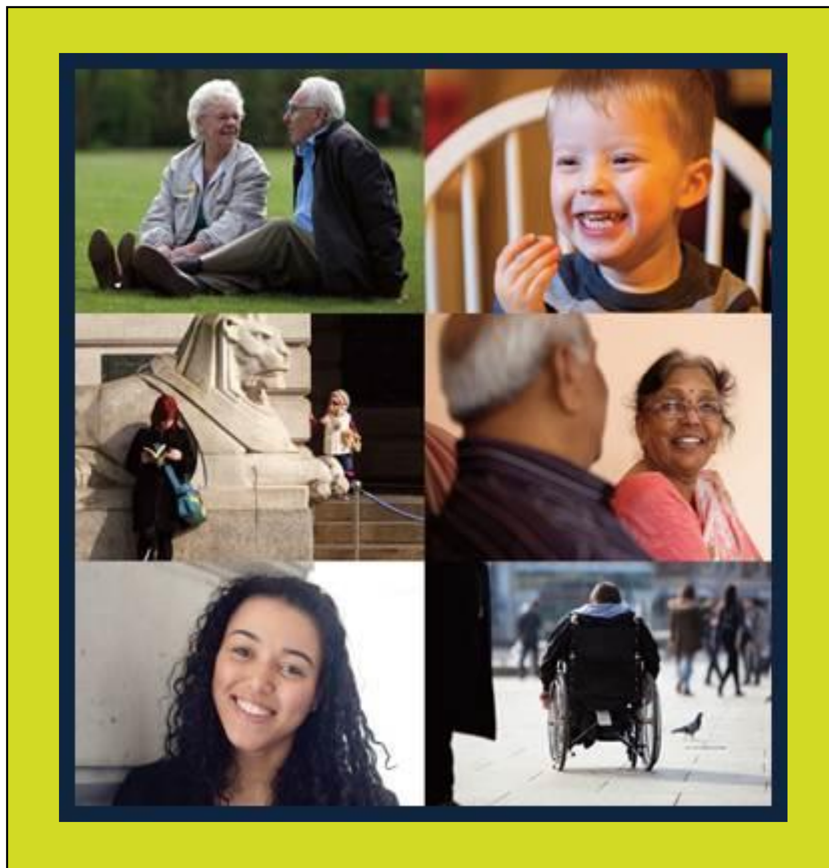
NHS
Nottingham City
Clinical Commissioning Group

2015/16 Operational Plan



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Introduction

We are pleased to present NHS Nottingham City CCG's Operational Plan for 2015/16. This sets out how we will continue to deliver the vision we described in our commissioning strategy for 2013-2016 in line with the intentions defined within NHS England's Five Year Forward View, which was published in October 2014.

As set out within our commissioning strategy, our priorities are, as follows:

- Improving mental health outcomes
- Early detection and improved outcomes for people with cancer
- Enhancing the quality of life for people with long term conditions (with a focus on diabetes and respiratory conditions)
- Improving the health and wellbeing of the frail and elderly
- Improving the health and wellbeing of children, young adults and students
- Developing an effective and efficient urgent care system

Two years on, these priorities remain relevant, and our programmes and activities centre on delivering improved outcomes and services for patients in each of these areas. We also remain committed to delivering the various obligations we have as an NHS commissioning organisation, including delivery of NHS Constitution standards and other key outcome and performance measures, many of which are addressed within this plan.

In addition to our commissioning strategy, our Operational Plan for 2015/16 should also be read in conjunction with a number of other interrelated plans:

- **Five Year Transformation Plan** – Overall, the citizens of South Nottinghamshire receive safe health and social care, however, it has been recognised that services are not consistently coming together to provide joined up, quality and sustainable systems of service provision for the population served. Furthermore, by 2018/19, a £100-140 million financial gap is forecast based on current models of health and social care service provision.

  In response to this, a South Nottinghamshire Transformation Partnership has been formed to reshape the health and social care system and develop a collective work-plan of transformational change. In the short to medium term, the Partnership, which includes members from all key health and social care commissioning and provider organisations, aims to optimise the current health and care system, ensuring improvement interventions are both aligned to, and support, the incremental building of the new system of care. The Partnership has described outcomes for the desired future state as presented below:

  - Care organised around individuals, not institutions.
  - The removal of organisational barriers, enabling teams to work together.
  - Resources shifted to preventive, proactive and care based closer to people's homes.
  - Hospitals, residential and nursing homes only for people who need to be in these care settings.

- High quality, accessible, sustainable services based on real needs of the population.

