Great Yarmouth and Waveney
Clinical Commissioning Group

HealthEast

NHS Great Yarmouth and Waveney Clinical Commissioning Group (CCG)

Five Year Strategic Plan

20 June 2014
FINAL SUBMISSION

Introduction to the Plan

This plan contains the following elements:- Page Number

Appendices (embedded documents)

System Vision

By 2018/19 the citizens of Great Yarmouth and Waveney will receive their health and social care, and some district/borough services, from a cohesive integrated care system (ICS). The ICS will be user focused, delivering high quality and safe services with an orientation to innovate and develop new methods delivering better care based on the ideas and ambitions of professionals and the feedback of users. Because it is operating in a coordinated way, eliminating inefficiency and waste, and striving for more effective delivery methods it will be using resources optimally and constituent member organisations will be in financial balance and able to invest in further improvements.

Andy Evans, Chief Executive, NHS Great Yarmouth and Waveney CCG

Better Health, Better Care, Better Value

The five year vision for NHS Great Yarmouth and Waveney Clinical Commissioning Group (NHSGYWCCG) is both clear and challenging – to develop a better, integrated, system to care for our population. Our ambition of 'Better Health, Better Care, Better Value' has been our abiding principle since the CCG was operating in shadow form, and has guided our commissioning strategy and commissioning intentions to date. Our ambition, shared with all of our local system partners, is to create an Integrated Care System with full citizen design and 'buy in' – one that is sustainable and affordable and which delivers flexible, quality services for our population. We plan to move substantially towards this five year vision over the intervening years and have set out our plans in more detail in our two year Operating Plan. Appendix One contains a high level 'roadmap' of our plans over the next five years to help fulfil this ambition, together with a supporting Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis. Appendix Two shows more granularity within our Delivery and Resourcing roadmap for 2014/15 around specific deliverables and responsibilities.

We are a CCG which has inherited a strong track record of clinical leadership and direction setting, and this has continued since our formation and with regards to the formation of our vision and plans around the Integrated Care System (ICS). Details of our stakeholder engagement activity are summarised in our Operating Plan.

In conjunction with our commissioning partners, Norfolk County Council (NCC), Suffolk County Council (SCC), Great Yarmouth Borough Council (GYBC), Waveney District Council (WDC) and NHS England (in respect of the direct commissioning of primary care) we have worked up and agreed a common vision of an ICS as our means of ensuring that we provide quality care to all of our population, that we ensure integration of pathways rather than the current fragmentation, and that we increase the efficiency and effectiveness of the care we give our population, as well as maximising scarce resources. These are the founding principles of our drive towards integration. As we move further towards our integration ambitions, there are a number of important strategic decisions, from a range of options, which need to be taken in conjunction with our commissioning partners. These include how we best maximise the integration opportunities by looking at the fact that some of the commissioners within the ICS provide as well as commission services. We also are in the process of working with them to describe a more detailed timetable of activities. The givens at present are that we will work together on the triad of key integration activities – combining budgets (using the Better Care Fund as a catalyst), streamlining the management of teams and co-locating teams. Together these activities will bring about improved outcomes for our population and reduced inequalities across the CCG.

Ultimately, we are considering whether at least the health elements of the GYW system should see a softening of the purchaser and provider split, to reduce bureaucracy and contracting requirements, multiple handoffs, and facilitate the effective functioning of clinical transformation teams and other teams across commissioners and providers. In five years, we will see an empowered ICS, commissioning at micro level in its own right. We will also see teams, whether at macro commissioning or micro commissioning level, operating interchangeably, and as one, across the ICS. However, this is a very early hypothesis, needing approval from all the governing bodies involved, modelling of the impacts on the system and obtaining any necessary approvals from NHS England, Monitor etc. How and if this integration of the commissioning and provision functions could be extended to include social care and district councils needs to be explored with our partners, but the fact that GYW operates only within part of the county council areas may militate against this.

Our vision can be described as: By 2018/19 the citizens of Great Yarmouth and Waveney will receive their health and social care, and some district/borough services, from a cohesive integrated care system (ICS) acting as a single provider of services. The ICS will be user focused, delivering high quality and safe services with an orientation to innovate and develop new methods delivering better care based on the ideas and ambitions of professionals and the feedback of users. Because it is operating in a coordinated way, eliminating inefficiency and waste, and striving for more effective delivery methods it will be using resources optimally and constituent member organisations will be in financial balance and able to invest in further improvements.

Our shared vision has been the result of intense dialogue with our partners and stakeholders – ensuring that all of our commissioner and provider strategies are complementary, and has culminated in letters of intent to work together being signed by our commissioning partners. This includes detailed discussions over many months with our Governing Body, Clinical Executive Committee and retained GPs. Our Governing Body and Clinical Executive Committee both include significant secondary care clinical representation. The plans have also been discussed with our member practices. This wide clinical engagement has allowed both the refining of plans in the light of clinician feedback, and has formed part of the development of a locally shared narrative about integration as we move forward with our partners.

The vision includes ambitious plans for acute and community health provision, primary care and mental health, both district and county councils – and all of the collective workforce, estate and financial resources.

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 achieving quicker and greater improvements in more disadvantaged communities.

We have developed a plan that demonstrates, over the next five years, how we will reach our vision. This plan is being built and developed in co-production with the people who use our services now, or who could use them in the future. The planning has also been built upon a Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis and the outcome of this planning over the next five years is shown in Appendix One to this plan. Appendix Two gives a more detailed set of timelines and responsibilities over 2014/15, and this will be updated for future years.

We plan to work in conjunction with our partners around scenario planning and modelling, to look at system wide impacts/outcomes from our joint interventions, modelling the financial impacts of these and looking at alternative scenarios. This is work in progress and will inform

our plans around prioritisation of interventions across the system, such as reconfiguring acute and community capacity, and the order of the roll out of integrated Out of Hospital teams. This is being matched against a range of interdependencies, such as staffing availability, potential double running costs and the needs for public consultation when looking to reconfigure the system, and reduce reliance on acute care. The Governing Body is focusing intensively on proposals around system reconfiguration during June and July 2014.

The other important focus of work which the Governing Body needs to consider in this regard is how we engage, before proposals are firmed up, with our clinical and public stakeholders, so they can contribute to discussions about service models, prior to proceeding to any formal public consultation required. Formal project scope and timelines will be developed as part of this process, and steering group(s) developed to provide the necessary degree of oversight of the process. In all of this, we will be guided by our recent experiences of the CCG running two successful major public consultation exercises, with the one on service reconfiguration in Lowestoft now complete, and the closure of Lowestoft hospital proceeding to plan.

We will ensure that our integration ambitions and expected outcomes reflect the seven improving outcome ambitions as defined in 'Everyone Counts'. We will also work towards improving health and reducing inequalities for our population, and achieve parity of esteem focussing on improving mental as well as physical health of our citizens. Our improvement trajectories are challenging but realistic, and set out in the metrics supporting our Operating Plan.

The main aims of integration are:

- to engage with our population, irrespective of which of the integrated services they are using, to learn about how they would like services to be configured to best meet their needs
- to improve the quality of the services across health and social care for our local population
- to improve the health of our population
- to reduce inequalities of both access and outcomes
- to secure a stable future for all health and social care organisations
- to improve the efficiency in the provision of the services.

This will bring about outcomes of:

- a system where services are developed based on need
- a system where patients are treated as individuals and not illnesses
- a system where early health and social care interventions improve lives and cost less
- a system where pathways adapt to the individual not the individual shaped to an appropriate pathway
- a system which does not let people fall into gaps between providers
- a system which provides affordable excellence, the Better Care Fund (BCF) is seen as a key enabler
- there is a recognition across Great Yarmouth and Waveney Health and Social Care Stakeholders that they are all in this together to make the above a reality.

We will do this by:

- working with our wider group of partners in the public, private and voluntary sector to build engagement and action in support of our vision.

This vision and five year strategy is reflected within our commissioning intentions for 2014/15, which are summarised within our Operational Plan.

Reducing Health Inequalities

We will proactively work with Health and Wellbeing partners to deliver the Health and Wellbeing Strategy, including those areas of the strategy focusing on health improvement and prevention.

We will actively contribute to health improvement and reducing inequalities by:

- giving every child the best start in life, working closely with Public Health to increase the rates of breast feeding initiation and continuation, reduce mothers smoking in pregnancy and reducing childhood obesity; particularly those from the disadvantaged areas of our population
- reducing the prevalence of obesity, working closely with Public Health in developing and implementing the obesity strategy
- decreasing the harm caused by alcohol to individuals and communities by working jointly with NHS England to ensure that those GPs signed up to the alcohol directed enhanced services (DES) offer appropriate brief intervention and referral where the alcohol tool assesses the need; and working with the county councils to ensure comprehensive treatment services are available to the population where those funded by the NHS are part of an integrated service including those funded by the local authority (LA)
- decreasing the prevalence of smoking, targeting areas of deprivation and thus reducing inequalities.

