Suffolk County Council

Norfolk County Council

NHS
the Clinical Commissioning Groups for
Great Yarmouth and Waveney,
North Norfolk, South Norfolk
West Norfolk and Norwich

Norfolk and Waveney CCGs Commissioning for 2017/18 – 2018/19

Contents

Executive Summary

In keeping with the footprint of the Sustainability and Transformation Plan, this document represents the single view of Norfolk and Waveney CCGs and their commissioning plans for the next two years.

Significant changes are required within the NHS to ensure it adapts to the world around it and in keeping with the need to change, this document differs significantly from the normal approach to commissioning intentions.

For each of the key domains within the NHS, the document details the high level strategy of the CCGs and practical examples of how this will be implemented.

Across planned care, CCGs will look to standardise pathways across Providers and improve the value of our offer to our populations. We will continue to shift work out of secondary care and closer to

patients. Whilst out of hospital models will be tailored to local need, there is a very clear and consistent consensus across all CCGs for models to be centred around primary care with an investment in primary and community care to reduce the need for people to go to hospital unless really necessary and a resulting shift of activity away from secondary care.

Within urgent and emergency care, the solution to a sustainable model of care lies both in the management of patients prior to attendance at a Provider and then what happens to them should there not be any alternatives than secondary care with this document setting out the specifics for how this will be achieved.

CCGs will continue to offer parity of esteem for mental health and, working with Norfolk and Suffolk County Council and wider partners, are committed to taking forward a system wide transformational approach to securing future mental health service provision.

Finally, contractual mechanisms will be developed around the principles above and used to catalyse the changes required.

Introduction

The local health and care system needs to change. Everyone reading this document will be aware of this fact and no doubt have been for some time. Arguably though, the evidence of this has never been greater than that seen in the last two years. This document sets out the views of the Norfolk and Waveney CCGs in collaboration with the Adult Care Departments of the County Councils on how this will be achieved and should be read in conjunction with the Norfolk and Waveney Sustainability and Transformation Plan (STP), the recently published NHS Planning Guidance as well as Provider specific coding and counting letters which may be issued (where necessary) by Coordinating Commissioners alongside this document.

We should rightly be proud of the services being delivered. Over the past few years, the NHS has improved significantly – cancer outcomes have improved, avoidable deaths have decreased, waiting times have generally shortened and public satisfaction with the NHS has increased.

At the same time, demand on the NHS has increased. Long term conditions now account for a much larger percentage of the NHS budget, people are living longer, new technologies and drugs are driving new treatments and patients expectations are increasing. Unfortunately, funding for the NHS has not followed this rise in demand and has led to a system that is unsustainable if it does not adapt to the world around it. If we do not change we will face a gap of almost £500m across the Norfolk and Waveney Health System by 2020/21. We need significant and rapid transformational change to bridge that gap.

This transformation can only be achieved by continuing to work jointly with colleagues across the health and social care system to bring about improved outcomes for our communities. Consistent with the footprint of the Sustainability and Transformation Plan, this document outlines the collective view of the five Norfolk and Waveney CCGs

- NHS North Norfolk CCG
- NHS Norwich CCG
- NHS South Norfolk CCG
- NHS West Norfolk CCG
- NHS Great Yarmouth and Waveney CCG

It shows how we intend to commission services to meet the needs of our local populations and, for the first time, we also include the commissioning intentions of Norfolk and Suffolk County Councils relevant to health.

As the name of the document reflects and in recognition of the change required, these intentions differ from the normal approach:

- This document sets out the Commissioners intentions for the next two years (i.e. through to the end of March 2019) in recognition of the need to take a 'forward view'.
- Commissioners have moved away from Provider specific intentions and towards intentions for sectors. This is in recognition of the changes likely to be seen within the system as a result of the move towards new models of care and the fact that the current organisation form of both Providers and Commissioners may not exist in the same way by the end of this transition. In some cases, e.g. acute and mental health services, this is likely to result in a transfer of activity to the community and in other cases, e.g. community services, it is likely that this will form part of new community based models of integrated working rather than the current disjointed delivery seen in current organisational entities.
- Over the course of the next two years, Commissioners will increasingly look to commission services based on outcomes rather than activity – not to replace traditional key performance indicators but to be the primary source of evidence for a services effectiveness (in addition to core standards like waiting times etc.).
- This document focuses on the high level vision for care in Norfolk and Waveney with a deliberate movement away from more service specific intentions. Whilst previous intentions had greater detail, they were isolated to specific areas and did not reflect the breadth of work that needs to take place. That said, the document does provide examples of how our vision will be implemented in some of the domains below therefore should be regarded by Providers as our issued commissioning intentions as part of the commissioning cycle. Detailed contracts will emerge through the process of negotiation with providers that will take place up to the 23rd of December 2016, when it is intended all contracts will have been agreed.
- Commissioners have joined together across Norfolk and Waveney with one voice, under the same footprint as that of the STP, to reflect the fact that there needs to be a more integrated approach so that all citizens can expect to receive the same standards of care. There will continue to be local differences in how services need to be delivered to reflect local circumstances. The Standard NHS Contract has adapted somewhat to the changes being seen in the health system. Commissioners welcome the option for shortened notice periods and the opportunity they present as a catalyst in implementing changes that are beneficial for patients. We are also conscious that they serve to provide stability for Providers. Going forward, Commissioners will attempt to balance Provider stability whilst also having an expectation that changes resulting in improvements for patients will not be unnecessarily delayed.
- This document is designed to help develop a more constructive dialogue with our providers, to help them plan for the longer-term and be equal partners in transforming the NHS for the benefit of the population of Norfolk and Waveney.

This document is not exhaustive, and will be subject to change following the publication of further national guidance therefore Commissioners reserve the right to amend or add to the areas listed. Equally the document is intended to prompt a discussion with Providers which may lead to further

revisions of this document, hence the document being a 'draft'. The issue of this document does not limit the opportunity for Commissioners to refine or initiate new service improvements/clinical pathways during 2017/19 or the term of any contracts agreed, where we believe it is in the best interest of patient care to do so. Neither does this document in any way limit opportunities for the Commissioners to refine nor initiate new service improvements/clinical pathways agreed during previous years or further opportunities that may emerge from our engagement with Providers in the planning round.

The Commissioners are committed to developing a health system that has patient pathways that flow across health sectors with all Providers playing their part to improve the quality of services and the patient experience.

As is explained throughout the document, the NHS will look very different in two years' time to what it does now. This offers significant opportunity for all Providers, but not least primary care which is at the centre of how improved community services will be co-ordinated and delivered. It is clear that the infrastructure is not in place in primary care currently to mobilise in the way in which the national direction requires. As part of the transition to full primary care co-commissioning, CCGs are committed to working with primary care to ensure this infrastructure is put in place.

Listed below are the key domains (planned care, urgent and emergency care, mental health and learning disabilities, children's and young people, out of hospital, cancer, palliative and end of life care and finance) within the Norfolk and Waveney health and social care system and the corresponding priorities of each. Reflected within these is an acknowledgement of the nine national 'must dos' and Norfolk and Waveney's intentions for how these will be achieved.

Planned Care

There is considerable variation in planned care activity both between CCGs and within each CCG area. Whilst some of this is explainable, a large proportion of this is for reasons which are not obviously a consequence of relative health need in the population. We will continue to use both local analysis and comparative information (such as "Right Care") to review the priority areas identified within the STP, as well as local specific opportunities and then take this forward with clinicians across the system.

We wish to adopt a more common methodology in future, using the "Right Care" approach which has already been piloted in the Great Yarmouth and Waveney system and follows the process below:

- Analyse existing activity, demand, capacity and costs
- Understand current pathway(s)
- Review "best practice" work on clinical pathway(s)
- Agree changes to/new clinical pathways
- Agree arrangements for providing services to achieve the above (including organisation(s) and funding
- Implement
- Review

Our overall aim is to achieve the best possible outcomes for individuals within agreed pathways. In most cases, achieving the best outcomes for patients will equally deliver best value which encompasses both productivity and efficiency. This principle will be followed across Norfolk and

Waveney CCGs and, unless there is a compelling case for a localised approach, work undertaken in each CCG area will be rolled out across Norfolk and Waveney CCGs.

By promoting a whole system approach our aim is to "transform" planned care in such a way that it can be delivered locally within an agreed financial envelope. There are a number of important principles that will govern this work.

- We will change how we undertake planned care so that we can achieve the desired outcomes for patients at a lower unit cost across the system.
- We will actively look to shift work from secondary care to out of hospital where appropriate (although this does not have to result in a change of Provider). Examples of specialties where work is already taking place include, but is not limited to, dermatology, ophthalmology, audiology and cancer.
- We will look to increase integration across Providers. This will be done in the form of integrated pathways across Providers, focusing on pathway specific specifications as opposed to being Provider specific. We will also only look to commission where capacity is available which could mean that certain specialties are no longer provided at hospitals where consultants are not available.
- Whilst needing to work within the legal framework that relates to choice and competition we are seeking to achieve our aims through a collaborative and partnership approach.
- We will utilise our current Better Care Fund Programme Board and local integrated governance structures to enhance integrated developments across the health and social care system.
- We recognise that there are a range of clinical and financial inter-dependencies between the delivery of planned care services and unplanned services within our acute hospitals. Any change in either who, how, or where, planned care is undertaken will fully take this into account to ensure that we are able to maintain a thriving and sustainable local hospitals along with a strong and integrated primary and community care system.

Our approach to planned care will be a progressive one over a period of time. CCGs have already begun reviewing local processes of pathway design and this will continue into 2017/18 and beyond but with more consistency across the Norfolk and Waveney CCG footprint. Pathway analysis will cover everything from pre-referral through assessment and diagnosis to specific operation and procedure interventions, subsequent follow-up, recovery and leading as fulfilling lives as possible.