  The Transformation Plan includes a workforce specific workstream, which is being mobilised with an initial focus on urgent care and the modelling of the future workforce for this service area. The Nottinghamshire Local Education and Training Council (LETC) and Health Education East Midlands (HEEM) are aligning their support to the Partnership's needs and providing learning from across the region through implementation of the Strategic Workforce Development Plan for Nottinghamshire 2014/17.

- **Integrated Care Programme and Better Care Fund** – There is a strong national driver to improve services through better integration. Integrated care is seen as being essential to meeting the needs of the ageing population by transforming the way that care is provided for people with long term conditions, enabling people with complex needs to live healthy, fulfilling, independent lives.

  Nottingham City has a good range of community services with skilled clinicians and carers supporting an increasing number of people with complex needs. However, it has been recognised that the system is often confusing and difficult for patients and citizens and carers to understand and navigate. In response to this, we have established an Integrated Care Programme in partnership with Nottingham City Council to deliver improved outcomes and ensure maximum benefit for patients and citizens. The objectives of the Programme are to:

  - Empower people with long term conditions including the frail and elderly to feel supported to manage their own health and care needs and live independently in their own homes for longer with less reliance on intensive care packages.
  - Engage and enable primary care clinicians and health and social care professionals to deliver the right care at the right time using a joined up approach, improving the citizen experience of health and social care.
  - Develop integrated and sustainable health and social care services.

  The Better Care Fund will support the delivery of the Nottingham City Integrated Care Programme, and as such, will be spent on health and social care services to drive closer integration and improve outcomes for patients and citizens. The fund equates to £23.3 million in 2015/16 for Nottingham City and will operate as a pooled budget arrangement under a Section 75 Agreement.

- **Primary Care Co-Commissioning Plan** – 2015/16 will be the first year that the CCG has taken on delegated responsibility for co-commissioning primary medical services. This is one of a series of changes set out in the Five Year Forward View, which emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. We see co-commissioning as a key enabler to developing seamless, integrated out-of-hospital services, based around the diverse needs of our local population. During early 2015/16, we will prepare a three-year plan that sets out how we propose to exercise the functions delegated to us by NHS England to enable and support a more responsive primary care system for the City.

We welcome any comments that people may have about our operational plan, and look forward to delivering it in collaboration with providers and other partners across the local health and care system.

Dawn Smith
Chief Officer

Dr Hugh Porter
Clinical Chair

1. Our performance against outcomes

The NHS Outcomes Framework sets out the high-level national outcomes that the NHS should be aiming to improve. The outcomes indicators are grouped around five domains and seven outcome ambitions:

NHS Outcome Framework Domains	Outcome ambitions
Domain 1: Preventing people from dying prematurely	1: Securing additional years of life for the people of England with treatable mental and physical health conditions
Domain 2: Enhancing quality of life for people with long term conditions	2: Improving the health related quality of life of the 15 million+ people with one or more long term condition, including mental health conditions
	3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
Domain 3: Helping people to recover from episodes of ill health or following injury	4: Increasing the proportion of older people living independently at home following discharge from hospital.
Domain 4: Ensuring that people have a positive experience of care	5: Increasing the number of people having a positive experience of hospital care
	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

The table at Appendix 1 shows how we benchmark against others in England for key outcome indicators across the five health domains. It also indicates the changes in outcome performance since the previous year. It should be noted that the data relates to the year ending March 2014, and many new initiatives and measures have been introduced since this dataset was released. We therefore expect to see a related improvement in performance against a number of outcomes for the year ending March 2015, although that is not to underestimate the extent of health inequalities in Nottingham City and our ambition to work with partners to address them.

1.1 Outcome 1 - Securing additional years of life for the people of England with treatable mental and physical health conditions

Across all domains, long term conditions and cancer remain the two principal areas where Nottingham City benchmarks poorly against other areas in England and this contributes to the poor outcomes relating to the potential years of life lost amenable to healthcare. As a key driver of health inequalities in our City, our plans to secure better outcomes in these areas are set out in section 3.

1.2 Outcomes 2 and 3 - Improving the health related quality of life of people with one or more long term condition, including mental health conditions & reducing the time people spend avoidably in hospital through better and more integrated care in the community

Community Type 1 Diabetes Service – Enhancing the quality of life for people with diabetes is one of our strategic priorities. In addition to commissioning services for patients with Type 2 diabetes, we are now piloting a service to provide care in the community for patients with Type 1 diabetes. Our aim for 2015/16 is to target patients who do not attend their follow-up appointments at hospital. The service is presently provided through a variety of clinics spread out across the City. A whole system approach to diabetes care will be procured in 2016 following a review. This will enable us to commission a more integrated service for patients.