The Future Shape of our System

As described in the section above, our vision for an integrated care system will bring about some significant changes to the way in which our system is currently configured. These changes will enable integration to proceed at pace, increasing the quality of what we commission and provide for our residents and patients. It will also ensure the sustainability of our providers (including primary care) moving forwards and maximise efficiency. It will also enable us to address the requirement to contain emergency activity and free up resources for the transfer into the Better Care Fund (BCF) in 2015/16 and beyond. We are working closely with our partners (and ICS commissioner colleagues) within Norfolk County Council and Suffolk County Councils to ensure close alignment between our plans for integration, containing emergency activity and changing system configuration, with the schemes for 2015/16 within the BCF. We have a commitment to ensure that schemes retain best outcomes for our population. We plan to move significantly beyond the minimum BCF pooled fund requirement.

Our high level BCF schemes are:

- Supporting independence by provision of community based support interventions
- Integrated community health and social care teams including out of hospital teams and integrated community palliative care
- Urgent care programme, including out of hospital teams
- Support for people with dementia and older people with functional mental health problems living in the community

The BCF schemes are the same schemes across GYW, although they are generated from the BCF plans for Norfolk and for Suffolk. We also have the same local metric across GYW.

Appendix Three shows these BCF schemes and how they support our plans going forward in more detail. This is work in progress and will continue to be developed in the coming weeks.

We continue to keep the sustainability of acute and emergency care services going forward under review, and are focusing on transparency of costs, and working with providers to help reduce their cost base as well as commissioner spend. Clear and honest dialogue is underway with providers about where services are under pressure due to demographic and workforce issues, and to identify innovative ways of maintaining services within an integrated care system.

We recognise the particular opportunities and challenges of working with one District General Hospital and continue to engage around sustainability and how James Paget University Hospital NHS Foundation Trust (JPUH) will become the central player in our ICS going forward. However, this in no way means entrenchment and undue concentration on acute services, working within a climate of funds increasingly transferring from the acute to community sector. We will ensure the sustainability of JPUH by increasingly using their skills and staff across the whole spectrum of care, including within the community. Other providers, for example East Coast Community Healthcare (ECCH), will continue to feature within our integrated services provided for our population, but working increasingly within the ICS envelope.

We also need to recognise the particular characteristics of our area and population – with limited access to other services due to our North Sea coastline, very poor links in our part of the country (no motorways) and lengthy travel times. We are pleased that the continuing role of small DGHs has been acknowledged by the new Chief Executive of the NHS.

We are working with our providers in acute and community health to foster a strategic alliance between JPUH and East Coast Community Healthcare (ECCH). We plan that JPUH will retain its provision of a full service District General Hospital (DGH), but drawing on the opportunities for a networked approach with Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) wherever appropriate, in order to ensure highest standards of clinical safety, but also ensure sustainability of services. We remain very clear that the relative isolation of some of our residents means we need strong local services. Whilst this covers all specialties, those below are notable for their topicality.

Stroke

Our commissioning intentions for 2014/15 set out our position in respect of stroke services: Having reflected on the NHS Midlands and East Stroke review process and findings, the CCG expects its two providers of hyperacute care (JPUH and Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)) to continue to work together to develop effective local clinical network relationships. This should embrace and go beyond collaborative working, to develop joint posts and rotas in order to improve stroke care at both sites, working towards seven day consultant cover and improving patient care and outcomes incrementally towards the gold standard specification set out in the review process.

We have carefully considered both the clinical evidence and expert opinion presented in the review, and also the opinion of our local population. We do not believe that reconfiguration of the provider stroke units at NNUH and JPUH would be clinically or cost effective, based on

the evidence presented. Our patients wish service provision to remain local. We therefore require both units to work together for the benefit of the patients of both Norfolk and Waveney, improving care across both sites. We do not support centralisation of the hyperacute units and will continue to commission stroke services from both sites in 2014/15. We remain open minded about emergence of new clinical and cost effectiveness data which may change our position in the future.

Our case, as set out in our Commissioning Intentions, is further supported by the fact that quality outcomes generally have improved in other areas as well as in London, with our local improvement exceeding the general nationwide improvement. Our local quality standards, measured by both outcome and process metrics, exceed the outcomes delivered by NNUH, which would be the potential central unit. Our long travel times militate against the delivery of acceptable call to needle times.

Cancer

The CCG plans to redesign local cancer services in partnership in order to respond to the future demographic changes which will lead to a significant increase in the number of cancer patients living "with and beyond" cancer in the community, but currently there is insufficient capacity and capability to support these patients in this care setting. Cancer needs to be considered as a long term condition (LTC) and integrated into the LTC community programmes of care and support. This is the purpose of the new integrated cancer care pathway.

It will also support the development of more nurse led elements of care (such as nurse led follow up) to support patients who are transitioning into survivorship and the management of late effects/potential recurrence requiring referral back into acute care systems. This will be a more patient led approach provided close to home. This will also support improved VFM as it will reduce acute consultant led outpatient activity. It will also build community capacity and capability to support the development of outreach chemotherapy services rather than expanding the acute care based provision.

These patients and their families also need support from social care as they finish the acute phase of their treatment and endeavour to return to their previous role within their family/local community. They frequently need welfare benefits advice and support concerning their return to work as well as psychosocial support about their diagnosis and treatment and its ongoing effects on their wellbeing.

The CCG proposes to build on the learning from the community cancer nursing pilot and establishment of the Louise Hamilton Centre to build a community cancer service which is integrated into the Out of Hospital approach and the health and social care multi-disciplinary teams working from community hubs such as Kirkley Mill. The CCG aims to work in partnership with local care providers, the independent and voluntary sectors, social care commissioners, the local EoE strategic clinical network for cancer and specialist commissioning to develop this new model of care.

Other services

Within these plans, we have taken into account the fact that Percutaneous Coronary Intervention (emergency and elective) is already undertaken at NNUH.

The current plans are for JPUH to remain as a major trauma unit, with regular discussions taking place with the Major Trauma Network.

We will continue our plans alongside our mental health provider, Norfolk and Suffolk NHS Foundation Trust (NSFT), to move services out of acute into the community wherever safe and practicable, in accordance with the public consultation just launched. This includes a localised team, with control of its budget. This will considerably help with our integration plans, with many pathways having close synergies with the services commissioned and delivered by our other partners in the ICS. These will be operated with an approach tailored to our locality of Great Yarmouth and Waveney. They can also support improved emergency demand management within JPUH.

Capacity and activity

A key element of maintaining a balanced financial position over the next five years is to reduce capacity within the system. This is covered in more detail later in our plan, but involves reviewing our acute hospital wards and changing the way we provide community based care. We will work with our acute provider to increase efficiencies by reductions in length of stay or by reducing the need for inpatient care. Our proposed reduction in community bed capacity involves commissioning care home bed days based close to local communities, together with providing higher acuity community beds as necessary. This represents a step change in the type of care we can offer in terms of greater personalisation, but as part of the changes, we will ensure that we engage with our stakeholders and communities and undertake formal public consultation as necessary. Our innovative Out of Hospital teams may provide the opportunity to find other ways of addressing community based bed need, using additional care home capacity locally. How we deal with emergency and urgent care is key to an affordable and sustainable system. Emergency admissions have reduced during 2013/14 compared to 2012/13 and we plan to build on the fact that our increasingly integrated working between health and social care is starting to manage down demand. We have plans to help manage the flow of patients into emergency services at the JPUH by innovative models of general practice.

We are focusing on how elective activity is commissioned going forward. Specifics of this include RTT delivery plans, rigorous monitoring of delivery with our acute provider, and involvement of the Intensive Support Team to give reassurance and advice around the robustness of processes.

We are working on pathway design around one stop services, and providing interventions in reduced activity settings e.g. increased day case activity and moving some day case activity to outpatient settings.

We are reviewing our Non Routine and Treatment Thresholds policy to adopt best practice and also to ensure adherence by primary and secondary care.

Primary Care

In this context we are working with our practices to help develop more robust and sustainable primary care and consider how they can collaborate, share learning and resource, and consider consolidation. These conversations are already well developed locally with three practices merging in Great Yarmouth, and discussions on greater collaboration well advanced in other areas. We believe that scale is an essential part of the answer to the challenges faced by this vital sector of our health system.