We are conscious of the ability of our Providers to accommodate the current levels of demand and so part of our focus will be on introducing new pathways that utilise less capacity within secondary care hospitals. Equally though, we must appreciate that for a given cohort of patients, a secondary care hospital may present the only feasible option and this needs to be accommodated within the Providers capacity planning. In some areas, this will require a more collaborative approach between the CCGs and our NHS Trust Providers.

In addition to the strategic detail highlighted above, areas of focus across the Norfolk and Waveney footprint are identified below:

- We wish to explore the potential for a system which GP and other referrers can access for advice from a secondary care consultant prior to referral. Included within this will be a review of the effectiveness of specialist nurse help lines. Alongside this, we will look to implement a referral information system that GP practices shall access from a one stop shop

to local and national guidance and information, required to support day to day patient care for primary care staff (and health and social care staff where relevant). With the aim of reducing variation, prioritising pathway development and providing smarter ways of clinical working. This action may lead to the decommissioning of Knowledge Anglia.

- We wish to improve the efficiency of the follow up process within secondary care. This includes the use of telephone follow ups, consistent thresholds (where justifiable) across contracts but will also acknowledge clinical concerns and the reasons for current behaviour (if due to a lack of commissioned services).
- There will be the expectation that any procedure that is clinically appropriate to be performed as an outpatient procedure will be performed and billed as such regardless of the setting in order to support the transition of these activities to the community services e.g. intravitreal injections, skin excisions.
- We will implement a consistent prior approval/procedures of limited clinical value policy that will be clinically informed and will reduce demand where there is not a strong clinical case for its efficacy.
- We will utilise all capacity available to Commissioners outside of secondary care to cater for patients that would otherwise need to be seen within secondary care. Furthermore, we will explore ways to influence the movement of patients to these Providers.
- We will roll out a new diabetes prevention service that provides targeted intervention and education for patients and aiming to either prevent or delay the onset of diabetes.
- We will continue to work with clinicians in primary and secondary care to develop pathways in light of new national guidance, e.g. NICE and will look to primary and secondary care to adhere to these.
- We will continue to monitor primary care variation and work with clinicians to understand and eliminate any unexplainable variation.
- Shared focus on achieving best value from supplies of equipment e.g. wheelchairs, orthotic products, insulin pumps, continence products including how personal health budgets might support choice and good value.
- We will work to implement consistent eligibility criteria across Norfolk and Waveney CCGs for non-emergency patient transport.
- Where patients can be followed up in the community there will be an expectation that the acute providers and the community services will collaborate to provide a seamless service closer to the patients home, e.g. cataracts/glaucoma.
- We will review the viability of the community paediatric team in its current form and consider alternatives to make the service more sustainable.

In addition to the above, there are proposals specific to certain CCGs.

- Across Central Norfolk CCGs, we will introduce a revised foot and ankle pathway across the system for both adults and children that will focus on patients seeing the right clinician at the first time of asking and will also reduce unnecessary demand.
- Across Central Norfolk CCGs, we will review the provision of epilepsy specialist nursing and its impact on reducing emergency admissions.
- Across Central Norfolk and Great Yarmouth and Waveney CCGs, we will review rehabilitation services with specific focus on why two services are delivered both in secondary care and the community. This is with a view to the potential rationalisation of such services.

- Across Central Norfolk CCGs, we will look to commission a new treatment service within community inpatient units that can accommodate cohorts of patients currently being treated within secondary acute hospitals, e.g. iron infusions.
- Across Central Norfolk, we will look to re-commission a Level 2 Fertility service directly with the successful bidder.
- Across Central Norfolk and Great Yarmouth and Waveney CCGs, we will review the use of ultrasound guided injections, the volumes undertaken and the pathways into the service.
- In North and South Norfolk, we will introduce a new respiratory service within the community that acts as an intermediary between primary and secondary care, both preventing referrals to secondary care and catering for earlier discharge from secondary care.
- In Great Yarmouth and Waveney CCG we will continue working to provide an integrated pain service linking the acute, community, primary care and mental health services.

Urgent and Emergency Care

The provision of a sustainable urgent and emergency care service remains a key priority going into 2017/18 and beyond. As is referenced throughout this document, transformational change is required alongside operational management to ensure this happens. Solutions to achieve this will be based on the agreed Norfolk and Waveney STP guiding principles, our systems overarching priority of "keeping me at home" and will be consistent with the wider strategy as set out in the Urgent and Emergency Care Review.

Norfolk and Waveney CCGs will take heed of national guidance and work with Providers to implement the five 'must dos':

1. Streaming at the front door – to ambulatory and primary care. This will reduce waits and improve flow through emergency departments by allowing staff in the main department to focus on patients with more complex conditions.
2. NHS 111 – Increasing the number of calls transferred for clinical advice'. This will decrease call transfers to ambulance services and reduce A&E attendances.
3. Ambulances – Dispatch on Disposition (DoD) and code review pilots; HEE increasing workforce. This will help the system move towards the best model to enhance patient outcomes by ensuring all those who contact the ambulance service receive an appropriate and timely clinician and transport response. The aim is for a decrease in conveyance and an increase in 'hear and treat' and 'see and treat' to divert patients away from the ED.
4. Improved flow – 'must do's that each Trust should implement to enhance patient flow. This will reduce inpatient bed occupancy, reduce length of stay, and implementation of the 'SAFER' bundle will facilitate clinicians working collaboratively in the best interests of patients.
5. Discharge – mandating 'Discharge to Assess' and 'trusted assessor' type models. All systems moving to a 'Discharge to Assess' model will greatly reduce delays in discharging and points to home as the first port of call if clinically appropriate. This will require close working with local authorities on social care to ensure successful implementation for the whole health and care system.

Equally, Commissioners will take heed of the demand management guide and expect that all providers will engage and agree the demand management plans.

The solution to a sustainable model of care lies both in the management of patients prior to attendance at a Provider (i.e. the typically transformational change) and then what happens to them should there not be any alternatives than secondary care.

Beginning with the former, the primary aim to the management of patients prior to referral is to identify those whose care can be provided in an out of hospital setting and thus minimising onward transfer to 999 and Acute Care. The specific intentions we have for affecting this change involve:

- The development of the integrated clinical hub model to manage 111 and 999 calls both in and out of hours. We will consider options to expand this to cover management of demand for all same day/urgent care requirements.
- The development of Single Points of Access into Providers in order to manage demand, effect clinically appropriate access and aid flow through to discharge and recovery applicable to all Providers including secondary care and mental health.
- Collaboratively working to share and review data to identify gaps in pathways, service provision and or communication/understanding of services available. This will be supported by ensuring that the Directory of Services is up to date, accurate and its use and functionality is maximised.
- The development of a 'Supported Care' service focused on providing support to patients to enable them to be care for in their own home, preventing the chances of emergency admission and a potential resulting stay in a community inpatient unit.
- Building on the 2016/17 Frailty CQUIN, CCGs wish to focus on the identification of the pre-frail and align services to support such patients and carers to minimise risk of escalation.

For those patients who do require further care, a more sustainable solution needs to be in place that does not result in patients defaulting to A&E departments. Commissioners' focus will be on establishing more integrated alternatives to A&E that provide access to same day urgent care and ensure a clinically appropriate response by ambulance services to 999 and with access to timely and clinically appropriate secondary care treatment as required. The specific intentions we have for affecting this change involve:

- Working with EEAST to develop an operational model in order deliver the clinically appropriate response (hear and treat, see and treat or convey) that is integrated across the health system.
- Implementing the NNUH A&E Front Door Redesign model to ensure access to the appropriate clinical intervention, including transfer into secondary care.
- Fully embedding the new contract for delivery of the Norwich GP-led Walk in Centre and develop to support both planned and unplanned care models.
- Reviewing current services for provision of out of hours primary care to identify options for aligning with the integrated model and improving most effective use of that resource.
- Evaluation of the ambulatory care centre at JPUH.

Whilst consortium contracting arrangements for ambulance services may previously have worked on the large scale with which they work at the moment, Commissioners are very keen to move to a model that is less centralised, better reflects the needs of the local population and is integrated with all the other local system changes we expect to see. Norfolk and Waveney will actively explore ways in which we can achieve more local influence and control over how ambulances services fit within our local system and drive better outcomes for our population.

Performance of the system will be measured by the achievement or otherwise of the 4 hour A&E target, achievement of ambulance and A&E handover targets, reduction in unnecessary ambulance conveyances, the achievement of 999 response targets, volume of calls and more crucially, management by 111 and the achievement of their subsequent targets.

Norfolk and Waveney CCGs will also undertake a review of stroke services across the region.

Mental Health and Learning Disabilities

Mental wellbeing is fundamental to a person's quality of life. It is linked to good physical health, better cognitive and physical functioning, increased productivity, better interpersonal relationships, longer life expectancy and a greater capacity to deal with stress and adversity. As in previous years, Norfolk and Waveney CCGs will continue to apply parity of esteem, namely an uplift in funding to the sector consistent with the uplift received by CCGs in the planning guidance.

The challenges the Health and Social Care systems in Norfolk and Waveney face in meeting their population's mental health needs are replicated nationally. Doing nothing is no longer an option. The Norfolk and Waveney CCGs working with Norfolk County Council and wider partners are committed to taking forward a system wide transformational approach to securing future mental health service provision.

In 2017/18 to 2018/19 the predominate focus will be on reviewing key elements of the Norfolk and Waveney mental health system, the determination of future models of care and the commissioning/contracting means by which these will be secured.