Hypoglycaemia pathway – A hypoglycaemia pathway for patients with diabetes was launched in February 2015. It aims to ensure that patients presenting as an emergency are triaged and managed in the community, without having to attend hospital as an emergency admission. This pathway will be incorporated into the review and redesign of diabetes services that will take place in 2015/16.

Increased availability of structured education programmes – We have commissioned a structured education programme for patients with Type 2 diabetes (not treated on insulin). Known as 'Juggle', this consists of four weekly sessions during which patients explore and learn about different aspects of diabetes. The programme helps people to understand their diabetes, and supports them in choosing to make the lifestyle changes that will benefit their health. Juggle has also been developed so that it can be delivered in other languages to target groups for whom diabetes is more prevalent. At present, this includes groups who speak Polish, Urdu or Punjabi. Furthermore, a signed programme targets people who are deaf, and we also run a course tailored to those with disabilities. We have also commissioned two further structured education programmes, with similar aims, to support patients with Type 1 diabetes (DAFNE), and patients with Type 2 diabetes who are on Insulin (2TONIC). The availability of structured education sessions will continue to play an important part in supporting patients to manage their own condition and to avoid hospital admissions throughout 2015/16

Improving services in the community through GP education – The CCG has implemented a successful programme of education and training for General Practice through the Practice Learning Time initiative. This aims to update healthcare professionals on the latest clinical guidance and best practice on a regular, planned basis. There is a strong focus on using these sessions to support practices to manage patients with long term conditions in the community, including diagnosis and management of chronic obstructive pulmonary disease (COPD), diagnosis and management of asthma, chronic kidney disease, hypertension, and atrial fibrillation. During 2015/16 this focus will be continued and sessions will include community teams as well as GPs and practice staff.

Cancer – With cancer increasingly being considered as a long term condition, improving the experience of people living with cancer and reducing the time that they spend in hospital is a key way in which the CCG will improve on this outcome during 2015/16. Through our benchmarking, we discovered that chemotherapy patients were being admitted for one to

two days on average, simply because they needed a change of prescription. We have since implemented a process whereby prescription requests are sent by the hospital to community prescribing teams, thereby reducing the need for patients to go into hospital. In addition, a 24/7 helpline allows patients to contact clinicians directly about their ongoing care as well as any complications from chemotherapy. These arrangements were piloted with breast cancer patients, and as a result of their success they will be rolled out in 2015/16 for patients with other cancers, including gynaelogical and colorectal. One of the complexities resulting from the fact that people with cancer are now living longer is that many patients experience complications following their treatment. This can sometimes escalate, causing the patient to be readmitted to hospital. We are commissioning a community cancer service to offer ongoing medical and psychological support, care and advice to these patients. Funded by Macmillan, our pilot will start in October 2015 and run for a year.

End of Life care – We have commissioned an Electronic Palliative Care Co-ordination System (ePACCS). This will record the latest information relating to patients who are either approaching, or experiencing the end of their life. This system will be accessible across ambulance, community and acute services so that clinicians are able to respond quickly to the patient's needs, regardless of where they are being cared for. It will also help to prevent actions and treatments from being administered (and an associated admission to hospital in some cases) if they are unwanted by the patient. Currently, End of Life Services are provided by a number of providers. We are retendering the service in 2015/16 to appoint a single provider who will co-ordinate all local services, eliminate duplication, and improve patient experience. We expect to award the new contract in June 2015.

Improving the experience of carers – There are 27,000 carers resident in Nottingham City (1:11 of the population) and of these, 28% provide in excess of 50 hours of care per week. Our Joint Carers Strategy 2012-17 sets out our commitment, along with Nottingham City Council, of improving the experience of carers in order to support better health and wellbeing outcomes. We will continue our work to ensure that vulnerable older people and those with long term conditions are able to live as independently as possible in their own homes through effective support of their carers. We aim to do this through the delivery of a range of integrated and comprehensive services that meet the needs of carers resident in the City in accordance with the requirements of the Care Act 2014. We will work to ensure that carers are able to access the appropriate support services at the appropriate time to enable them to continue to care for family members in an independent setting. A holistic offer of provision is planned ranging from universal advice and support to end of life respite with all Nottingham carers targeted. Referral into provision will be dependent on the nature of service provided but the Community Carers Hub will be the first port of call for City carers in relation to understanding what services are available to meet their needs and how to access these. In addition, our Primary Care Support Service aims to raise awareness of carer support provision among primary care staff and carers accessing primary care.