The leadership displayed by three of our local practices in merging is cause for optimism that the agility and dynamism at the heart of the Independent Contractor model will meet the

challenge and can deliver improved quality (including improved accessibility) and integration while preserving the continuity and localism that our population value so highly. We believe that the potential for both innovation and continuous improvement which comes from independent contractor status has been one of UK primary care's great unsung strengths, and we wish to preserve these strengths in our local provider market. We therefore remain committed to partner-led independent contractor models of provision, while recognising that different organisational and indeed different provider forms or contracts may be appropriate in specific circumstances. Where these circumstances arise we will work to ensure that the same principles of continuous quality improvement, clinical leadership and ongoing innovation benefit the populations served.

Discussions with our member practices about what scale means for them will continue over the years ahead. We do not believe that one size will fit all. In particular the solutions right for our urbanised areas are likely to be different for the market towns of the Waveney valley and the northern villages.

In addition to the challenges of scale, we recognise the profound challenges of an aging population and the need to "wrap" community and outreach specialist services around our vulnerable populations. We recognise the centrality of primary care in delivering these integrated approaches, and have already been incentivising multidisciplinary team working. However our two year operational plan sets out how we will commission "Out of Hospital Teams" across our whole area (implemented in 13/14 in Lowestoft) to support general Practice in looking after patients closer to/in their own homes. This will require different ways of working which understand the primary healthcare team in a wider and more multidisciplinary fashion. We will work with our practices locality by locality to explore how best to do this in their contexts and will continue to invest (for example via the £5/head) to support them as they do.

We are considering the implications of the Keogh urgent care review and what opportunities this may offer given the challenges of scale discussed above. Our draft Urgent Care strategy seeks to interpret the direction of travel regarding more integrated and co-located Urgent Care centres in the context of Great Yarmouth and Waveney. We will be discussing this, and the options that flow from it during the months of June and July 2014.

We have discussed NHS England's recent invitation to co-commission primary care with our local system partners and members. There was strong support from our partners for us to engage with NHS England as this was seen as fitting firmly within the narrative of an increasingly integrated local health system. We recognise the importance of full CCG membership buy-in to this direction of travel, however, as it affects not only the system that they provide services to patients within, but also their day-today business relationships, and potentially alters the relational dynamic between CCG and members. For this reason we took a formal membership vote on the issue.

Our members indicated their support for us to discuss how we might take on a wide scope of co-commissioning with NHS England, and we look forward to taking detailed proposals back to the membership about how this could work to the benefit of the people of GYW. We recognise it will require changes to our formal CCG structure in order to manage potential conflicts of interest. Specific plans will be agreed by the members at a future vote.

Urgent Care Strategy

The Urgent Care Board is reviewing services across GYW to inform the strategy for delivering and developing urgent care strategies, guided by the four principles in the Urgent and

Emergency Care Review – phase 1 report and Evidence Base. Following the development of this strategy, an updated programme of work will be agreed which will incorporate the key recommendations within the Keogh report.

Our assessment of our current state and future state are part of a larger mapping exercise (wider than just the Urgent care elements) which was reviewed by our Governing Body in late June 2014.

We recognise the recent guidance regarding the evolution of UCBs into "System Resilience Partnerships" taking on an increased role in the monitoring and assurance of RTT, and the non-recurrent funding associated. Given our local system's challenges around RTT we have already put in place formal intensive (weekly) monitoring of RTT delivery with the JPUH on a list by list basis. We are committed as a system to this important constitutional standard. In the light of our five year strategy, we will explore how we can strengthen this system wide engagement on this important issue, recognising the role of our Governing Body as the sovereign body within the CCG, our Clinical Executive Committee where system partners are present at the highest delegated decision making group we have, and our successful UCB where a dedicated, detailed operational approach to system urgent care pressures has reaped dividends in terms of both delivery of key targets, and development of operational relationships.

It is important that none of these is undermined, while increasing system ownership of the RTT and elective delivery issues. We will work with our partners to find the right local fit for this priority work.

We are pleased that JPUH was recently quoted as 7th best A&E performer nationwide for 13/14, with the position being even better if children's hospitals are excluded. (reference http://www.bbc.co.uk/news/health-26790545).

Whilst the system cannot afford to be complacent about this excellent performance, it is an indicator of an emergency and urgent care system that is in control, and the contribution that the wider system has played to maintaining performance is acknowledged by all parties.

Our 111 provider is part of the functional ICS and instances of co-location across system, GP in A&E (supporting working as part of functional integration) Points of access to urgent and emergency care will be reviewed including urgent social care, and single point of access developed. 111 will become increasingly pivotal in an integrated system and a readily remembered number by members of the public.

NSFT have developed their Trust Service Strategy and we have consulted publicly on the implementation of this is Great Yarmouth and Waveney. We will announce our decision on the way forward on these proposals in autumn 2014. This will include further clarity on our vision for the future of mental health services locally, with a particular focus on ensuring that these services are fully embedded in our integrated care system over the next five years.

Over the course of the next five years, during which time we will tender for 111 services, we will have worked with all integrated providers to consider a different model of care 24/7, maximising sharing of available resource across all providers – for example JPUH overnight services, Out of Hospital team etc.

We have a very productive relationship with our public health colleagues, with a strong emphasis on prevention. This will necessitate reviewing the emphasis of public health

interventions, for example increasing exercise initiatives to help increase mobility and prevent falls.

Workforce

As an employer

Our focus on the development of our people and our organisation was forged prior to authorisation as an NHS statutory body and our internal workforce approach over the next five years will remain focussed on four key areas:

- capacity and capability to deliver
- quality and governance
- leadership and organisational effectiveness
- engagement with staff, public, primary care and other system providers, CCGs and our CSU

Our direction of travel is articulated in our Organisational Development Plan as outlined in Appendix Four. We will continue to develop this plan over the next five years to ensure we have the capacity and capability to deliver our strategy.

Workforce planning across our system

Demographics show Norfolk and Suffolk has an ageing population well over and above the UK natural average. This is also forecast to grow still further and thus increase demand for NHS services. This will necessitate both an increase in commissions and creates an urgent need to accelerate enhanced productivity and new service delivery models of care.

In order to deliver the CCG's ambitious vision for an ICS it is essential we are aware of the workforce implications and work closely with our providers and Health Education England (HEE) to ensure GYWCCG have the right staff with the right skills in the right place delivering excellent quality safe care. To this end we fully support HEE workforce planning intentions for 2014/15 and beyond and will play an active role in their delivery working alongside the Great Yarmouth and Waveney system providers to ensure their workforce plans:

- are both consistent with service plans developed in accordance with the NHS England guidance and are affordable
- support transformation of services and workforce deployment to ensure appropriate access to high quality services
- describe safe staffing levels
- are developed collaboratively and signed off by senior managers and clinicians
- are transparent and agreed with all relevant stakeholders.

The CCG has invested in our internal workforce and organisational development expertise and these staff will work closely with the Director of Workforce for HEE to ensure that our two year and five year system service plans are reflected in the provider forecasts and the CCG will play an active role during the system review phase's going forward. Workforce implications will be considered as part of all the CCG's inititaives.as we develop and implement our five year strategy.

As part of the local system

Our plans for an integrated care system will require us to instigate and support organisational and workforce development across the local system.

Our strategy is to build efficiency, the right capabilities, skills and capacity in all workforce planning. We will also take the workforce opportunities gained through an emphasis on self-care, to build community capacity whilst drawing on the range of support networks in the voluntary and community sectors as well as the growing carer workforce. We want to ensure people stay independent in their own homes or communities so that emergencies are prevented or minimised where possible and that hospital admissions are planned and discharge timely and effective.

All of this requires a different way of working among existing staff, potentially the creation of new roles and better use of the workforce resource across the whole health and social care system to cater for the increasing demographic pressures and to reduce the demand on the medical and nursing workforce.

We aim to ensure there is a robust workforce lens on service improvement designs across Great Yarmouth and Waveney so that workforce planning and development is integral to both design and implementation of new ways of working.

We will continue to work with HEE to secure funding for a number of workforce proposals that will result in shared bespoke learning programmes that build resilience and develop a culture of readiness for change across the health and social care system. We are particularly focused on developing action learning with integrated teams that result in real service delivery. Another focus will be on roles that cross both social care and health care, co-located teams and joint posts will also be considered as we develop our integrated care system, where services work collaboratively together, with integrated management and team structures, where professionals have immediate access to other parts of the integrated care system. In order for this to be successful our training programmes will include cultural change development with a “one team” approach at the heart of what we are trying to achieve, where the patient comes first.

Our planning will also support the development of integrated neighbour teams and networks with the aim of maximising the available workforce resource and so reducing demand on medical and nursing capacity.