This does not mean, however that within the next two year period, mental health service provision will remain static. Norfolk and Waveney CCGs, working with our partners will, continue to move forward with developments in line with the Norfolk and Waveney's STP and driven by:

- NHS England's Five Year Forward View: Implementing the Five Year Forward for Mental Health
- Norfolk County Councils, Promoting Independence Strategy
- The Health and Well-Being Strategy for Norfolk
- Right Care objectives
- Prime Ministers challenge for dementia and;
- Norfolk Children and Young People's Mental Health Local Transformation Plan.

Our vision is to ensure the provision of excellent, safe, sound, supportive, cost effective and transformational services for people with mental health needs that in turn promote independence and empower, wellbeing, and choice and that are shaped by accurate assessments of community needs.

We will do this by focusing on the following key priorities, all of which will be driven forward through the principle of supporting people's mental health needs through securing integrated operating models and responses.

1. Mental health prevention and early intervention including improving quality in services offered locally and within primary care
2. Rehabilitation and recovery; supporting people with complex needs
3. Crisis Care and suicide prevention

4. Securing a future whole systems model to the delivery of Child and Adolescent Mental Health Services (CAMHS) and ensuring the delivery of peri-natal mental health services.

1. Mental health prevention and early intervention including improving quality in services offered locally at within primary care.

Key to this priority is driving forward the development of a more preventative approach to supporting people with mental health needs, that enables early intervention and that is delivered through an integrated approach centred on primary care provision.

We have moved some way forward across Norfolk and Waveney with this aim through the commissioning and implementation of the Well-being service. However further steps need to be taken in moving this model even further in terms of integrated approaches and in supporting the implementation of the related Five Year Forward View for Mental Health expectations: namely:

- Enabling increased access to psychological therapies (19% by 2018/19),
- The further integration of these therapies within physical health care; and
- Ensuring that fully integrated service provision is rolled out from 2018/19
- Improving access to psychological therapies for people with psychosis, bipolar disorder and personality disorder

The provision of timely dementia diagnosis and community based support is key within future models of primary care focused integrated support. Norfolk and Waveney CCGs are not yet meeting the expected national dementia diagnosis rates of 67% and further work is needed to ensure that pathways of care are working to best effect for both patients and their carers. Within the next two years current dementia diagnosis, care, support and treatment will be reviewed within a whole systems approach, with options for future models of delivery determined.

Suffolk ACS intend to continue to work collaboratively across the system to strengthen early intervention and prevention services, crisis and recovery services.

2. Rehabilitation and recovery: supporting people with complex needs

We recognise there is a strong link between the recovery process and social inclusion. As they are developed (in partnership with Providers, and wider partners), new care pathways will be holistic and support people to regain their place in the communities where they live and take part in mainstream activities and opportunities along with everyone else.

New care pathways and service developments will lead to new collaborative commissioning arrangements within the STP that will enable the delivery of new innovative services from 2018/19.

We will be partners in the Norfolk and Suffolk Foundation Trusts commissioning of a robust service capacity assessment, which will have a focus on acute care pathways and associated community services. Within this considerations will be made on the balance of resources between community and inpatient provision.

For patients in acute care and in accordance with Five Year Forward View for Mental Health we will ensure that:

- By the end of 2018/19 53% of those people aged 14-65 experiencing first episode psychosis will have access to NICE compliant services graded at level three within two weeks of referral.

- More people with severe mental illness will receive a full annual physical health check. Physical health checks will be will provided for 30% of the population with SMI on the GP register in 2017/18, increasing to 60% population from 2018/2019.
- There will be improvement in access to **individual placement and support** (IPS), enabling people with severe mental illness to find and retain employment.
- In 2017/18 we will work with Providers to implement a new acute care pathway
- We will review and where needed strengthen the monitoring of inappropriate Out of Area Treatments (OAT'S) and will aim to deliver a demonstrable reduction in these by March 2017.
- We will (working with our Providers) consider bidding for centralised funds to trial the further development of community based support which focuses on preventing avoidable secure in-patient admissions and enabling step down support from these admissions.

3. Crisis care and suicide prevention

Key to the implementation of this priority is progress in rebalancing the mental health system across Norfolk and Waveney as outlined above. This will seek to reduce the demand for crisis care. Alongside this it is important that the crisis care pathways we have are reviewed and further developed (where needed) to ensure the best possible care people at the time of most need.

We will (in accordance with Five Year Forward View for Mental Health):

- Review the current position of the systems Crisis resolution and home treatment teams (CRHTT) by the end of 2016/17 and in 2017/18 we will develop plans to ensure future provision is delivered in line with best practice criteria by 2020/21.
- During 2016/17, within the STP develop and agree an approach to the future commissioning of mental health liaison services within our acute community hospitals. Learning from the national evaluation of crisis care for children and young adults we will seek to ensure further developments of these pathways.

Preventing suicide is a key priority across Norfolk and Waveney. This complex Public Health challenge requires close working across the NHS and other partner organisations in order to deliver the priorities identified in the National Suicide Prevention strategy. We will fully contribute to the development and delivery of local multi-agency suicide prevention plans, together with our partners.

4. Children and Adolescent Mental Health (CAMHS) and Peri-natal Mental Health Services

During 2017/18 and 2018/19 we will be taking forward a review of the Norfolk and Waveney CAMHS with a view to securing the future CAMHS delivery model from the beginning of 2019/20.

Key within this will be ensuring delivery of the CAMHS Implementation plan and in meeting the CAMHS objectives within the Five Year Forward View for Mental Health:

- Ensuring the development of 24/7 crisis resolution services for children and young people, increasing access to community based services to 32% in 2019/20 (subject to change following review in 2018).
- Further development of the Children and Young People's IAPT programme.
- Ensuring Performance against the new access and waiting times standards for CAMHS eating disorders services is measured and monitored.
- We will work with NHS England to develop collaborative commissioning plans for children's in-patient units and will agree local trajectories for aligning in-patient beds with local need.

- Ensure Provider compliance with the children and young people elements of the Mental Health Services Data Set.
- Emotional Wellbeing - we will work collaboratively with children, young people, parents/carers, health Commissioners and service Providers to implement the Suffolk and Norfolk Emotional Wellbeing Transformation Plan for Children and Young People.

  The Norfolk and Waveney CAMHS transformation plan 2015-2020 will establish a joined-up, family-focused response to all children, young people and families/carers presenting with emotional, behavioural or mental health need. Four priority areas have been identified through local needs assessments and conversations with young people and families, and are also in line with key themes from the Department of Health's Future in Mind report:
  1. Early help and prevention
  2. Eating disorders
  3. Crisis support
  4. Accessibility
- Transforming care - determine future commissioning model for CAMHS including the potential for a neurodevelopmental service which might include ASD, ADHD and CAMHS services for CYP with Learning Disabilities:
  a. Include outcomes from the local Learning Disability review within this model
  b. Include outcomes from the local ASD/ADHD pathway work within this model
  c. Implement *Transforming Care* recommendations for children and young people and system wide pathway across health, social care and education.

Over the next two years we will take steps to review and further develop our peri-natal mental health services.

During 2016/17 we have reviewed the current peri-natal mental health provision in line with guidelines and started to plan for the necessary improvements to deliver NICE compliant services across Norfolk. We have also made a bid to national funding to enable the further development of these services.

Further detail on CAMHS is covered in the Children's and Young Persons section.

Mental Health Payment Proposals

- There will be no further changes to the payment rules for 2017 – 2019 with block contracts remaining in place. CCGs will however acknowledge and take heed of national guidance.
- The local payment rules will be linked to locally agreed quality and outcome measures and the delivery of access and wait standards in line with the recommendations identified in the National tariff proposals for 2017/18 and 2018/19 published by NHS England and NHS Improvement August 2016.
- The use of the IAPT payment model will be mandated from April 2018.
- An MOU and risk sharing agreement will be established between Providers and Commissioners to enable us to move to this new payment model.
- These proposals will exclude CAMHS AND Secure or Forensic Services however Providers and Commissioners may choose to include these services within the scope of the payment approach agreed.

Learning Disabilities

The Norfolk and Waveney CCGs will work in partnership with Norfolk and Suffolk County Council to continue to drive forward with the objectives within the Transforming Care Plan. The Norfolk Joint Commissioning Strategy for Learning Disability Services will be published during 2016 this will include the involvement of younger adults with a learning disability and their carers.

During the next two years we will work jointly with our partners to review the needs of patients with complex joint learning disability, mental health and behavioural needs with a view to (where appropriate) ensuring the delivery of coordinated community based services.

We will continue to work with colleagues in Primary Care and wider services to support the delivery of annual health checks for people with a moderate, severe or profound learning disability.

We will work across health and social care to ensure that learning disability patients with physical and/or mental health needs are being met by the responsible CCG in line with Responsible Commissioner guidance, with the view to ensuring that this guidance is clear to all people working across the learning disabilities sector and that clarity of responsibly commissioner is obtained as early as possible within a patients care.

Suffolk county council and Great Yarmouth and Waveney CCG (amongst others) have developed a Joint five year Strategy (2015 - 2020) detailing how people with learning disabilities (aged 14 and over) and their families should be supported to live good ordinary lives in Suffolk.

The Strategy was developed with people who have learning disabilities, families, health and social care professionals, supporters and community organisations. Our vision is that people with learning disabilities live good lives as part of their community with the right support, at the right time, from the right people. The Strategy aspires to transform the way services and opportunities are accessed.

At the very heart of the strategy are the underlying principles of empowerment, choice and control. These principles must be held strong if the Strategy is to be delivered in the current climate of financial challenges in order to enable and change people's experiences. These principles will underpin every work stream, approach and decision.