Working with our local hospital to prevent admissions and readmissions to hospital – Working with the hospital to prevent admissions to hospital, particularly for people with a long term condition is an ongoing piece of work, which will continue in 2015/16. Plans have been developed with partners across the health and social care community in Nottingham through the System Resilience Group. As part of this work, we will ensure that clinicians working in the Emergency Department have access to services that can support them to

avoid admitting someone with a long term condition (including people with a mental health condition) to hospital. We will do this by enabling better access both urgent outpatient slots within the hospital and alternative services in the community. This will include extending the provision of the Rapid Response Liaison Psychiatry Service. All specialities within the hospital will develop plans for reducing readmissions to hospital and we will carry out regular audits to monitor how well this is working.

1.3 Outcome 4: Increasing the proportion of older people living independently at home following discharge from hospital.

The Care and Support Minister, Norman Lamb, announced in January 2015 that Nottingham City has become a Wave Two Pioneer site for Integrated Care. As a pioneer, we are showcasing innovative ways of creating change in the health service, which the Government and national partners want to see spread across the country.

Our Integrated Care Programme is run in partnership with Nottingham City Council and Nottingham CityCare Partnership. The Programme includes the improvement of reablement and rehabilitation services, and aims to keep more people healthier in the community, preventing admissions and readmissions. Reablement services are currently offered by both health and social care. These services vary accordingly, and patients or carers are required to refer themselves to the services they need through two different routes. From the summer of 2015, we will be implementing the 'independence pathway' model, which will enable a single, integrated approach. In future, patients requiring reablement services will be able to call a single telephone number, and will undergo an assessment to determine the various packages of care that are right for them. Hospital staff will also be able to refer patients on discharge. This will improve patient experience, ensure that over 65s have access to the health and care services they need, and ultimately help people to realise the maximum level of independence possible.

Work is also underway to improve the transfer of care process from our acute provider. The aim is to assess and review all patients with complex needs within the community, and to ensure that the appropriate support is put into place as quickly as possible. This will mean that patients can be discharged as soon as they are medically stable, rather than having to wait for arrangements to be made.

Addressing social isolation is a key priority for improving the health and wellbeing of vulnerable citizens in the City, including older people and those with long term conditions. Evidence indicates that those who are socially isolated often access mainstream primary health provision as a means of addressing isolation, thus stimulating demand and capacity pressures. Social isolation is a contributing factor to a more rapid deterioration in physical and mental functionality and, therefore, a need for more intensive provision. During 2015, we will commission a single co-ordinated service to help prolific users of health and social care to become better socially connected to other people and to their local community. Each of the eight recently established Care Delivery Groups within the City will be assigned a Community Pioneer who will be the designated key worker responsible for working with individuals using a person-centred approach to understand and overcome barriers to becoming socially active. They will encourage individuals to become volunteers and arrange their own social activities. Community Pioneers will also be looking to identify carers who

may not have identified themselves as carers and will signpost them to the appropriate advice and support to enable them to continue with their caring role in a supported way.

1.4 Outcome 5 – Increasing the number of people having a positive experience of hospital care

Effective hip replacement case-mix – The indicator for hip replacement case-mix suggests that Nottingham City has some of the poorest outcomes in the country. However, there have been concerns expressed nationally about the validity of this outcome measure, not least because patient numbers are so small. We know that there is a national issue with clinicians failing to submit the three forms required to measure this outcome, and so we are working with our local hospital to make improvements. However we have not been complacent and through our community-based Integrated Clinical Assessment and Treatment (ICAT) Service all patients identified as possibly needing a hip replacement are assessed to establish their suitability. This triage process has been proven to improve the effectiveness and quality of care. We undertake a local assessment with independent clinicians and have found outcomes to be good. For this reason, we will continue with local arrangements and reassess the position as methods of assessing this outcome improve.

Responsiveness to inpatients personal needs – The data on which these scores are based relate to care delivered in 2013 and we expect that the work that has been ongoing by our acute provider will have improved these scores as they have continued to implement a range of measures and initiatives to improve patient experiences. Scores across the relevant areas in the annual inpatient survey have shown an improvement year on year. We will continue to check progress during 2015/16. Further information on how the CCG will set measurable ambitions to reduce poor experience of inpatient care is set out in section 7.1.

1.5 Outcome 6 – Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

This outcome relates to access to and experience of GP services. Whilst the CCG is not an outlier on these measures, we continue to respond to falling levels of satisfaction. We have a number of activities already underway, and others planned for 2015/16 which will be supported by the CCG having been granted delegated authority to commission primary care services from April 2015. Details of our plans in relation to improving access to GP services are described in section 5.