Delivery will move us from a provider focus on workforce issues to a system-wide focus building relationships between key players and partners. By involving all it will be possible to look at ways to redistribute demand for medical and nursing staff through the imaginative use of the total resource across the health, social care and voluntary sectors. Most importantly projects undertaken will have buy in and oversight from all those affected from the inception through completion and will support system-wide integration.

GYWCCG have invested in specialist resource in organisational development and workforce planning expertise. As a result we are able to take an active part in all strategic workforce committees across both Norfolk and Suffolk. As members of these groups, Great Yarmouth and Waveney will take a strategic overview of the priorities and needs of the health and social care workforce with a particular focus on supporting collaborative working. We will take a lead in task and finish groups, provide intelligence on workforce practice and challenge; recommend and help implement changes that support the development of new service models.

Primary Care development will also be a key workforce priority over the next five years and we will work very closely with HEE to develop sustainable plans for the future. The CCG has worked with all our GP Surgeries to provide a wealth of narrative to HEE so we can inform and support the development of primary care workforce plans going forward.

In order for patients to receive seamless quality services over seven days our aim is that staff from all organisations in our system work together across both professional and organisational boundaries for the good of the patient. Although this culture of co-operative working is evident across some areas there is still much work to do and we aim to focus our workforce plans to achieve this culture fully across GYW.

Our emerging priorities, recognising the imperative to maintain focus and morale in this huge time of change, are:

- communication, consultation and culture
- roles, working arrangements and co-location
- processes and policy.

We intend to work collaboratively with our partners to ensure that the staff aspects of integration are managed in such a way that support a sustainable, viable and effective integrated care system with:

- maximised and appropriate capacity and capability – and staff working to common values
- workforce plans that align to the vision
- excellent leadership with system resilience for the future
- joint posts and co-located teams
- collective budgets used effectively for staff development, generic roles and system organisational development.

Our two year operational plan contains more detail on how we intend to progress these system wide plans over the next two years.

Financial Planning and Sustainability

Whilst we have a clear direction of travel around our ICS we need to be mindful of the need to ensure value for money and radical and innovative models of care. We will look at opportunities for competitive dialogue and tendering of services where appropriate. We will also work in conjunction with our commissioning partners to maximise opportunities to share scarce resources and exploit different procurement avenues. We see the BCF as a catalyst to achieve a functional ICS and have agreed with our county council colleagues to expand the scope and scale of the BCF. We are embarking upon at scale system redesign, bringing health and social care services together with integrated commissioning and service provision as the outcome. We are using the opportunities of scale to pool and align funds to produce larger budgets, with proportionately lower percentages of absolute savings required, with appropriate risk share arrangements. Our headline list of schemes will be further refined as this work proceeds.

Financial planning including, Quality, Innovation, Productivity and Prevention (QIPP) savings and investments, needs to ensure a healthy recurrent underlying financial position. In the current climate making savings as part of an efficiency driven and collaborative approach and

taking account of any transactional savings to help balance the annual financial position is crucial. Prioritising non-recurrent funds strategically to pump prime invest to save projects that will have a return on investment in future years that is greater than cost is key.

Appendices five and six set out the financial challenges facing the CCG and our headline opportunities to bridge the financial gap.

Vital to service planning in the future will be not only what we provide and where, but what we no longer provide, either in a particular setting or at all. An integral part of the financial plans is to achieve the potential reduction in hospital activity. What we must drive, in collaboration with our partners, is a radical transformation of how services are provided which will enable public funds to be used more cost effectively, across all sectors.

The local health system will only remain financially sustainable through integration and collaborative commissioning, through working closely with providers and ensuring that future decisions are made for the benefit of the local system.

Figure 1 overleaf shows our five year vision.

FROM
Citizen engagement
TO
“Better Health/Wellbeing, Better Care, Better Value.”

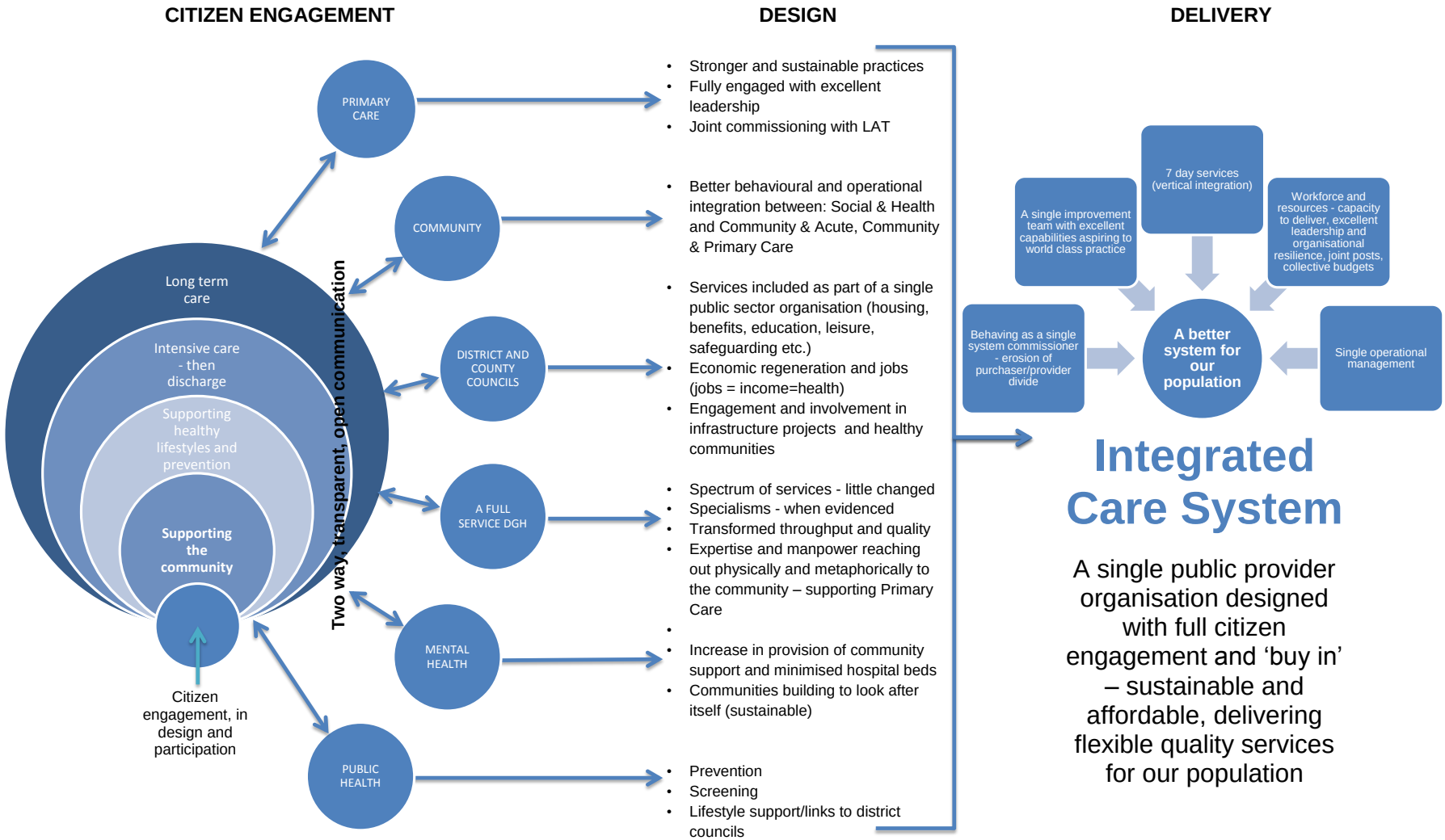


Figure 1

Integrated Care System

NHS Great Yarmouth and Waveney CCG operates across both Norfolk and Suffolk County Boundaries encompassing two county councils and two district councils.

The ICS is a radical, ambitious and transformational approach towards integration, working across two county councils and two district councils. Its prime purpose is to put patients and clients at the centre of services, with the needs of the person dictating the way the system responds, rather than their needing to move between organisational and artificial funding barriers. The Great Yarmouth and Waveney approach builds on our strong history of community engagement and input from the four distinct communities in Great Yarmouth and Waveney and builds on the successful operational integration of teams to date. We expect to increasingly see blurring of the boundaries between our acute and community providers, with shared teams, and inreach and outreach services between the organisations. These will build on our Out of Hospital strategy, and also draw on the different service models as integration of the services available via the CCG, the two county councils and districts proceeds.

Figure 2 shows the players within the ICS and the expected benefits of integrated working.