The Suffolk "My Life, My Future" Programme has as its main objective the implementation of the Joint Learning Disabilities Strategy.

Children's and Young People

Our vision is that all children and families in Norfolk and Waveney have the right to: be kept safe, the best education, physical and emotional health and successful preparation for adulthood and employment.

The CCGs are committed to the healthcare of children, young people and their families. To do this effectively, it is important that we work collaboratively with the Norfolk and Suffolk local authorities, education departments and public health Commissioners and police wherever possible in terms of services for children and young people. We will focus on areas where it has been identified that closer integrated working will achieve the maximum impact for both individuals and organisations alike, and we intend to build on existing projects and examples of good practice, where the benefits of integrated working can be shown and with the children and young people at the centre of all we do.

Norfolk and Waveney has its own challenges specific to children and young people. Children living in poverty in the Great Yarmouth and Waveney and central Norwich areas are higher than the national

average. The Rowntree Foundation have recently identified that poverty increases the risk of mental health problems and can both be a causal factor and a consequence of mental ill-health. The Child Health Profile Key Areas from Public Health will be used to inform the areas of focus for Commissioners during the next two years.

In 2014/15 the hospital admission rate for self-harm in young people was higher than the national average. There is also a higher than national average in some areas for emergency admission of children due to asthma

a. The rate of emergency hospital admissions for children and young people is increasing – with problems of the respiratory system the most common cause in children aged 0-4, and "injuries and poisonings" the leading causes as children get older
b. The rate of hospital admissions for accidental and deliberate injuries in children aged 0-14 is statistically significantly above the national average
c. Significant health inequalities exist within the county – in the most deprived areas children are more likely to have an emergency hospital admission

It is estimated that there are just over 10,000 children and young people aged 5-16 who are living with mental health problems – 9.4% of this age group.

In all the commissioning work to be undertaken, we will ensure that the voice of children and young people is heard through working with Healthwatch, and other representative organisations, and seeking out ways to innovatively gain input and involvement.

Specific streams of work that are in place or due to commence are as follows:

- Priorities for Prevention, Reducing Inequalities and Improving Health - our priorities will include the right care identified areas of improvement for Norfolk and Waveney within maternity and early years. These include:
    a. Reduction of smoking levels, especially in pregnancy and at time of delivery.
    b. Improving uptake of flu and whooping vaccination in pregnancy.
    c. Improving childhood obesity.
    d. Undertake system wide work to reduce unplanned paediatric admissions to hospital, including the rate of emergency admissions for health needs as highlighted by *Right Care (e.g. emergency admissions for asthma).*
- Collaborative commissioning arrangements - with the local authorities and between the CCGs:
    a. Formalise joint commissioning arrangements and governance, to include arrangements for shared care and tripartite funding
    b. Continue to work together to sustain the improvements made to the quality and timeliness of health assessments and review assessments for Looked After Children
    c. Consider the service offer available for care leavers
    d. Ensure that the health needs of children and young people with complex needs are met in community settings (home, school or local authority short break provision) – by reviewing the CCNT and health funded short breaks nursing offer

    e. Working jointly with Norfolk and Suffolk Local Authorities, continue to implement the requirements of the Children & Families Act 2014 including those for children and young people with - Special Education Needs and Disability (SEND) - taking forward the Governments commitments to improve services for vulnerable children and young people including development of personal budgets.

- Continuing Care - review the local arrangements and service availability for children and young people with continuing care needs, to ensure children and young people do not remain in hospital unnecessarily and have their needs met in a timely, effective way:
    a. Continue local work around market development and availability/sustainability of packages of care – including how specialist mainstream services support the needs of children and young people
    b. Continue local work to ensure care available is at the right place and right time
    c. Consider expansion of personal health budgets
    d. Consider need for case management services.
- CCGs in central Norfolk will review their offering of residential short breaks for children and young people working with Norfolk County Council to identify a joint commissioning process including joint referral criteria. Alongside this, Central Norfolk CCGs will review the Children's Community Nursing and Therapy Team and whether it meets the needs of the population.

Maternity

Within maternity, our priorities are:

- To increase flu and whooping cough vaccine uptake in pregnant women.
- To decrease the numbers of pregnant women smoking at the time of delivery.
- To implement the saving lives care bundles (aim to reduce stillbirths and neonatal deaths).
- To develop a local maternity system (LMS) to deliver the maternity services outcomes as part of the STP.
- For the maternity services liaison committees to work more closely and to be involved in the LMS.
- Perinatal mental health, taking heed of the new national guidance.

Cancer

The commissioning vision, aims and objectives for cancer care in Norfolk and Waveney are aligned to the new National Cancer Taskforce report, Achieving World Class Outcomes: A strategy for England DH 2015-2020, the national performance indicators for cancer waiting times, Right Care and the new Quality Premium for cancer. Cancer care shall be provided and commissioned as part of the East of England Strategic Clinical Network for Cancer (EOE SCN) and as part of the forthcoming EOE Cancer Alliance.

CCGs will continue to work with Providers to achieve world class outcomes and the sustainable delivery of core cancer standards. Recognising the predicament that local services are in, Commissioners will expect Providers to work closer together as a way to sustain delivery and quality of care provided.

Specific intentions for how this will be achieved include:

- Continuing to support the integrated care pathways project at the NNUH and JPUH including survivorship, holistic needs assessment and risk stratified pathways across all Providers.
- The implementation of the national cancer taskforce recommendations.
- Reviewing the feasibility and potential implementation of supportive cancer care and chemotherapy administration in the community, building on the transfer of work into the community that has already taken place.
- Supporting the roll out of evidence based best practice cancer pathways.
- Supporting general practice and working with Public Health England to improve earlier cancer diagnosis and prevention.
- Clinical service review of local cancer services in Great Yarmouth and Waveney.
- Implementation and monitoring of the national quality of life measure for all local cancer patients once it has been published nationally.
- Implementation of the local cancer dashboard in line with national guidance.

Palliative and End of Life Care

The CCGs will work collaboratively to optimise delivery of generalist and specialist palliative care to support people to live and die well in their preferred place of care and prevent avoidable admissions to an acute setting. This will include the phased implementation of EPaCCS and consideration of a 24/7 patient/carer helpline. We will also explore the potential to enhance levels of community provision to facilitate early supported discharge from specialist inpatient care and to support people at home (or as close to home as possible) at the end of life where it is safe to do so. CCGs will continue to promote the Thinking Ahead documentation (Yellow Folders) to support Advance Care Planning.

Out of Hospital Care

For the sake of explicitness, out of hospital care is intended to cover intentions for the primary care and community sectors (including community mental health). These have deliberately been amalgamated to reflect the future direction of travel whilst also addressing the current arrangements, e.g. individual practice contracts.

The Norfolk and Waveney STP highlighted that well-designed schemes to move healthcare closer to patients own homes can deliver benefits in the long term and that costs of delivering care in the community may be lower than delivering care in acute hospitals. To that end, Norfolk and Waveney CCGs will actively look to shift care out of hospitals and into the community on a system wide approach.

Underpinning this is a clear strategic direction of travel for local systems, focusing on providing the right services in the right place, supporting independence and based on a consistent and focused set of objectives and outcomes including;

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

Given the national emphasis on clinically led GP commissioning it is a key component of the transformation and change programme in Norfolk and Waveney that any system-wide planning must be owned and created locally with ownership from primary care.

There is consensus across Norfolk and Waveney CCGs that there is not a need for the current number of community inpatient beds in their current guise. Commissioners will focus on the alternatives that need putting in place to support patients in their own home rather than an inpatient setting.

With the forecast increase in primary care activity and the necessary shift in activity away from acute setting, new models of primary care will be needed to deliver these integrated services at scale. Nationally the Five Year Forward View gives examples of Multi-Specialty Provider (MCP), Care Homes Pilot and Primary and Acute Care are not mutually exclusive and elements of each feature in various Norfolk and Waveney developments. That said, there is a very clear and consistent consensus across all CCGs for the model to be centred around primary care with an investment in primary and community care to reduce the need for people to go to hospital unless really necessary and a resulting shift of activity away from secondary care, i.e. more in line with a MCP model.

Much debate has been happening at both locality and county level around the type, size and number of integrated community care centres across the Norfolk and Waveney footprint and whilst there are differences in current thinking about 'form' there is consensus that they all should reflect key design features. These design features to further shape a Norfolk & Waveney integrated community service will be likely to include:

- Shift of "acute" services into hub/spoke arrangements. The range of examples includes outpatients, diagnostic services, urgent care, diabetes, dermatology and community mental health services, gynaecology, social care and voluntary agency support.
- Systems implementation of "Integrated Urgent Care Commissioning Standards", contractual and service integration of NHS 111, out of hours and wider urgent care services aligning to local solutions.
- Progression to "full delegated commissioning" of primary care in 2017/18, "following due diligence and appropriate authorisation and CCG governance arrangements". This will include CCGs working closely with NHSE to ensure the appropriate implementation of the "General Practice Forward View" and the national commitments to support General Practice and Primary care.
- Development of Primary Care at scale (variations of general practice models, no single approach but based on local determination) to ensure sustainability and achieve greater access to 7 day services across localities
- Enhancement of out of hospital integrated teams, health and social care plus the 3rd sector, aligned to hub and spoke/cluster approach.
- Increasing close joint working with a range of partners, Local Authorities (County and District), including for example; aligning Better Care Fund (BCF) initiatives; mental health reablement and rehabilitation processes and pathways, prevention and early intervention programmes.

The foundations for this integration are at different stages across the CCGs and localities in Norfolk and Waveney; however it is recognised that building on these early developments whilst sharing learning and experience will give the wider system the best opportunity for optimising the necessary "shift in care".