1.6 Outcome 7 - Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

The CCG performs well on this outcome and in 2015/16 we will continue to ensure that this performance is maintained through a variety of robust arrangements designed to ensure that we can understand and measure any harm that may occur in healthcare services. These are set out in detail in section 6.2.

2. Improving health in partnership

Developed and led by the local Health and Wellbeing Board, the Nottingham City Joint Health and Wellbeing Strategy runs from 2013 to 2016. It has four priorities, identified using a process which reflects that set out in Public Health England's *Commissioning for Prevention Report*, published in November 2013. Key health problems and principal gaps were identified utilising the Joint Strategic Needs Assessment. Partners and stakeholder then came together to prioritise, based on assessing where the greatest additional impact could be made to improve health and wellbeing through joint working between local agencies and joint commissioning. This enabled a small set of priorities to be established which build on and complement the City's existing partnership working towards the Nottingham Plan to 2020. The four priority programmes are listed below:

- Prevention of alcohol misuse - to reduce the number of people who drink at levels harmful to their health and to prevent alcohol-related disease.
- Provision of more integrated primary and secondary health and social care services that will ensure a better experience of care is offered to older people and those with long term conditions.
- Earlier intervention to increase the number of local people with good mental health, including improving early years experiences to prevent mental health problems in adulthood, and enabling people to begin working or remain in work where previously their health (especially mental health problems) has been a barrier.
- Support for priority families to get into work, improve school attendance and to reduce levels of anti-social behaviour and youth offending, and improve health outcomes.

The strategy is delivered by the partnership through a range of evidenced-based and innovative interventions. Progress is monitored and evaluated by the Health and Wellbeing Board on a regular basis, with additional input and governance through the Board's Commissioning Executive Group. During 2015/16 the Commissioning Executive Group will lead the development of a timetable and process for reviewing the strategy and the development of a new Health and Wellbeing Strategy from 2016.

3. Reducing health inequalities

3.1 Key Facts

- Life expectancy in Nottingham City is significantly lower than the England average, with three years less for men and two years less for women (Nottingham: 75.7 men; 80.7 women. England: 78.6 men; 82.6 female).
- In several wards (St Ann's, Bulwell, Bridge, Arboretum and Radford & Park), people are living on average ten years less than those in more affluent wards (Wollaton West).
- The largest contributors to the difference between Nottingham City's life expectancy and England's life expectancy are cardiovascular disease, cancer and respiratory disease.

- Smoking is the biggest preventable cause of premature death, and most cancers in Nottingham City are due to smoking; 50% of the gap in life expectancy is due to smoking.
- People with poor mental health experience poor physical health and reduced life expectancy. Data that is currently available, together with national models of need suggest that Nottingham City has worse mental health than nationally.
- One in 20 deaths in the City is alcohol-related and there are rising numbers of alcohol-related hospital admissions.

3.2 Our Approach

We have a clear vision that is built around our ambition to end health inequalities in Nottingham City. The following paragraphs set out how we will continue to close the gap in life expectancy through the development of services to support the delivery of our strategic objectives; by implementing the cost-effective high impact interventions recommended by the NAO report on health inequalities; by implementing the revised Equality Delivery System and making progress against the first NHS Workforce Race Equality Standard.

3.3 Reducing health inequalities through our strategic objectives

Three of our strategic objectives have particular relevance here as they were derived from detailed analysis of what health conditions contribute to the life expectancy gap. They are:

- Improving mental health outcomes.
- Early detection and improved outcomes for people with cancer.
- Enhancing the quality of life for people with long term conditions (with a focus on diabetes and respiratory).

During 2015/16, we will further develop our understanding of which groups in our City experience the worst outcomes, which will inform the development of our new commissioning strategy from 2016/17.

Improving Mental Health Outcomes

In Nottingham City, around 46,000 people have a commonly occurring mental health problem. Adults diagnosed with mental ill-health are more likely to make unhealthy lifestyle choices and suffer a greater burden of disease and premature mortality. Mental health is a priority for all partners across Nottingham City. In collaboration with Nottingham City Council, we have a joint mental health and wellbeing strategy called *Wellness in Mind*. The Health and Wellbeing Board agreed the strategy in August 2014. Key elements include:

- Promoting mental resilience and preventing mental health problems.
- Identifying problems early and delivering improved outcomes through effective treatment and relapse prevention.