The ICS (virtual at first) will encompass the activities of all of the local organisations responsible for health, social care and district council services. This will deliver high quality, person friendly services in a coordinated way, which removes organisational and transactional barriers and costs so that the maximum proportion of funding possible is used for the care of the population. We aim to care for all sections of the community but will focus particularly on those most needing care and help and those at risk of becoming so.

Planning and development towards an ICS has involved whole system working with letters of intent signed by each commissioner organisation including local county councils and districts. The Great Yarmouth and Waveney System Leadership Partnership with members from all public sector commissioners and providers, plus Healthwatch and the voluntary sector, together with the police, have been involved in the ICS and BCF planning process. A Great Yarmouth and Waveney ICS event was held in December 2013, attended by all public sector commissioners and providers from the area, including health and social care. At this event the declared intention to develop an ICS was fully debated including the opportunities presented by the BCF. Key principles were agreed and the areas discussed in more detail to inform the early development of the ICS and the BCF included seven day services, cohesive pathways, combining budgets and workforce. These discussions and engagement with partners has guided GYWCCG's approach to two year operational and five year strategic planning to improve outcomes for the public, provide better value for money and be more sustainable, where health social services and district councils work together to meet individual needs.

It is clear that if primary care is to be the foundation of which our integrated care system is based, then ensuring that it is robust, providing uniformly high quality services and able to 'respond to individuals' needs is vital. We believe that to do this, primary care will need to work more closely together, within the integrated care system, potentially in alliances or federations between neighbouring practices. We have the ambition of supporting the development of larger, stronger, better resourced teams of GPs, nurses and other professionals working from multi-disciplinary healthy living centres in close concert with non-health partners such as benefits officers, community police staff and social care professionals.

The BCF gives us an opportunity to accelerate progress in delivering the vision of GYWCCG. In particular the focus on early intervention and prevention, ensuring services are integrated at the point of delivery, that there are seamless health and social care services with staff working across organisational boundaries for the good of the person.

Health and wellbeing encompasses a person's life experience and includes a sense of physical, mental and social wellbeing. Many factors contribute to a person's wellbeing, for example, how safe they feel in their community and whether they are able to find a job. Through working jointly across health, local government and wider communities we can make a real difference in improving the health and wellbeing opportunities for those across our area.

To drive this vision forward, as well as the established Great Yarmouth and Waveney System Leaders Partnership, the system leaders have created an Integrated Care System Programme Board whose role is to develop and oversee action plans for delivery. Members are accountable to a range of audiences to deliver rapid progress towards an ICS. They will work closely in partnership with all local organisations responsible for health, county and district council services to ensure whole system engagement, commitment and implementation of ICS principles through aligned activities, sharing of budgets and pragmatic integrated projects. The Programme Board will develop and oversee action plans, and agree workstreams, including seven day services, combining budgets and workforce development, as well as agreeing risk share and arrangements and identifying risks and mitigation. We see this as an iterative process, learning from developments as we go along, and focusing on pragmatic integrated projects.

GYWCCG is delighted to have been awarded Early Adopter status for seven day services, which is an essential component of our integrated vision, which was commended by the national team of NHS Improving Quality (NHS IQ) for its clarity. Coupled with our work with seven day services, we will work to identify which pathways may be amenable to a move away from tariff, and towards costed packages of care for certain combination of conditions.

The planned financial modelling referenced earlier will help us identify the initial coverage of our ICS – during the first year of 2014/15 probably around a selected number of pathways where we will combine budgets between the commissioners, streamline management and co-locate teams. We will evaluate the success and impact of this work during 2014/15 and expand on the number of combined pathways and budgets during 2015/16. We will also look to rationalise the use of estate between the partners. The development of the ICS is likely to require both staff and public consultation with regards to some elements.

Our other headline local quality improvement plan is our Out of Hospital strategy. This facilitates a move away from traditional bed-based models within acute and community care, to a model that supports people remaining safely at home, wherever possible. The first Out of Hospital team, to support one of our two main centres of urban population, is effective from April 2014. This is an integrated team of health and social care workers, using shared facilities, increasingly sharing data and with streamlined management. We are expanding care home capacity in the area, to accommodate those patients who need a period of more intensive input than services at home will be able to provide. We have tendered for the first set of care home beds to be put to this use. The Out of Hospital teams will be expanded over the course of the next two years to cover the whole of our area, once we have tested and refined the model.

We also have other improvement initiatives in course of planning, which are shown in Figure 4. These are intended to ensure that we deliver improvements in quality as set out in the NHS Outcomes Framework, and to support our overall drive to quality.

We are setting discussions in motion with our integration partners about how we best utilise and gain access to data between us. This includes innovative methods of modelling how individuals pass through the system and assessing the impact of changes.

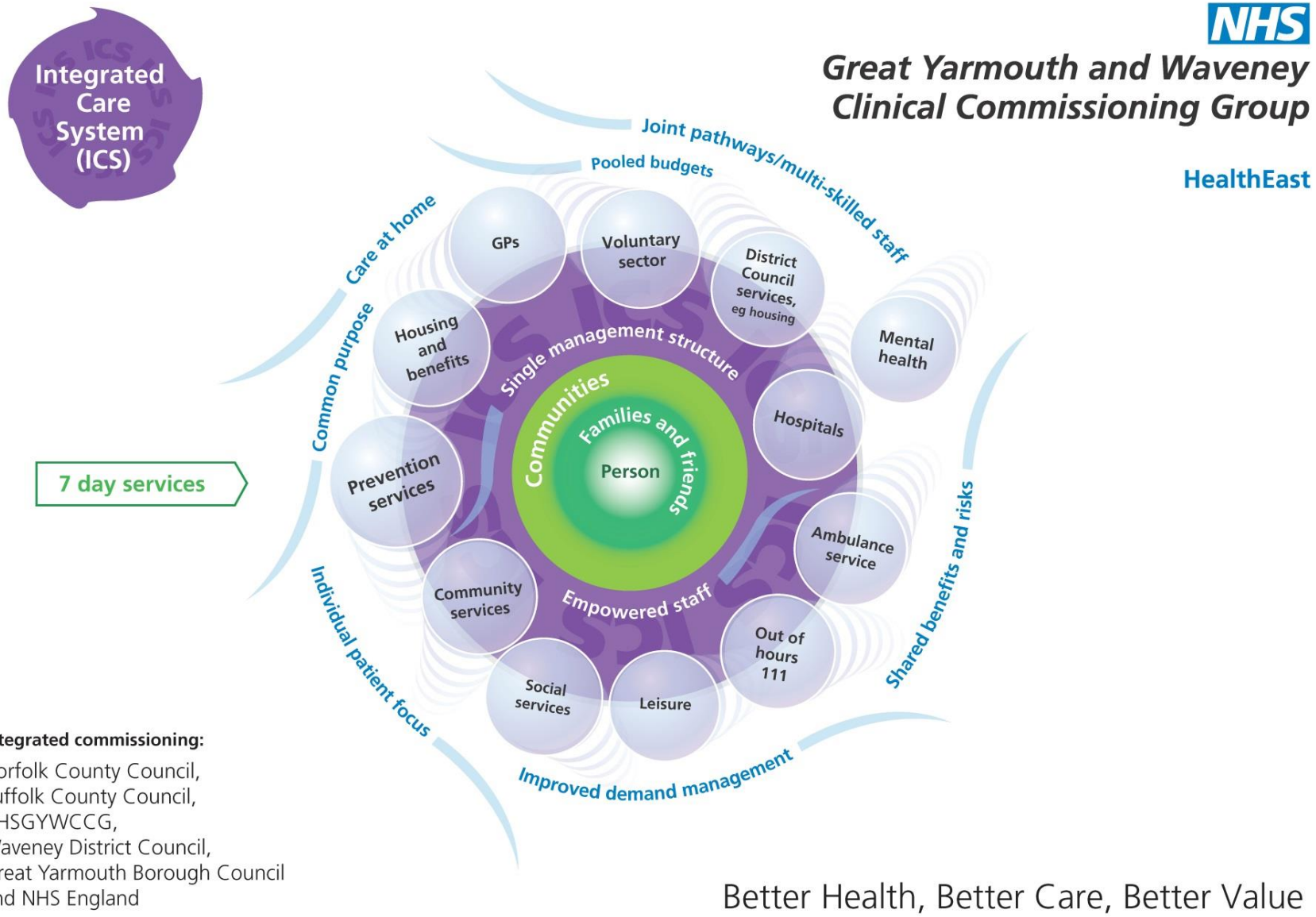

Integrated Care System (ICS)
NHS
Great Yarmouth and Waveney Clinical Commissioning Group
HealthEast
Joint pathways/multi-skilled staff
Pooled budgets
Care at home
Common purpose
7 day services
GPs
Voluntary sector
District Council services, eg housing
Mental health
Hospitals
Ambulance service
Out of hours 111
Leisure
Social services
Community services
Prevention services
Housing and benefits
single management structure
Communities
Families and friends
Person
Empowered staff
Shared benefits and risks
Individual patient focus
Improved demand management
Integrated commissioning:
Norfolk County Council,
Suffolk County Council,
NHSGYWCCG,
Waveney District Council,
Great Yarmouth Borough Council
and NHS England
Better Health, Better Care, Better Value

Figure 2

Plan on a Page

We have developed a Plan on a Page, Figure 3 overleaf. This sets out our system vision and simply describes, on just one page, how we will work together as a system to deliver this vision over the next five years, as follows:

System Vision: This sets out what we plan our health economy to look like in 2018/19, with a system-wide focus.