Further detail on the local work being undertaken is listed below:

North Norfolk CCG

North Norfolk CCG is working with practices to develop an MCP model that will be able to take services out of hospital where appropriate into a community setting whilst also putting in place preventative care for patients, particularly those with long term conditions. The focus will be on the patient rather than the Providers of the care, ensuring that the patient receives high quality care, at the right time, at the right place. The CCG aims to build on the work that has already taken place, refining it as necessary to make sure that pathways are clear to all.

We currently have 4 clusters developed around GP practices, with patient populations of around 40,000, sharing health and social care staff resources. A team of 8 Integrated care Co-ordinators (ICCs) who work in pairs to support each GP cluster, run their MDT meetings and facilitate referrals to voluntary sector services. The ICCs have access to both health and social care databases and support the holistic care of patients.

The North Norfolk social care team and community nursing team have aligned their staff to support the 4 GPs clusters and they are also co-locating their teams at a central hub based in North Norfolk where health and social care duty and hub teams sit.

Our intention is to more formally align the community nurses with the GP practices. This is already taking place within the NN4 locality with an expectation that this will be rolled out across the locality. An admin allocator and triage nurse have been appointed to directly manage the community nurses workload at a GP cluster level and respond to a dedicated line for admission avoidance calls from GPs. They will also access the ICC's and SWIFTS Team.

Additional services will be built on to this base including links and support from other services such as mental health service, specialists, ambulance service and out of hours. Our intention is for care to be centred around primary care and for the sector to be bolstered to deliver at scale.

Norwich CCG

Norwich New Model of Care

The Norwich new model of care has been in development for 3 years. The intention is to establish a comprehensive, integrated model of care, bringing together teams of health and social care professionals alongside local support organisations to improve the lives of people in Norwich.

Programmes already in place include:

Healthy Norwich

Focused on prevention and well-being, working through partnerships with District Councils and Public Health and delivered through local initiatives and community assets. There is continued commitment to support this work which aligns with the commitment included in the STP.

HomeWard

Specific new work relating to HomeWard will include:-

- Phased implementation of a 24/7 integrated urgent care response model to support admission avoidance and early supported discharge from the acute and community inpatient settings. This will initially include integration of HomeWard, the 4 hour Community Nursing & Therapy response, Procured Beds, community beds (e.g. Alder Ward) and Norfolk First Response (NFR). It is the final intention to have a single point of referral, multi-Provider triage, rapid assessment, clinical coordination and patient tracking to address immediate patient needs and once these

are addressed, the patient's holistic needs will be reviewed by health & care partners (including voluntary sector) to prevent illness and promote wellbeing.
- To understand the benefits versus the cost implications of continuing the Community IV Therapy element of HomeWard service.

Development of Multi-specialty Community Provider (MCP) and Norwich New Model of Care –

The CCG and the Norwich New Model of Care Leadership Board (NNMCLB) will work together to develop a MCP model for Norwich. There are many capabilities that already function in Norwich which are being drawn in as components of a successful MCP.

NHS England and NHS Improvement will be inviting applications for national support for future MCPs in autumn 2016. In line with the guidance that the most compelling plans for the next MCPs are likely to cover specific communities in 2017/18 with wider spread thereafter (rather than all of the CCG or whole STP footprint at the same time), the CCG will support a bid from the NNMCLB to NHS England in autumn 2016 for national support.

To underpin the transformation programme, the CCG will support the NNMCLB to have appropriate, transparent governance structures and accountability arrangements.

It is the intention that services of the Norwich new model will be delivered on a hub and cluster basis.

Potential hub services: Urgent care services; Extended hours e.g. access to out of hours appointments; Diagnostics; Minor surgery; Outpatient clinics – the first specialties to be considered will be dermatology and diabetes – redesign may require a change in service delivery by both the acute and community Provider; Clinical observation; Pharmacy.

Potential cluster services: Community Mental Health & Wellbeing; Locally Commissioned Services with Primary Care; Outpatient clinics; Community Nursing & Therapy; Social care.

Additional Norwich specific intentions aligned to MCP:-

- Scope and re-design locally commissioned services (LCS) to provide primary care at scale using a prime Provider contractual model or similar. This will include phlebotomy services that may lead to a change in which services are commissioned.
- The CCGs expectation (as commissioning of primary care moves to the CCG) is that the care home and home visiting service being planned by NNMCLB, to be provided by Norwich primary care at scale, will align to the aforementioned plan regarding a 24/7 integrated urgent care response.
- Transformation of local community mental health service provision, aligning to the emerging Norwich MCP therefore provision on a hub and cluster basis. In keeping with the principles outlined in the Mental health section, the CCG will achieve this through:
    - Develop a business case for post diagnostic support for patients with dementia and their carers.
    - Review (and if required re-commission) the memory assessment service currently provided by NSFT. To look at opportunities to develop delivery models in line with the emerging MCP in Norwich.
    - Develop a community based multi-disciplinary triage for all mental health referrals to ensure the right care is received in a timely manner. We will expect NSFT capacity released through

improving the referral process to be partly re-invested back into the MCP and also to improve performance in MH secondary care.

- Work with partners to scope a Wellbeing Walk-in hub to act as a focal point for prevention services and navigation into community assets.
- Work with partners to scope an evening café to offer an alternative resource and improve people's wellbeing out of hours.
- Assess the support needs of vulnerable women who have experienced sexual assault and/or domestic abuse and identify appropriate interventions.
- Work with existing mental health Providers to offer training and awareness for primary care staff to improve early identification of mental health problems and subsequent support for these people.

Great Yarmouth and Waveney CCG

NHS Great Yarmouth and Waveney CCG has begun implementation of 24/7 multi-disciplinary, multi-agency out of hospital teams, supported by beds with care in local care facilities. The consequence of this vastly improved model of care has been to reduce the number of hospital beds, acute and community (physical and mental health) within our local system. Community services in the area were under strain, and several community hospitals were old and not fit for purpose. System wide, patients, health and social care partners recognised a need for a new model of care which prioritised care closer to home through a reablement approach and reduced reliance on admissions.

The out of hospital model consists of two key components: an Out of Hospital Team and Beds with Care. The values underpinning out of hospital team care are - patient centred care; staff sensitive to the needs of family and carers; care provided in patients' home whenever safe and sensible; the team will be easily accessible to patients and their families/carers. If it is not safe for a patient to remain at home but they do not require an acute admission, they can be admitted to a Bed with Care. All admissions to beds with care are managed by the OHT following assessment of the patient. The OHT provides in-reach to beds with care and supports the patient to prepare for discharge back home. This admission will be managed by the team which provides extensive in-reach nursing and therapy support and is supported by a local GP surgery. The focus is very much on activities of daily living, social interaction and rehabilitation.

Patients may be experiencing an acute exacerbation of their long term condition; have their mobilisation be rapidly deteriorating; their current care package need urgent review; require a supported hospital discharge to their usual place of residence or require short term input as part of the Palliative and End of Life pathway.

The team is an inter-disciplinary team of health and social care professionals providing intensive, short term care to patients which reduces as that patient regains health and independence. The team works 24/7. It accepts referrals from health and social care professionals. Assessments are carried out within two hours or a one working day depending on urgency. The team works closely with the patient's GP who continues to provide medical input and with other community services, specialist nurses and mental health services to ensure all necessary support is in place.

Since 1 April 2016 GYW have been working with local primary care Providers in order to develop an overarching Primary Care Strategy. This work is continuing and some key elements are included below in terms of commissioning intentions.

Review of the following Local Enhanced Services-

- Anticoagulation
- Near Patient Testing
- Care Homes
- Practice Clinical Support
- Luteninising Hormone Releasing Hormone
- Minor Injury

As a Community Education Network Provider pilot we will continue to develop the workforce plan to support primary care, develop different models and create greater resilience within primary care for the GYW population.

The new models of care will seek to further develop the concept of integrated teams working within primary care hubs and will include the Voluntary sector and Social Care.

The Integrated Primary Care Hubs will look at providing extended hours, different clinical provision, staff resources and shared estates and back office functions. The hubs will seek to utilise and improve community resilience, working closely with district and borough councils amongst others.

In order to achieve the above we will set up practice support teams to work with practices to support new initiatives and also any areas where they may be considered outliers in terms of performance.

South Norfolk CCG

2017/18 will see the development and emergence of new models of care and new ways of working within the primary care and wider community setting, with the anticipated aim of individuals health and social care being managed in a more integrated and cohesive approach within the out of hospital/community setting. It is expected that Providers will fully engage with and assist in the development and implementation of new models of care. South Norfolk CCG is looked to replicate the CN&T model being rolled out in North Norfolk, specifically around embedding staff within the local area and aligning them to local practice, e.g. dedicated named nurses.

It is the intention of SN CCG to bring Primary Care, health and social care, voluntary providers and commissioners together to develop and facilitate seven day clinically lead, integrated (health and social care) primary and community care 'service wrap around' transformational hubs. These hubs will (i) be stable and sustainable, (ii) be patient focused, (iii) be quality driven, (iv) deliver care at the right place at the right time and (v) see more individuals and their carers cared for, holistically, in the community.

Through the adoption of the above, commitment is expected for working across all organisational boundaries and structures, benefiting all people within South Norfolk and increase opportunities for system efficiencies. This is essentially the MCP model.

Currently working as four localities, South Norfolk has a total patient population base of circa 240,000 (w) (235,000 (a)), sharing health and social care resources and with the intention of further developing and embedding multi-organisational working across all organisations (for example, 111/OOHs, ambulance, mental health, district and local council services and the voluntary sector.