- Ensuring adequate support for those with mental health problems.
- Improving the wellbeing and physical health of those with mental health problems through delivering effective interventions.

Our various programmes of work over the next year include:

- Piloting a children and young people's behavioural, emotional or mental health needs pathway. This was launched in December 2014 (see section 4).
- The introduction of a self-harm pathway for young people by October 2015.
- Further development of Nottingham City's *Fit for Work* service, which supported 700 people in 2014/15 of whom just over half had mental ill-health.
- The promotion of smoke free environments and smoking cessation support for people with mental health problems. A number of these services are detailed below as part of our strategic objective to improve outcomes for people with cancer.
- Continuing to ensure that there is parity of esteem between mental and physical health conditions (see section 4 for more information on this item).
- During 2015/16, we will implement a new Black and Minority Ethnic (BME) community mental health service (see section 5).

People with Cancer

The prevalence of, and mortality from, most cancers for people of all ages is significantly higher in Nottingham City than in the East Midlands. Cancer is the joint largest contributor to the life expectancy gap for women in Nottingham City, and the second biggest contributor for men. We are tackling the following key considerations:

- Smoking is the largest preventable risk factor for cancer in the City.
- Most modifiable lifestyle risk factors are higher in areas of deprivation, and we need to help reduce the known risk factors, such as smoking and obesity.
- People are presenting late with symptoms of cancer, particularly those living in areas with higher levels of deprivation, and those from certain BME communities. We need to increase community awareness of symptoms and encourage people to seek the appropriate medical advice to help increase early presentation and detection of cancers.
- Supporting *Change Makers for Cancer Awareness* and delivering any service changes that are recommended.
- Screening uptake needs to be higher to enable earlier detection of cancers, particularly those of the breast, cervical and bowel. Along with lack of awareness, there are particular barriers that are preventing people, particularly those from BME communities, from accessing these services.

We have around twenty programmes or activities underway to make improvements across the entire cancer pathway, from awareness and prevention, through to survivorship and end of life. These include:

In-reach smoking cessation services – We are funding a specialist smoking cessation service, which will be delivered by two advisers based at Nottingham University Hospitals from September 2015. While patients are in hospital and unable to smoke, it is an opportune time to encourage them to stay smoke-free through prescribing nicotine replacement products, offering support, and following up with them once they are back home. This will increase both the number of referrals to the *New Leaf* services - which are already established in the community - and the number of quitters across Nottingham City. We are also planning to roll the service out to Nottinghamshire Healthcare NHS Trust within the same timescale.

Addressing wider issues relating to smoking – We will continue to work with partners on the Health and Wellbeing Board to develop tobacco interventions on a wider scale. The Board has just signed up to a single declaration on tobacco, which is a milestone achievement. This will help to define future areas of work, including the development of programmes and policies to improve education, de-normalise smoking for young people, reduce the illicit trade, introduce more smoke-free zones, and increase advocacy.

Macmillan Early Diagnosis of Cancer Programme – We are recruiting a *Macmillan Early Diagnosis of Cancer* Project Manager, who will develop a volunteer workforce to promote screening and early diagnosis, and help to raise awareness. This programme will target areas of deprivation in the City and areas with a high ethnicity mix, working in the centre and the north of the City in particular.

Research into bowel screening take-up – We have commissioned a bowel screening research programme to help us understand the barriers that prevent people from BME communities accessing screening. The findings will inform appropriate interventions for us to commission in future, and will feed into the early diagnosis project mentioned above. Led by Nottingham Trent University and supported by 12 community researchers, the study is due to conclude in March 2015 and actions to address its findings will be developed and agreed by the Bowel Cancer Screening Group during 2015/16.

Addressing low uptake in GP Practices – We are working with GP practices where there is a low uptake by their patients to access bowel cancer screening services. We have identified priority practices and will continue to support them directly in encouraging patients to undergo screening tests.

Over 55s bowel screening programme – We are implementing the new national bowel screening programme for over 55s.

Raising awareness of prostate cancer – A joint pilot service with Nottingham City Council called '*Hear Me Now'* will promote awareness of prostate cancer to Black African and Black Caribbean men, with the aim of increasing the number of those who undergo screening. This group is currently three times more likely to die from prostate cancer.

Community-based screening for chest cancers – Lung cancer is the most significant reason for poor outcomes in cancer across Nottingham City, linked directly to a high prevalence of smokers. Our local population experiences comparatively high numbers of lung cancer cases with high levels of mortality, and issues relating to late presentation and diagnosis. The main symptoms of lung cancer include a persistent cough, which most smokers have in any case. Consequently, cancers are often detected very late in their development. In 2015/16, we will pilot lung cancer screening in those parts of the City with high numbers of smokers, with the use of mobile CT scanners based in the community.