Outcome ambitions: We have reviewed the seven improving outcome ambitions set out in the planning guidance for patients, 'Everyone Counts'. We have mapped our work against these ambitions with a local Great Yarmouth and Waveney focus. We have also included the metrics here by which we will measure our success.

Improvement Interventions: These explain the key improvement interventions which we plan to deliver the outcomes and ensure quality and sustainability.

Finally, we set out the necessary governance arrangements which will oversee the delivery of these plans, including our success measures. The Plan on a Page finishes with a summary of the values and principles we have adopted as a health and social care system.

We will share this Plan on a Page widely with all our stakeholders and publish it on our website.

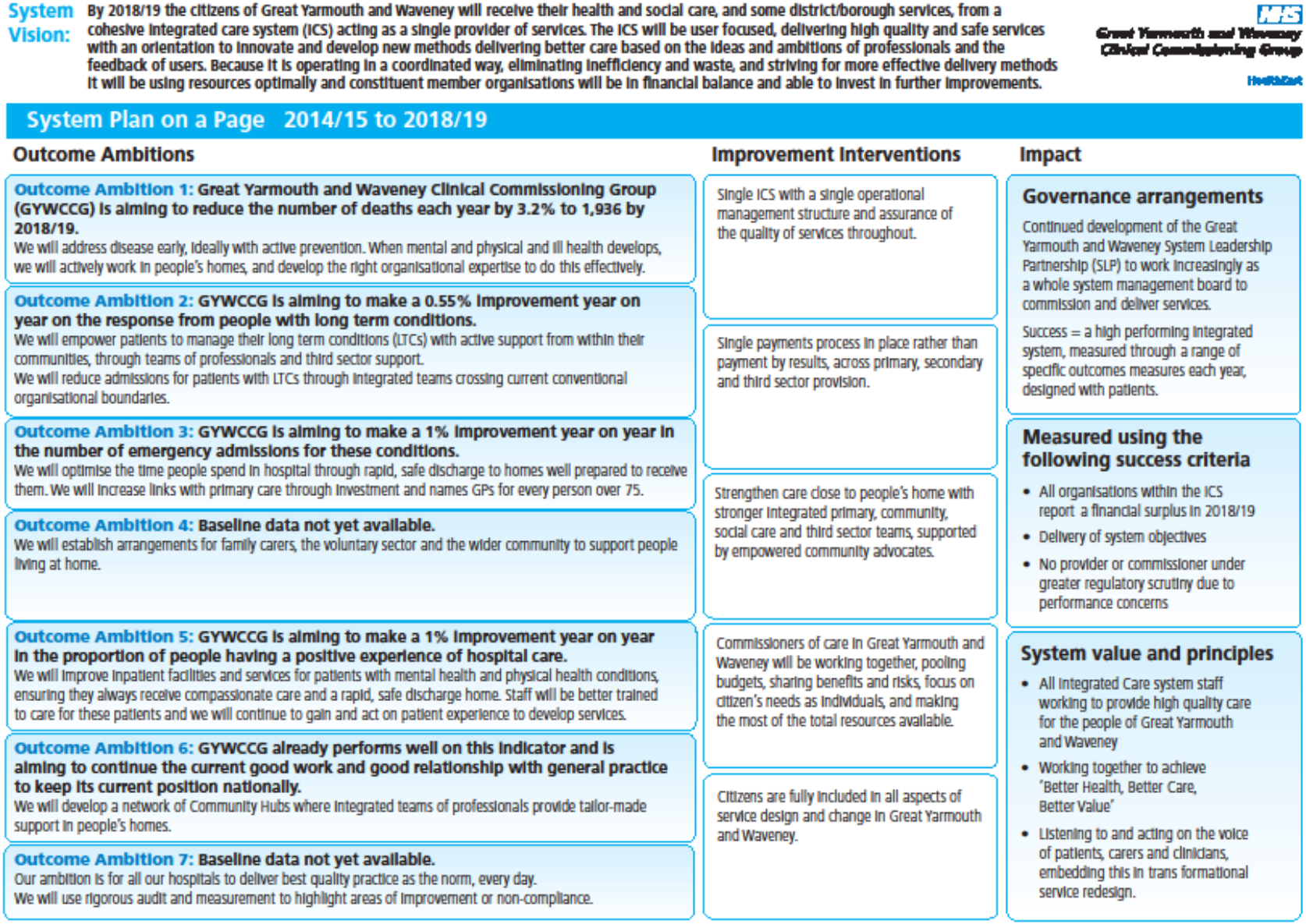

System Vision:
By 2018/19 the citizens of Great Yarmouth and Waveney will receive their health and social care, and some district/borough services, from a cohesive integrated care system (ICS) acting as a single provider of services. The ICS will be user focused, delivering high quality and safe services with an orientation to innovate and develop new methods delivering better care based on the ideas and ambitions of professionals and the feedback of users. Because it is operating in a coordinated way, eliminating inefficiency and waste, and striving for more effective delivery methods it will be using resources optimally and constituent member organisations will be in financial balance and able to invest in further improvements.
NHS
Great Yarmouth and Waveney Clinical Commissioning Group
System Plan on a Page 2014/15 to 2018/19
Outcome Ambitions
Improvement Interventions
Impact
Outcome Ambition 1: Great Yarmouth and Waveney Clinical Commissioning Group (GYWCCG) is aiming to reduce the number of deaths each year by 3.2% to 1,936 by 2018/19.
We will address disease early, ideally with active prevention. When mental and physical and ill health develops, we will actively work in people's homes, and develop the right organisational expertise to do this effectively.
Outcome Ambition 2: GYWCCG is aiming to make a 0.55% improvement year on year on the response from people with long term conditions.
We will empower patients to manage their long term conditions (LTCs) with active support from within their communities, through teams of professionals and third sector support.
We will reduce admissions for patients with LTCs through integrated teams crossing current conventional organisational boundaries.
Outcome Ambition 3: GYWCCG is aiming to make a 1% improvement year on year in the number of emergency admissions for these conditions.
We will optimise the time people spend in hospital through rapid, safe discharge to homes well prepared to receive them. We will increase links with primary care through investment and names GPs for every person over 75.
Outcome Ambition 4: Baseline data not yet available.
We will establish arrangements for family carers, the voluntary sector and the wider community to support people living at home.
Outcome Ambition 5: GYWCCG is aiming to make a 1% improvement year on year in the proportion of people having a positive experience of hospital care.
We will improve inpatient facilities and services for patients with mental health and physical health conditions, ensuring they always receive compassionate care and a rapid, safe discharge home. Staff will be better trained to care for these patients and we will continue to gain and act on patient experience to develop services.
Outcome Ambition 6: GYWCCG already performs well on this indicator and is aiming to continue the current good work and good relationship with general practice to keep its current position nationally.
We will develop a network of Community Hubs where integrated teams of professionals provide tailor-made support in people's homes.
Outcome Ambition 7: Baseline data not yet available.
Our ambition is for all our hospitals to deliver best quality practice as the norm, every day.
We will use rigorous audit and measurement to highlight areas of improvement or non-compliance.
Single ICS with a single operational management structure and assurance of the quality of services throughout.
Single payments process in place rather than payment by results, across primary, secondary and third sector provision.
Strengthen care close to people's home with stronger integrated primary, community, social care and third sector teams, supported by empowered community advocates.
Commissioners of care in Great Yarmouth and Waveney will be working together, pooling budgets, sharing benefits and risks, focus on citizen's needs as individuals, and making the most of the total resources available.
Citizens are fully included in all aspects of service design and change in Great Yarmouth and Waveney.
Governance arrangements
Continued development of the Great Yarmouth and Waveney System Leadership Partnership (SLP) to work increasingly as a whole system management board to commission and deliver services.
Success = a high performing integrated system, measured through a range of specific outcomes measures each year, designed with patients.
Measured using the following success criteria
• All organisations within the ICS report a financial surplus in 2018/19
• Delivery of system objectives
• No provider or commissioner under greater regulatory scrutiny due to performance concerns
System value and principles
• All Integrated Care system staff working to provide high quality care for the people of Great Yarmouth and Waveney
• Working together to achieve 'Better Health, Better Care, Better Value'
• Listening to and acting on the voice of patients, carers and clinicians, embedding this in trans formational service redesign.