Commissioners will; (i) review and where necessary re-design local commissioned services to ensure full alignment to new models of care, (ii) ensure easy to follow care pathways and protocols are in place to support clinicians and individuals, (iii) clear governance structures and accountable arrangements are in place; (iv) be individual focused; (v) work with practices to identify existing and

future services which can be delivered with the community; (vi) work with the Local Pharmacy Committee and NHS England to identify how local pharmacy can best support the health and social care system; (vii) to improve structure, organisation, use of clinician time and planning whilst reducing hospital admissions, promoting appropriate admissions and relieving pressure at practice level; (vii) align with the STP; (viii) develop 7 day service model(s); (ix) reduce variation across practices; (x) a dedicated focus on care homes within primary care to better manage expectations whilst ensure high quality care

Through the development of new primary care focused models of care and budgetary devolvement, the future benefits to patients may include;

i. Reduced travel time, as a greater number of services may be available within one locality
ii. Integrated care delivery and working, e.g. services / GPs not having to re-refer from one specialty to another, with healthcare professionals having the ability to cross-refer.
iii. For the individual and their career(s), improved flow through their care pathway.
iv. Patients perceive a better care experience.
v. Improved quality and delivery of care.
vi. Seamless service delivery.
vii. Through the Digital Roadmap, the development and use of a single care record, accessible by the patient and their care professionals.
viii. Individuals feeling in control and responsible for their health care.
ix. Improved Polly-pharmacy and medication compliance, resulting in better health and life outcomes for the individual.

To achieve the above, we must continue with intelligent commissioning and also harness the innovation and local knowledge of colleagues in primary care, community, mental health and acute care. There is no single response to these pressures. However, to sustain high quality primary care, change across all organisations will be required and must be clinically lead and driven, shaping the future of local provision.

Primary Care requires a funding injection to help sustain, support and implement new ways of working and in order to do this funding must be redistributed from existing providers, including the acute sector, without impacting on quality of care.

West Norfolk CCG

A key element in the development of local health services in West Norfolk will be the contribution of a “Sustainable” General Practice service. In West Norfolk we will be using the opportunities presented through the national strategic approach contained within “General Practice Forward View” to develop local sustainable General Practice services. The first step towards this has been agreement across our Practices that they will come together to provide a vehicle for delivering services that fall outside of the national “core” contract, and to enable the CCG as a commissioner and other local health service organisations to work with them to maximise their contribution to delivering the system’s plans for transforming care within this document.

We expect all Practices to join a single organisational vehicle (“West Norfolk Health”). We recognise however that General Practices in the King’s Lynn area in particular have some additional and distinctive challenges to be achieve a sustainable position and that they will need to work together through what may (at least initially) be an additional separate organisational form.

The West Norfolk system will work directly with West Norfolk Health and the King's Lynn Practices to identify a range of services that they can provide in future as part of the overall delivery of our Transformation Plan.

An equal focus in 2016/17 and beyond will be to ensure that we have a fully robust and sustainable range of General Practice "core" services. Whilst there may be individual Practices who choose to merge our expectation is that "core" services will continue to be provided by these Practices. The responsibility for commissioning these services may well be delegated to the CCG from April 2017.

It is unclear exactly what contractual vehicle will be used to achieve this in future years but our intention is that we are able to offer a full range of locally accessible "core" services for West Norfolk patients including enhanced access to "in hours" services as well as the continuation of "out of hours" services.

We have also been developing our out of hospital services in partnership with other local Provider organisations. We have drawn up a model for the further development of an integrated approach to adults and older people with frailty and long-term conditions. This model brings together community health, social care, and enhanced Primary Care, including the development of strong Intermediate Care services, and an "Extensivist" model for the most complex and challenging patients. There will be an emphasis on prevention, working with the District Council and a range of third sector organisations.

This model will include Community "hubs" based around clusters of General Practices and will join up seamlessly with what is offered by QEH as part of a fully integrated model incorporating the features articulated in the 'MCP' new model of care. A particular emphasis will be placed on strengthening communities through small-funded 'neighbourhood network' schemes, drawing together people in their own community to generate the kind of support that matters to them, locally.

In addition, Care Homes will feature prominently, with several new initiatives to connect them better with community health, social and voluntary services, as well as improving the communication and referral pathways with emergency care services. Schemes such as the Care Home Matrons will provide clinical support to improve the confidence and consistency of Care Home services and standardise the way they access services from GPs right through to hospitals. This will have a positive impact on reducing unnecessary trips to hospital.

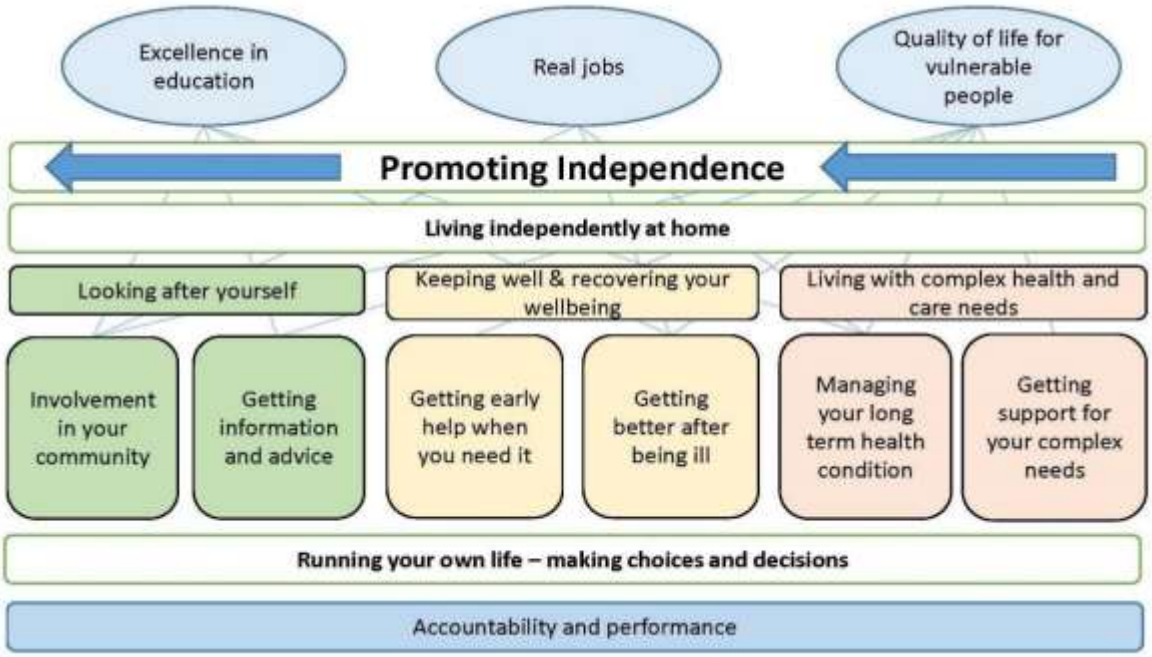
The whole ethos of the West Norfolk Community Services MCP approach is to increase over time the facilities available in the community to reduce health crises and to keep people independent. The 'Extensivist' physician will lead a team including a clinical pharmacist, Nurse Practitioner, Mental Health Practitioner and Social Worker, with access over time to enhanced diagnostic equipment to provide near patient testing as well as some treatments such as IV fluid replacement and other procedures that could prevent admission to hospital.

Critical to the success of this model will be a review of public estates, a combined workforce development strategy and a fundamentally different approach to data sharing and innovative Information Technology.

Norfolk County Council

Norfolk County Council's Promoting Independence Strategy is a renewed approach to adult social care in Norfolk and is firmly rooted in maintaining and restoring people's ability to live independently of formal care services.

Future commissioning will be founded not on matching people to a list of services, but rather on understanding with someone, and their support network (family, friends and local community), how they can best be helped to meet their care and wellbeing needs. Commissioning activity will support improved outcomes for individuals as well as reduce the financial burden on the public purse and provide good value for people and carers.



In Norfolk (excluding Waveney) the Council invests £290m in the care market, with the majority of this commitment currently allocated on the following services.

	Older adults	Younger adults	Total
Residential care	£85m	£56m	£141m
Nursing care	£12m	£4m	£16m
Home care	£33m	£21m	£54m
Day services	£4.6m	£24.4m	£29m
Supported housing	£10m	£32m	£42m

Throughout, but not limited to, 2016 to 2018 the Council will be implementing its commissioning intentions as published in Norfolk County Council's Care and Support Market Position Statement 2016/17. Commissioning to support a market the promotes independence where services are focussed on restoring independence wherever possible by reducing the need for additional care and support services and delaying for as long as possible the need for additional care and support.

Strategic theme 1: Looking after yourself

People are able to remain living independently through access to information and advice which provides solutions to their needs within their communities, and without the need to call on more formal sources of care. This includes the development of the Council's 'Community Links', which introduces people to universal services that can meet their needs in their own area.

Information and Advice Commissioning Intentions

We plan to develop services that ensure everyone, not just those eligible for social care, is able to get the information they need, supporting them to be better able to self-care and avoid entry to formal care systems.

We want services that will:

• Provide information that enables people to be more independent

• Promote solutions rather than just signposting to social care

• Link explicitly to locality resources, voluntary sector and into district councils

• Develop a different relationship with the public as part of the changing offer from Norfolk County Council to the public

• Explicitly address advice needs of carers

• Help people to understand and get the full range of support available through commercial companies and community organisations

Carers Services Commissioning Intentions

Over 94,000 people in the county provide unpaid informal care every year which would cost the taxpayer over £500m to buy. The Council is reviewing its carers service and will revise carers provision both within the council and externally to deliver a range of services to be provided in a personalised way to support carers in their caring role.