Direct GP access to CT scans for suspected chest cancers – We will continue with our new programme to enable GPs to make direct bookings for CT scans, where they suspect that a patient may have chest cancer following a normal chest x-ray. This addresses the issue that chest x-rays can sometimes be a poor way of identifying certain lung cancers. Our pilot in this area has shown that this step accelerates the diagnostics pathway by eliminating the need for a consultant referral and outpatient appointment. It enables the earlier diagnosis of cancer and also better patient experience.

Identifying high-risk patients from practice lists – A cancer audit was completed in 2014/15, and findings will be shared and applied in 2015/16. This will include the implementation of the cancer decision toolkit. This is an automated software tool, which works with GP computer systems to identify patients who have a high risk of cancer. It notifies GPs of the need to make appropriate referrals and undertake diagnostics, therefore facilitating the earlier diagnosis of cancers.

Further education for GPs – We will undertake a series of webinars for secondary care clinicians to meet with GPs and discuss appropriate referrals for cancer patients. This is an educational approach to help clarify the latest NICE guidelines, including how GPs might interpret them, and when patients should be referred to ensure the best care and outcomes.

Enhancing the quality of life for people with long term conditions

Diabetes – More than 15,000 local people have diabetes, and the number of people developing diabetes is rising continually, linked to both an ageing population and to rising levels of obesity. We know that diabetes is particularly common amongst people with South Asian and Black African and Black Caribbean backgrounds, with an earlier age of onset in the former group. Diabetes reduces life expectancy, and outcomes for people with diabetes are a major health inequality issue within Nottingham City. This is therefore a key group for us to target to support improved outcomes. In June 2014, we commissioned a BME outreach worker through *Self Help Nottingham* to work directly with communities to address greater prevalence of diabetes, lower levels of recommended physical activity levels, and a higher likelihood of obesity. Patients and carers from BME communities can now become engaged in activities that will help to enhance their health and wellbeing. We have recently commissioned an 18-month long exploratory research study to inform how we can best work in partnership with local BME communities to increase the uptake of long term conditions primary and community services in Nottingham City. Focusing on diabetes and respiratory services, the findings will help us to have a better understanding of the issues and barriers preventing people from accessing these services. In turn, this will help us to tailor our commissioning approaches accordingly. The study is expected to conclude in September 2016.

Respiratory – Following an extensive audit of respiratory services, we will commission a respiratory rehabilitation and transition service that will create capacity on wards and reduce the number of patients readmitting with respiratory conditions. Current readmission data demonstrates that patients may be being discharged too quickly, therefore, we will work with our acute trust to understand the reasons for readmissions in a bid to better understand patients' needs. This assessment will include advanced care planning to ensure

patients are ready to go home with all relevant social networks in place, with assistive technology now being offered to every patient. In addition, a virtual COPD clinic will start in April 2015 so patients at 'high risk' of readmission will have direct access to a hospital consultant.

3.4 Implementing the five high impact interventions

In December 2013, the National Audit Office made recommendations on the five most cost-effective, high impact interventions to address health inequalities.

Most of these areas are covered across Nottingham City by Quality and Outcomes Framework (QoF) targets at practice level, which are aimed at improving the identification of health concerns, as well as the monitoring and management of patients, and ensuring follow up. Performance is monitored through a variety of indicators and data from practices. These are then discussed in more detail with individual practices during their annual peer support visits. Pathways are in place and are regularly reviewed to ensure smooth transition for patients between primary, community, and secondary care specialist services.

Delivery of a number of the high impact interventions is also supported through NHS Health Checks, which is a vascular assessment and management programme commissioned by Nottingham City Council. The programme is aimed at helping to improve life expectancy and reduce health inequalities. In Nottingham City, health checks are largely undertaken by GP practices, with a smaller number carried out by pharmacists and outreach services.

Those assessed at higher risk are then offered a range of interventions, including lifestyle change counselling, stop smoking services, and programmes for weight management, physical activity, and alcohol harm reduction.

Increased prescribing of drugs to control blood pressure – NICE guidance addresses the various causes of blood pressure. The majority of cases within Nottingham City are managed in primary care, and medicine management support is available to promote and encourage appropriate prescribing. Support services are also available in secondary care to enable urgent access to specialist support if needed. We will remain focused on increasing awareness of guidelines and promoting the importance of patient assessment to identify those with high blood pressure. We will also continue to highlight the need for regular monitoring and medication reviews to ensure that each patient’s treatment is tailored to their needs.