Figure 3

Engagement, Strategy and Co-production

Patients are the focus of all we do in NHSGYWCCG. Across, the CCG there is active patient, carers, service user and public engagement. Commissioning Programme Boards include representation from patients, family carers, service users, voluntary sector representatives and the public on all programmes. There is also patient representation in other forums, including on our Governing Body. Patient representatives are co-opted to Urgent Care Board projects as when necessary.

The views of these groups are regularly sought through Commissioning Programme Boards and wide range engagement events to inform the development of integration and future commissioning intentions. These include public consultations, working alongside our patient groups in all our GP Practices, working with Healthwatch and our local Health Scrutiny Committees. NHSGYWCCG has listened to what they have said and included their views in strategic and operational planning including CCG overall approach to the BCF.

We will need to develop habits of flexibility, compromise, transparency, honesty, engagement and listening to our customers and patients. In order to deliver better outcomes and greater efficiencies there needs to be more integrated approach to service provision. This includes all organisations working more closely across organisational and professional boundaries and changing staff behaviours to encourage system and whole team working. This is underpinned by a passionate belief that we are doing the right thing.

We have a programme in place to ensure that we engage with our patients and public about the design of our services going forward. This includes a programme of events such as a public participation forum in February 2014, and plans for further regular events of this nature.

We consider that it is essential we provide feedback to patients and carers who are engaged in our commissioning work about how their views and feedback have been included in our operational and strategic work. We do this through giving specific feedback on our progress on implementing suggestions and feedback at our bi-annual Patient, Public and Community Events, Patient Participation Group Forum, Patient and Public Experience Group, following market research insight work e.g. most recently on stroke and mental health services, and through our Programme Boards and workstreams. Our recent public consultation on the reconfiguration of services in Lowestoft produced a report which answered every question posed by the 600 plus respondents, and explained our actions in response to the issues raised. The consultation on services provided by NSFT has produced over 1000 responses.

Patients, carers and our local community have all been involved in helping to develop our five year vision for healthcare in Great Yarmouth and Waveney. During 2013 we held two public events with patients, carers and community members.

Some of the key themes from these workshops have been woven into our five year strategic plan:

- co-ordinated health care and social care
- support for the family/carer
- more education required for patients
- better communication between GPs and the hospital
- 24/7 access
- clinicians available at weekends to enable discharge

- avoiding multiple assessments
- ‘walking sign posts’ like the Gorleston Connected Care initiative and our Community Advocates
- joint health and social care plans, owned by the patients which include goals, support and key workers
- integration will work and support Carers if services are seven days a week.

Improving Outcomes and Quality

Our Operational Plan covers in detail the outcomes to deliver across the five domains and seven outcome measures, measures to improve health and reduce inequalities and to ensure parity of esteem. Our measures of quality outcomes improve, year on year, and how they will be supported by QIPP schemes, are shown in Appendix seven.

Our Operational Plan also addresses how we will ensure consistent excellent delivery against a number of areas which are very important to the public, and high profile in media terms – such as RTT and IAPT.

The five most cost effective high impact interventions in the National Audit Office (NAO) report of health inequalities have been assessed and we will try to implement the NAO recommendations to increase the prescribing of drugs to control blood pressure and reduce cholesterol, as well as working with public health to increase the capacity of smoking cessation services.

We have used the five steps in the framework for commissioning prevention to identify and plan initiatives to improve the health of our population and reduce inequalities.

1. Analyse the most important health problems at population level.

Using the joint strategic needs analysis (JSNA) and the Commissioning for Value (CfV) pack, we have identified that our population has significantly greater rates of years of life lost due to premature mortality for chronic obstructive pulmonary disease (COPD), lower respiratory infections, gastrointestinal diseases and trauma/injuries.

We have significantly high elective and non-elective admissions for people with cancer, circulatory and respiratory diseases. Currently the prevalence of diabetes is not significantly high, but with high levels of obesity in our population, the projections show a significantly high increase in diabetes prevalence over the coming years. We are also aware that increased focus on diabetes will improve cardio vascular outcomes.

The Better Value Pack shows that potentially we could save on cancers, CHD, respiratory disease and GUM. GUM services are currently out to tender and savings may be made with a new provider. Moving away from tariff based pricing will enable better analysis of pound per head spent.

Commissioner spend data is currently skewed by the application of tariff. Public health specialist analysis is currently underway, with early discussion planned with clinicians; including other high spend areas as well as those mentioned above.

The Anytown model suggests that rural models are more applicable to us and we are currently reviewing whether any of the suggested initiatives may be beneficial for us. The modelling around the Better Care Value pack and Anytown model is being led by our public health colleagues.

We are benchmarking our data by carrying out public health analysis on A&E admissions, top 5 reasons for attendances and conducting statistical process analysis at CCG level, to compare trends in our population with other areas.

Additionally, we are reviewing growing morbidity in comparatively younger populations compared to previous years.

Analysis regarding the JSNA is currently underway, including strengthening data to support the delivery of the children's and families act for 0- 25 year olds.

2. Working together with partners and the community, set common goals or priorities.

3. Identify high-impact prevention programmes focused on the top causes of premature mortality and chronic disability.

We will prioritise integration of respiratory services to improve the health of patients with respiratory illnesses and reduce hospital admissions by improving care in the community, early diagnosis and interventions and work towards reduction in the smoking prevalence.

We are developing a scheme whereby the amount of specialist support and training available to primary care around improved management for patients with diabetes is increased. We are drawing on the specialisms available within our acute provider and making them more readily accessible to primary care. We are also working with Public Health to reduce the prevalence of smoking and obesity in our population, particularly in areas of greater deprivation.

4. Plan the resource profile needed to deliver prevention goals.

Our colleagues in Norfolk and Suffolk County Councils have a strong drive to increase prevention of ill health and dependency on social care services. We plan to develop BCF schemes for 2015 to 2016 that build on the prevention agenda.

5. Measure impact and experiment rapidly.

The Operational Plan covers our plans around how we will achieve ambitions but realistic improvements in the seven improving outcome ambitions.

With regards to improving the productivity of elective care over the next five years we have set an expectation that JPUH provide a plan as to how this will be achieved and we are expecting this in the near future. Specifics of activities and innovations include:

- Treating the same numbers of patients at lower cost, by implementing one stop shops to reduce numbers of separate attendances e.g. for wet AMD. Implementation of some early one stop shops this year will support learning on how to expand these during 2015/16
- Increasing our already high day case rates e.g. breast mastectomies as day cases (already in place) and exploring shift from day case to outpatients
- We intend to work through service by service with individual leads in secondary care to identify what is possible and achievable, seeking to front load the plan with one stop shops and demand reduction in high volume areas such as ENT and dermatology
- At the same time, we are trialling more restrictive referral form for low clinical value procedures and more rigorous application of evidence based thresholds for other elective procedures e.g. in ENT
- We are also doing work around referral proformas, to include tick boxes around diagnostics and the possibility of generic diagnostic requesting, to allow JPUH to decide the most appropriate x-ray/scan and improve efficiency.

The Trust has developed a dedicated Transforming Surgical Services project with an objective of delivering improvements within the Trust's operating theatres to improve utilisation and effectiveness of the available capacity. The transformation approach covers the patient's journey from the decision to treat, through to discharge and focuses on the following five areas:

1. pre-assessment and admission
2. planning – scheduling and allocating theatre lists
3. utilisation and theatre processes
4. day surgery
5. specialty reviews.

The objective is to realise achievable and sustainable changes to theatre efficiency. The programme is led by the Divisional Director for surgery with wide clinical engagement to ensure ownership and aid implementation. The underlying theme will be to fully align demand and capacity in all specialties, based on referral patterns and emerging commissioning intentions. This project will also include developing new ways of working for the new theatre templates of the new Day Surgery theatre suite, which will be fully operational during 2015.

Sustainability

Our Operational Plan contains more detail about how we will ensure financial sustainability going forward. Our strategic approach to achieving a very challenging QIPP target in 2014/15 and undertaking transformational change to prepare for 2015/16 and beyond, is predicated on the following principles:

- using the opportunities offered by out of hospital care to reduce the number of people requiring hospital admissions.
- efficient and effective integrated pathways, through the vehicle of our ICS and the BCF. This will improve quality, reduce duplication and handoffs and ensure a more person centred approach.
- close attention to transactional savings, to maintain our current efficiencies
- contractual efficiencies
- some potential de-commissioning, yet to be fully determined and agreed.