Strategic theme 2: Keeping well and recovering your wellbeing

To support people to keep well and recover their wellbeing commission priorities include

Floating Support Commissioning Intentions

The council will remodel its floating support provision to focus on vulnerable groups at risk so it is targeted at those most in need and is accessible across the county.

Day Opportunities Commissioning Intentions

As investment shifts and reduces the council will be working with the sector to review day service provision. With the expectation that:

- Day services for older people playing a bigger role in helping people to stay well and maintain their independence and having stronger links with other care and support services.
- There will be a transformation in daytime support for younger adults, focussing much more on pathways to employment, training and access to leisure.

Strategic theme 3: Living with complex health and social care needs

For those who are living with often multiple or complex conditions and in need to health or more formal social arrangements, provision will encompass long term support that enables maintenance and recovery of independence as well as short term crisis response services that align with existing health and social care provision.

Home Support Commissioning Intentions

The council will support and develop a thriving homecare market with diverse and resilient Providers who complement and reflect the objectives of enabling choice and independence for citizens.

Residential Care Commissioning Intentions

The Council intends to reduce its use of long-term residential care in favour of home and housing based support. This is particularly important in relation to younger adults

Nursing Care Commissioning Intentions

The sector is experiencing difficulty recruiting nurses, and homes are de-registering, the council will undertake a review with health partners the commissioning model in this market.

Age / condition Appropriate Housing Commissioning Intentions

The council will be working with housing Providers to develop and implement alternatives to residential care.

Suffolk County Council

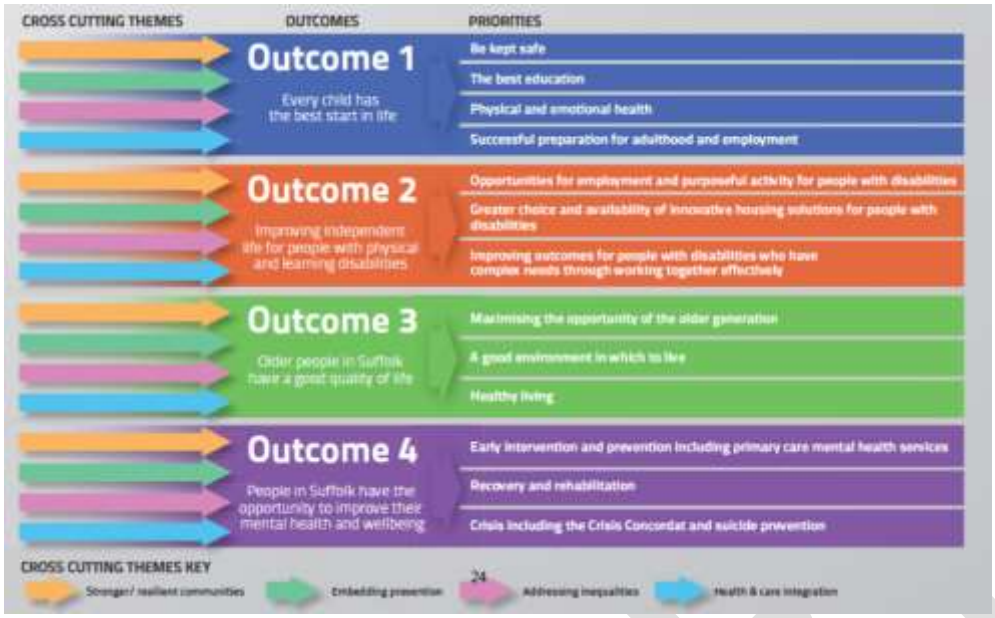
Suffolk's Joint Health and Wellbeing Strategy 2012–2022 sets the long term strategic framework for improving health and wellbeing in Suffolk. It guides the direction of a considerable range of statutory, voluntary, community and private sector agencies that impact on health and wellbeing in Suffolk. It sets a number of outcomes designed to the deliver the vision: "People in Suffolk live healthier, happier lives. We also want to narrow the differences in healthy life expectancy between those living in our most deprived communities and those who are more affluent through greater improvements in more disadvantaged communities."

The Health and Wellbeing Strategy sets the outcomes for the next three years to achieve the vision. The State of Suffolk 2015 (a key part of the Joint Strategic Needs Assessment) has informed the refresh of the Joint Health and Wellbeing Board Strategy ensuring that the Strategy is evidence based and focused on the relevant key issues including: inequalities, demographic pressures and re-designing services to meet need and enhance opportunities for prevention.

Our aim is to create strong resilient communities so that individuals have less need for interventions from public services. When communities and individuals do need services, we want these to be delivered at a local level so that people will receive seamless, coordinated care and integrated services, which are not duplicated or leave gaps. This means that resources are used more effectively, and by taking early action will prevent or delay the need for long term care. Through working jointly across health, local government, other public sector partners, the voluntary sector and wider communities we can make a real difference in improving health and wellbeing opportunities for people in Suffolk.

The themes from the State of Suffolk Report have been embedded across the four Health and Wellbeing Board priorities, and have been refreshed within the "Joint Health and Wellbeing Strategy

(refresh 2016-2019)." The refreshed Strategy reflects the changing environment for public services in Suffolk and sets out four key outcome and associated priorities:



Suffolk Adult and Community Services (ACS)

Our aims within Suffolk ACS are to work in partnership to support people to live independently for as long as possible reducing, preventing and delaying the need for 'formal care', safeguarding those who need help to stay safe, whilst ensuring all people have maximum control over their lives.

Supporting Lives, Connecting Communities (SLCC) continues as our way of working across Adult & community Services and shapes how we work with people, families, communities, partners and Providers.

Three responses to Customers:

Looking forward, what Adult and Community Services success looks like in 2018:

- ACS will be a sustainable service delivered through our way of working: Supporting Lives, Connecting Communities (SLCC).

- ACS will play a key part in Public Sector Reform and the Devolution deal through our work on integrating Health and Social Care.
- Key to all of this work is reducing demand through SLCC and targeted savings projects through our Sustainability and Transformation Plans.
- Workforce that is proud, capable, confident and engaged; that is flexible and can adapt to the changing work environment and successfully implement the ACS priorities.

ACS Priorities 2016-2018

1. A care market that is safe, sustainable and value for money.	
Objectives: 1. Commissioning for customers with disabilities. 2. Implementing Support to Live at Home (StLH) 3. Capacity building and prevention including Housing Related Support. 4. Residential and nursing home redesign.	Changes we will see: People lead independent lives for longer. People have choice and control. We see a better relationship with providers based on a mutual understanding of our separate and joint responsibilities.

2. To influence the design and support the implementation of the Sustainability Transformation Plan.	
Objectives: 1. Support the Most Capable Provider work in GY&W. 3. Design and implement a strong offer of integrated short term recovery or assistance. 4. Agree access arrangements that support integrated care delivery. 5. Develop with partners robust modelling across Health and Care System.	Changes we will see: More joined up and efficient use of resources to support the customer. Smoother processes across health and social care. A workforce more able to achieve good outcomes with partners. Affordable future design for operational teams agreed for customers.

3. To evolve SLCC as a practice model across the system.	
Objectives: 1. Make sure all customers have a personalised outcome-based plan. 2. Confirm the model for future operational delivery. 3. Drive SLCC practice in integrated teams. 4. Develop robust financial and activity models to support savings.	Changes we will see: Our workforce will be approachable and more inclusive of other support networks (i.e. advocacy, digital solutions). Our workforce will work with people and their assets to maximize their independence with proportionate use of council resources. Personalised health and care plans for high risk individuals. Creative plans to identify informal support for people. Strong working with communities and other partners.

4. To create an effective and flexible infrastructure.	
Objectives:	Changes we will see:

1. Replace case management system and associated modules. 2. Facilitate a “paper light” office. 3. Facilitate Digital Personalisation. 4. Enable a “single data view” of a customer’s records. 5. Enable effective demand management through better use of digital solutions and assistive technology. 6. Deliver local digital roadmap to feed into and enable health integration.	A new case management system that is easier to use providing good quality data. Development of a core offer of technology for front line practitioners allowing a mobile and effective workforce. Good quality data. Digital records and paper free.

5. To create a commissioning function fit for the next 10 years.	
Objectives: 1. Joint commissioning aligned to NHS and other directorates on agreed geographical footprints. 2. A commissioning approach which adopts a presumption of prevention and of personalisation rather than contracted services. 3. A clear understanding of roles and pathways between commissioning and contract management. 4. A market shaping approach which encompasses the whole market and is driven by co- designed change.	Changes we will see: Better VFM through joint service redesign /market development. Genuinely collaborative planning. More comprehensive understanding of markets (supply and demand) and ongoing dialogue with markets - shaping supply.

IT

The importance of Information Technology has often been understated however its potential within health is hugely significant and is increasingly being recognised as a key enabler of change and transformation. Technology is transforming our ability to predict, diagnose and treat disease and will be integral to our ability to transform the system. The Five Year Forward View made a commitment that, by 2020, there would be “fully interoperable electronic health records so that patient’s records are paperless”. This was supported by a Government commitment in Personalised Health and Care 2020 that ‘all patient and care records will be digital, interoperable and real-time by 2020’.

In keeping with the national direction, Commissioners are committed to aligning levers and incentives to achieve the ambition of being paper free at the point of care. This is in recognition of the benefits this will bring to Providers and Commissioners alike in using Information Technology to change the way that healthcare is delivered and reduce the inefficiencies that arise when it is not used to its maximum potential.

There is significant advantage for all Providers and Commissioners in having IT systems that are interoperable across organisational boundaries. Commissioners expect Providers to recognise these benefits and require them to work to develop systems that are interoperable with those in use in primary care (especially in plans that may be afoot to move towards an electronic health record).

