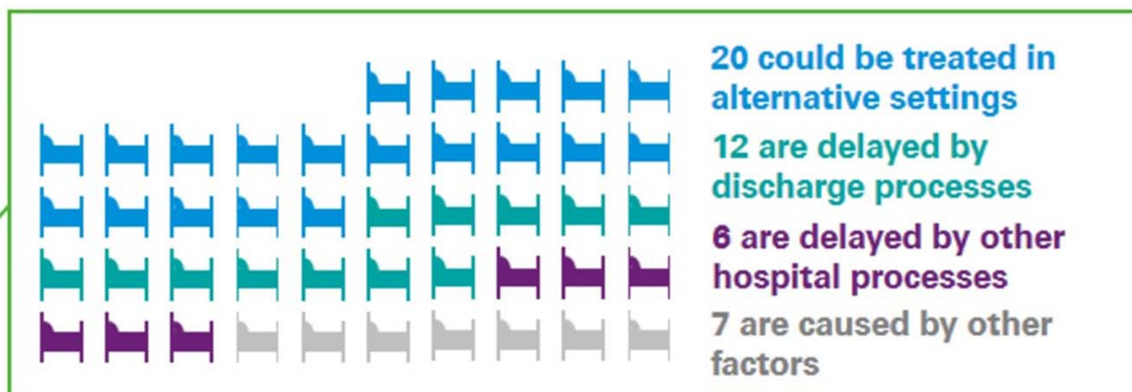
NHS

Reducing Acute Activity – Reducing Length of Stay

Oak Group Report found that for every 100 bed days

45 don't need to be in hospital





STP Ambition

Reduce the number of bed days by 20% through improved community care

Reduce the number of bed days by 15% through improved discharge and hospital processes

Key targets: Those with LoS >1 day, complex and frail elderly patients

Solutions

Integrated Out of Hospital Teams

& Solutions reducing admissions

Improved internal acute processes (Keogh review)

Improved system discharge processes

Prevention & Good Health in Communities

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Key Workstream Objectives

- Prevention and wellbeing
  - Improve prevention, detection and management of **major chronic illnesses**.
  - Increase individual and community capacity for **self-care**.
  - Development of **social prescribing** model.
- Primary Care - Development of primary care provision model that improves **access and capacity** and addresses **retention and recruitment**
- Integrated Models of Care - Development and implementation of **optimal integrated care models** by locality to ensure **consistency** and **reduced variation** across Norfolk & Waveney

Priority Projects

1. Target conditions – Obesity and diabetes, including Making Every Contact Count
2. Social determinants of health –Social prescribing
3. Optimising Health Care through a Right Care Approach
4. GP input into 111
5. Ambulance conveyance
6. Same day access to primary care
7. Improving primary care access & capacity through phone triage, pharmacy support and sharing of Resources
8. Improving Staff Retention & Recruitment within Primary Care
9. Out of hospital integrated teams
10. Social Care transformation
11. Telemedicine for residential care
12. Individualised Care Planning and Co-ordination

Demand Management

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Key Workstream Objectives

Managing the flows of patients into elective care by:

- Ensuring only **procedures of clinical value** are commissioned and provided
- Ensuring CCGs adopt consistent **clinical policies and procedures** across the system
- Ensuring **effective pathways** are in place and complied with
- Ensuring consistent approaches to demand and referral management and **reducing unnecessary variation** in referral

Ensuring there is **good access to a range of providers** and encouraging more delivery in the **community** where appropriate

Ensuring our provider infrastructure has the **capacity** to deliver the care it needs and ensure **equitable access**

Ensuring we have good quality, consistent, up to date **data systems** that help us track, review and adjust patient flows

Delivering **savings** to the system

Priority Projects

1. Developing an up to date Demand & Capacity model for Norfolk & Waveney
2. Implementing the "Right Care" programme, focusing on the areas of highest impact
3. Developing an education programme to develop best clinical practice
4. Addressing and clearing the RTT (Referral to Treatment) backlog
5. Delivering agreed QIPP (Quality, Innovation, Productivity and Prevention) objectives

Acute Care Reform

Key Workstream Objectives

- Developing the **strategic direction** for acute services delivery and exploring opportunities for back office efficiencies between the acute, community and mental health providers
- Reducing acute activity:
  - **Improved demand management** (supporting the other work streams to deliver admission avoidance schemes)
  - **Reduced length of stay** by improving the process of care
- Ensuring **acute clinical service sustainability** at an STP footprint level across the key nominated specialty areas and their interdependencies

Priority Projects

1. Acute Services Review Phase 2
2. The development of a sustainable capacity solution to RTT workload across the three acute Trust sites
3. Taking forward the Carter Review reforms
4. Identifying and delivering ‘back office’ opportunities for the constituent providers

Mental Health Reform

Key Workstream Objectives

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

Priority Projects

1. Enhance community provision that supports people with dementia in the community, promoting a "shift left" in provision, whilst supporting the projected increases in population
2. Implement a consistent Mental Health liaison service across N&W
3. Supporting people with Mental Health Co-morbidities