Use of prevention to help with sustainability of our system

For the sustainability of our health and care system, we will plan for transformational changes in how we commission and provide our services. The emphasis will be on prevention, stopping people becoming ill and taking steps to avoid their long term conditions worsening.

The ageing population and increased prevalence of chronic diseases require a strong reorientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated. Treatment and care of those with long-term conditions accounts for 70 per cent of the primary and acute care budget in England (DH 2011). It is estimated that 80 per cent of cases of heart disease, stroke and type 2 diabetes, and 40 per cent of cases of cancer could be avoided if common lifestyle risk factors were eliminated (WHO 2005). Around 70–80 per cent of people with long-term conditions can be supported to manage their own condition, and thus prevent their condition worsening.

We will try to implement with our partners the evidence-based interventions including: supporting individuals to change behaviours, for example, through brief advice during a consultation; systematic community interventions in schools to reduce childhood obesity; and regulatory actions, such as controlling the density of alcohol outlets.

Improvement Interventions

Figure 4 overleaf shows our headline vision and ambitions in respect of each of the elements of transformation change specified in 'Everyone Counts'.

The CCG takes seriously the need to inform our improvement efforts with both data (metrics, finance and activity etc) and information (patient and clinical feedback, site visiting, clinical audit and service reviews – our "Go and See" methodology). All of this is worked together iteratively with stakeholders so that final outputs are recognizable descriptions of current state reality for those using and delivering the service. Improvement actions are collaboratively worked up with providers in keeping with our ethos of integration and collaborative working. We recognise the value in using validated improvement tools such a flow and value stream mapping, fishbone diagrams, pareto diagrams etc. However we also recognise that the "harder" elements of improvement science can disengage frontline clinicians and thus while these tools may be used, we talk with local clinicians about "making things better" not (for example) Kaizen!

Finally we have reflected as we formed on our experiences of predecessor organisations and transition. We have noted three key aspects of successful local health system improvement which we are paying particular attention to as we undertake large scale change.

- Clinical Leadership, clinical engagement – we invest in time from local clinicians to be involved at every stage of our improvement and commissioning work, and have spent time training them in formal improvement techniques; we continue to meet with them regularly using "Action Learning" methodology to work together to progress our plans.
- As well as involving our primary care colleagues, we recognise the importance of involving secondary care clinical colleagues. Our involvement includes their attendance at senior level meetings with JPUH, representation on the Urgent Care Board, our Clinical Executive Committee and as a non-voting member of our Governing Body.
- We also ensure we maintain close links with non clinical bodies, for example the third sector, through developing individual relationships as well as their valued membership of the GYW System Leaders Partnership
- The importance of relationships – while we recognise the importance of contracts, we have found that people do things for people, not for contracts. We have therefore spent time developing relationships across the area (wider than just the health system) to support the change agenda and to help us to improve.
- Improvement Cycles – we have been explicit with our partners, stakeholders and providers that we know that large scale change cannot be expected to land perfectly from day one. We actively encourage constructive feedback as we implement, and have formal mechanisms for reporting incidents (Quality Incident Reports) from which we can learn and improve further.

Timescales for implementing improvement initiatives and milestones of 5 year plan

As referenced earlier, appendices one and two contain a five year high level set of milestones and supporting SWOT analysis, together with a more granular resourcing and delivery plan during 2014/15. It should be noted that the five year plan is subject to further discussion and development with our integration partners.

Characteristic	Our ambitions, intentions and vision for a health and social care system in Great Yarmouth and Waveney
Citizens involved in all aspects of service design and change and patients that are fully empowered	• Transparent, open communication and full citizen participation • A single public service provider organisation with full citizen design and 'buy in' – sustainable and affordable, delivering flexible, quality services for our population • Communities building to look after itself (sustainability) • Engagement and involvement in infrastructure and healthy communities • Creating well-being not just delivery of health care • A focus on the whole population • Provision of care at home or in local communities wherever possible
Wider primary care, provided at scale	• Stronger and sustainable practices - fully engaged with excellent leadership • Joint Commissioning with our local area team • Investment in primary care • Stimulating prevention and early treatment
Modern model of integrated care	• Driving integration, across the whole public sector not just health - all services included as part of single public sector organisation • Prevention playing a greater role in securing improved health for our population • Greater behavioural and operational integration between social/health and community/acute • Behaving as a single system commissioner – erosion of purchaser/provider divide • A single improvement team with excellent capabilities aspiring to world class practice • Collective budgets used effectively to the benefit of the population • Achieving the best use of total resources available for local citizens • Sharing benefits and risks with commissioning partners and providers • Removing perverse incentives for providers
Access to highest quality urgent and emergency care	• 7 day services (with specific focus on out of hospital care and discharge from secondary care) • A full service DGH • Transformation and different pathways of care in some conditions and disease areas e.g. respiratory care, diabetes, falls management, palliative care, discharge management, bed management • the creation of an out of hospital team
Step change in productivity of elective care	• Transformed throughput and quality
Specialised services concentrated in centres of excellence	• Specialisms – when evidence based

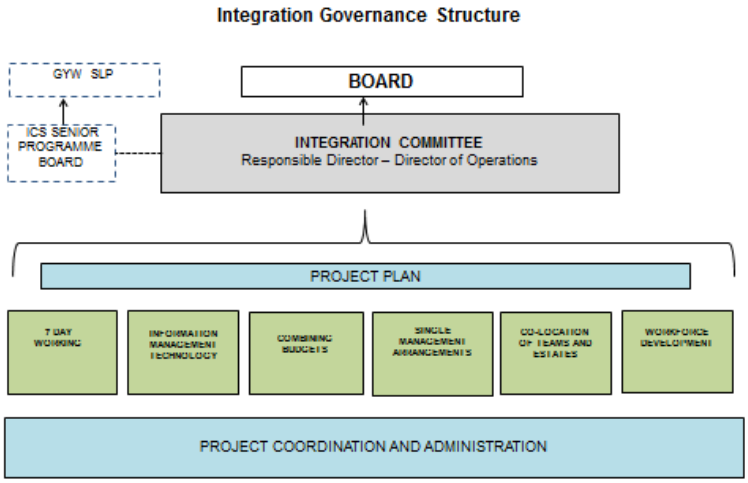
Figure 4

Governance Overview

Our Operational Plan contains more detail about our delivery mechanisms. We will ensure that we retain robust governance by means of:

- regular reports to our Governing Body around quality, finance, performance, progress against our transformational initiatives and public and patient engagement. These reports include reference to our performance against the NHS Constitution metrics.
- the work within our Clinical Quality and Patient Safety board committee, which scrutinises quality of our providers and the quality outcomes of our service initiatives, for example the commissioning of care home beds to support our out of hospital strategy
- the clinical direction setting and scrutiny undertaken by our Clinical Executive board committee, which holds delegated authority from the governance body to approve business cases up to a limit of £250K
- a newly established Integration board committee, which will retain oversight of our progress towards an integrated care system, that we are abiding by competition and procurement requirements, and in connection with our proposals around combining budgets with our commissioning partners and in terms of the administration of the Better Care Fund
- our Audit board committee, and Finance and Performance sub-committee, which retain oversight of financial probity, safe and effective systems and improving performance.

Additionally, we have established a maturing ICS Senior Programme Board, comprising director level members from each of our commissioning partners. This board has responsibility for delivering the ICS, and reports to the Great Yarmouth and Waveney System Leaders Partnership, as well as the governing bodies or equivalent of each of the commissioning bodies. Our main provider organisations will shortly be invited to become members of the board. Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH) is a peripheral provider for the GYW system, so it is not planned that they would become members of the ICS programme board. The NNUH involvement is as a partner in functional clinical networks supporting certain aspects of service provision, for example, ENT, cardiology, neurology and stroke. However they are not part of the organisational transition to the ICS.



Appendices

Appendix 1
Achieving the Great Yarmouth and Waveney Integrated Care System – Plan on a Page 2014-2019

Appendix 2
Delivery and Resourcing Roadmap 2014/15

Appendix 3
Better Care Fund Plan on a Page – Great Yarmouth, Norfolk
Better Care Fund Plan on a Page –Waveney, Suffolk

Appendix 4
Workforce and Organisational Development Plan 2014/15

Appendix 5
Finance Strategy

Appendix 6
QIPP Plans

Appendix 7
Quality Outcomes 2014/15 to 2018/19