Commissioners will require the use of e-referrals and have the expectation that by the end of the next contract round, all secondary care referrals (unless for exceptional reasons) will be received via

this method. This is in keeping with the planning guidance which forecasts e-referrals becoming the only form of referral by April 2018 across the system.

In a more radical sense, Commissioners will work with Providers to use Information Technology more innovatively in managing patients care. Technology, for example 'apps', have the genuine ability to transform the way care is provided – towards a model that can identify the relative risk of patients without the need to see the patient and treat them accordingly based on clinical data. Within the current challenges, CCGs will increasingly look for more innovative solutions to the demand we are facing and IT will be at the heart of this.

Transforming Care Agenda

The STP is committed to 'Building the Right Support' through delivery of the local Transforming Care Plan published in July 2016.

Finance and Efficiency

The national financial challenges facing the NHS are well understood and this is being seen at a local level with the vast majority, if not all, Providers and Commissioners having significant QIPP programmes. Indeed the STP evidences the size of the funding gap facing the Norfolk and Waveney system. Norfolk and Waveney CCGs are committed to the belief that the only way to manage these is to look for ways of reducing duplication, maximising efficiency across organisations and to work collaboratively as one health and social care system. Organisational boundaries should not and must not be a cause of increased spend.

CCG QIPP programmes, in part, will be informed by national guidance not yet released and so the exact detail at this stage is unknown. Commissioners respect the fact that each organisation has its own statutory responsibilities and Commissioners are no different in this regard. CCGs will contract as they deem fair and without the transference of risk from one organisation to the other but likewise, do not have the funding to support Provider QIPP programmes.

As is made clear in the Five Year Forward View, transformational change is required in order to address the funding gap and to achieve this, Commissioners expect all organisations to take a share of this risk in the interests of patients who should remain the primary driver for change. We will actively encourage collaborative ventures between Providers of care to reduce transaction costs, share infrastructure investments, building services along integrated care pathways, whilst minimising disruption to patient access and continuity of care.

Commissioners require ongoing assurance throughout 2017-2019 regarding the Provider's internal QIPP/CIP including the potential impact of any cost improvement on the clinical quality of the service, workforce and front line delivery of care which is of particular importance to Commissioners. Commissioners require a full sight of and understanding of the impact of any cost improvement plans going forward into 2017 - 2019.

The Commissioners reserve the right to revisit these Commissioning Intentions in the light of any changes arising from the resource allocation process and national/local guidance. The contract negotiation timeline will allow for open and transparent discussions with Providers regarding funding levels for 2017 - 2019. Funding levels will be considered by the Commissioners in totality across all care Providers and not in isolation for each individual Provider.

The Commissioners reserve their right to reinvest any funding relating to the application of contract levers/financial consequences and will publicise how we have used such funding in line with national

guidance. The Commissioners will not pay for any activity that is undertaken by the Provider where prior approval has not been sought in line with the existing policy (incorporated into the contract).

Contractual Mechanisms

As is evident from the narrative above, contractual mechanisms and payment mechanisms need to evolve to better reflect, and indeed encourage, wider changes within the system. Commissioners and Providers will contract for two years in line with national guidelines with contracts being agreed (or referred to mediation) by the 23rd December 2016.

Aside from the length of the contract, Commissioners are cognisant that there is a need for more substantial changes to better reflect the specific requirements of these commissioning intentions and to reflect the changes in clinical pathways and service delivery proposed by the local STP. Our ambition is to move away from the heavily transactional and narrowly focused way of contracting to something that is simpler, focused on outcomes and not organisationally constrained. Conscious of the reduced timeframe for negotiation, Commissioners will take a pragmatic approach to this year's contract process. If providers are able to work more closely together we will explore options for contracting beyond existing organisational boundaries. However it is likely that we will still have to sign contracts with individual Providers, as is currently the case. Commissioners are clear however that they wish to contract in such a way that there are not fragmented contracts and multiple individual relationships between various Providers and Commissioners. With that in mind CCGs will continue to work together in their current Coordinating commissioner approach but will contract together under the STP footprint and hence in all of our biggest spend areas (acute, mental health, community, non-emergency patient transport, out of hours and 111), Providers will hold one contract with Norfolk and Waveney Commissioners.

The Coordinating CCG will be the prime point of contact for all contractual work with the 'Provider'. This will include Coordinating the planning process, leading negotiations and chairing contract management meetings. These lead activities may be supported by or delegated to NEL CSU Anglia POD colleagues through an agreed scheme of delegation.

Commissioners will continue to contract on a block basis in those sectors where this is already in place. Furthermore, Commissioners will move away from National Tariff/Payment by Results within the acute sector and to a model that provides the system with more stability and certainty as well as reducing perverse incentives in place. Commissioners are open to discussion on the specific form of such a contract and will discuss this with Providers in the negotiation round. Activity and shadow pricing will be required to assist in the establishment of revised activity baselines for future years and to accurately track the impact on activity of the various interventions described elsewhere in these commissioning intentions. Where STP plans are agreed and supported this method of contracting has many attractions to mitigate short term risk and allowing all parties to develop on the pathway changes required.

Regardless of the nature and type of contract developed under pinning all the work need to be a clear consistent understanding of the activity of all Providers. Whilst many of the acute Providers have well established efficiency metrics this needs to be applied consistently across all Norfolk and Waveney Providers and further developed in the mental health, community and primary settings as well as social services (where appropriate). A primary role of Commissioners is to demonstrate to the taxpayer that Providers are delivering value for money and are operating efficiently. This may be done by looking at activity levels and benchmarking against other comparative Providers.

In the longer term, i.e. beyond March 2020, Commissioners expect contracting to take a very different approach:

- The focus will move away from multiple contracts with multiple Commissioners and Providers to single contracts covering multiple Providers and Commissioners. For example, our expectation by March 2020 is that one contract for core secondary care will be held on behalf of all Norfolk and Waveney Commissioners with the Norfolk Provider Partnership and thus utilising capacity at all secondary care hospitals in Norfolk. Commissioners encourage the Partnership to consider this and submit a proposal for how they believe this should work to Commissioners by 31st December 2016.
- New contracting forms will begin to be used, e.g. alliance contracts that are aligned to the national and local strategic direction and encourage better integration and cross-organisational working. In many cases however, these will be established long before March 2020.
- Out of hospital care will evolve in line with the STP and whilst further detail will be developed during the next two years, the clear direction given by primary care is the establishment of multispecialty community Providers (MCPs). This is as opposed to a vertically integrated Primary and Acute Care System (PACS) although secondary acute care will continue to play a vital role in this MCP model. This will clearly have an impact on what is commissioned, from whom and in what form but with a clear expectation that this will be centred on primary care. Commissioners will work with Providers, as they are already are, to manage this transition.
- In line with the above, Commissioning organisations are likely to change with the possibility of a single strategic commissioning organisation to support the development of MCPs.

The principle of standardised working across Norfolk and Waveney that runs throughout this document, will equally apply to contractual mechanisms. Commissioners will be looking for Providers to adopt pan Norfolk and Waveney contractual terms and conditions. This will include standardisation in local process, local pricing, efficiency metrics (which will remain for the next contracting round), minimum data sets and policies unless there is a justification for local negotiation. Where possible Commissioners will look to develop contractual metrics and arrangements with community and primary care Providers.

Whilst individual contracts will be held in 2017/18, there are some known services that are unsustainable under their current Provider. This will be addressed and where Providers are only able to provide a service through a subcontracting arrangement with another Trust, Commissioners will look to eliminate this bureaucracy and commission from a single Provider.

Where a pathway is taken out of a specific Provider contract for these purposes care must be taken to ensure that the governance arrangements for the provision of services are clearly determined and responsibility for all transition costs are adequately recorded and noted. The financial flexibilities afforded to Providers and the expected requirement for system control totals in future periods allow innovative funding mechanisms to be adopted. Commissioners are willing to be flexible where legally possible around contract length in these circumstances to support the wider integration and prevention agenda.

Commissioners will continue to seek regular assurance over the quality of services being provided. The Clinical Quality Review Meeting (CQRM) for each main contract will monitor service delivery of standards throughout the year, using all contract levers available to us to ensure standards are met.

We will do this by ensuring that the quality of services against the CQC standards and/or performance remedial or recovery plans is embedded within contract quality schedules. The expectation will be that contractual standards will be delivered as business as usual with improvement plans in place if that is not the case. The Commissioners expect and will seek from Providers that quality and safety are embedded within their culture.

The purpose of contracting is to support the provision of safe and efficiency services. Norfolk and Waveney Commissioners are willing to explore any opportunity that better establishes a fair contractual arrangement in the health and social system to support the wider strategic aims in this document.

CQUIN

Norfolk and Waveney CCGs remind Providers that local CQUINs are a discretionary payment and should not be assumed in financial planning. Local CQUIN provides an opportunity for discreet funding to be used to deliver the transformational change required for the benefit of Providers and Commissioners. CCGs will review the ways in which CQUIN can be used most effectively for these means with an acknowledgement that this may be a change from the norm. Commissioners will also take note the recent planning guidance and the changes proposed within for CQUIN payments. CQUIN schemes are expected to be agreed by the 23rd December, in line with the main contract. Commissioners reserve the right not to offer a CQUIN scheme should schemes not be agreed by this time.

Conclusion

The size of the challenge ahead and the resulting need for change is clear for all concerned. Only through a system-wide set of changes will the local NHS be sure of being able to deliver the right care, in the right place, with optimal value. Norfolk and Waveney CCGs remain committed to meeting this challenge and this document sets out our intentions for how this will be achieved with our Provider colleagues.