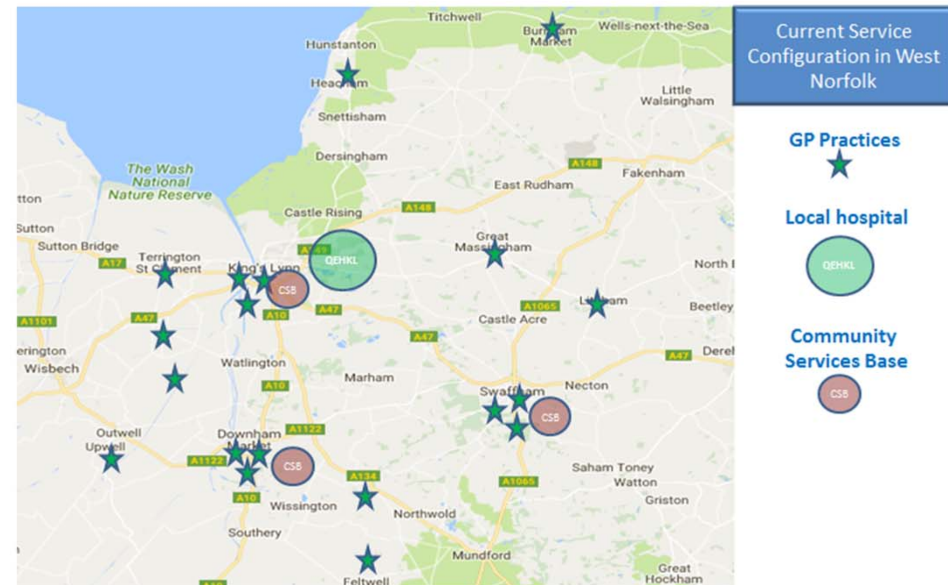
Our Vision

Our Vision is: **"for the people of West Norfolk to have high quality care, delivered locally, within our available resources"**

Our vision for how health and social care will be delivered in West Norfolk by 2021 is ***"a thriving local hospital, a strong and united network of GPs,and a group of Out-of-Hospital providers of physical, mental health and social care services, all of whom behave as one integrated 'whole system' delivering high quality care by staff who are proud to work and live in West Norfolk"***

This future Vision of one integrated whole system assumes that the organisations delivering health and social care in West Norfolk will be reduced in number to enable the model to be created. This does not mean less staff providing services, rather, it means more flexibility about redeploying resources to the place they are needed by reducing duplicated tasks, functions and roles. This will increase the effectiveness and responsiveness of face-to-face patient and resident care and reduce bureaucracy and overlaps between the many organisations involved.

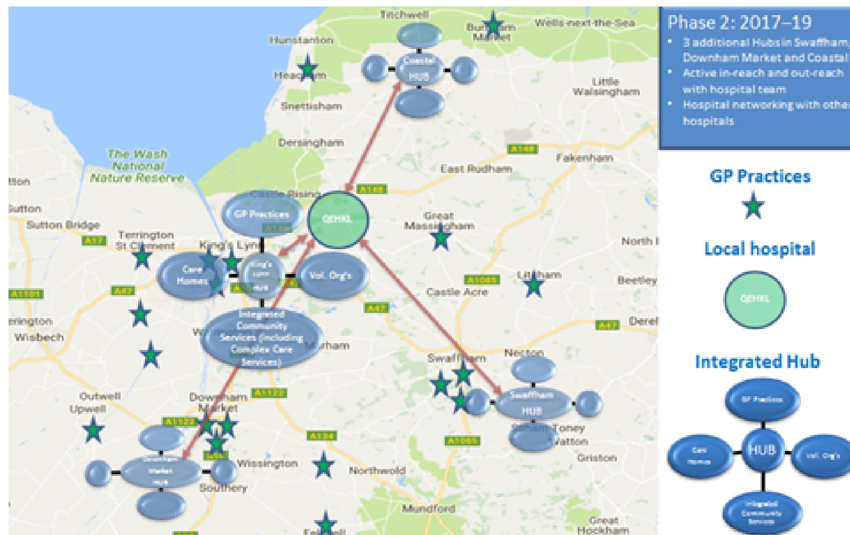
Figure 4: Current Service Configuration in West Norfolk



An evolving transformation in phases is depicted in illustrations from Figures 4 to 7. This vision has been articulated and discussed over a number of years with the West Norfolk Alliance and the current financial and political drivers make it an urgent, imperative action.

For West Norfolk, this means starting with one integrated community complex care hub in King's Lynn (see Figure 5), incrementally adding formal and informal services that work together through arrangements such as honorary contracts and risk-sharing agreements. Out of necessity, this will initially be limited by the clinical space available currently but over the next 12 months, a capacity and fitness review will be conducted of all 'public estate' to determine the opportunities to

Figure 6: Phase 2 2017-19: Additional Hubs and Hospital Outreach/Networking



accommodate the various developments planned that require premises and could potentially be delivered in the same space. For example, General Practice bids for new premises are being considered by NHS England at the same time as the West Norfolk Transformation Plan is working up proposals for community complex care hubs, acute mental health facilities and emergency primary and secondary care collaboration. These need to be considered in totality, with all agencies working to one local vision. Ultimately, the West Norfolk Transformation Plan will recommend a series of reform proposals for consideration by each organisation, to move from the current state to a future, reduced number of organisations, working as one integrated care delivery system (see Figure 7). The financial impact this would have on individual organisations and on the future sustainability of local services will be a key focus for the programme.

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

Figure 7: Phase 3 2019-21: Accountable Care Organisation