Increased prescribing of drugs to reduce cholesterol – We are working with public health colleagues to support implementation of this high impact intervention within GP practices. We have developed guidance and supporting resources to help front-line clinicians in targeting their efforts to those patients who will benefit most from cholesterol-reducing drugs, in terms of improving both the length and quality of their lives. Patients are both assessed against, and advised on, the benefits and risks of the treatment. Involving patients in prescribing decisions helps to ensure that they are fully informed and committed to their treatment.

Increase smoking cessation services – The New Leaf NHS Stop Smoking Service has been operating in Nottingham City since its establishment in 2000, and we plan to expand the service in 2015/16 to enable in-reach services (see section 3.3). Health Equity Audits

demonstrate that the service is typically accessed by smokers on lower incomes and from the more disadvantaged areas of the City. They also show that the four-week and twelve-month quit rates are better than many other areas with similar levels of deprivation outside of Nottingham City. Services have evolved to respond to a range of preferences indicated by local smokers, and offer individual and group support on a face-to-face basis, as well as drop-ins and access to services and support via the telephone, email and texts.

Increased anticoagulant therapy in atrial fibrillation – National NICE guidance has directly informed local clinical guidelines relating to anticoagulant therapy in atrial fibrillation. These have been developed in collaboration with secondary care through the Nottinghamshire Area Prescribing Committee, and are presented in a user-friendly format to help front-line clinicians apply them in everyday practice. This measure will help to ensure consistency of approach and treatment choices, as well as enable clinicians to direct patients to appropriate medicines support services if needed. Educational events are underway for GP prescribers, pharmacists and community services to increase awareness of both the various options for drug treatment, and the facilities available to support patient decision-making. An education event for GPs will reinforce new NICE guidelines relating to the prescribing of anticoagulant medication. We will also introduce a tool, known as 'GRASP-AF', to GP practices. This is used to help GPs assess the risk of atrial fibrillation related stroke across their patient registers, and to support the effective management of these patients. A review of the findings will help us to identify any commissioning gaps that we still need to address.

Improved blood sugar control in diabetes – The Community Diabetes Specialist Nurse Service provides teaching clinics for Type 2 diabetes patients, with the aim of managing and monitoring their blood sugar levels. Since January 2014, Type 1 patients are managed through the Integrated Diabetes Service, which also measures blood sugar levels and monitors the nine 'care processes' relating to diabetes. We also provide structured education programmes for all diabetes patients, and more about these can be found in section 1.2. A new hypoglycaemia pathway was introduced in February 2015. We are working with ambulance crew staff to ensure that patients experiencing hypos receive advice together with a leaflet on the risks of these and how to prevent them. At the same time, ambulance staff refer the patient to the relevant community service for follow-up and ongoing management and support. During 2015/16, we will undertake a tender exercise to remodel existing services to enable a whole-system approach to diabetes. This will provide a simple triage process for patients, with one referral point for GPs. We also plan to bring together structured education, podiatry, dietetics, and counselling clinics as a 'one stop shop'. Our vision is to improve self-management for patients so that they remain independent and feel empowered.

3.5 Implementing the Revised Equality Delivery System (EDS2)

We have already adopted the revised Equality Delivery System (EDS2) as the framework through which we assess our equality performance. The system is built around eighteen outcomes, grouped under four overarching goals, and it is against these that organisational performance is required to be analysed and graded, and appropriate action determined. The four EDS Goals are listed below:

Goal 1: Better health outcomes

Goal 2: Improved patient access and experience

Goal 3: A represented and supported workforce

Goal 4: Inclusive leadership

Meeting once a year, we have established Grading Panels to consider and grade our equality performance, taking into account supporting evidence and feedback from patients and staff. One panel focuses on Goals 1 and 2 and membership is drawn from our People's Council, which is an advisory group comprising key representatives from the local population. The other panel focuses on Goals 3 and 4, and includes members of our Staff Reference Group. Both panels include appropriate independent membership from our Governing Body and committees. CCG officers are invited, as needed, to provide both panels with advice and information. Both panels met in January 2015 and noted that we take the requirements of all the EDS2 outcomes very seriously. However, they also recognised that the CCG is a lean organisation with limited capacity that needs to balance the demands of completing a robust annual EDS2 evidence-gathering assessment process, with delivering priority equality actions. Referring to EDS2 guidance to help make the process more manageable, the panels supported a proposal to assess our equality performance from 2015 onwards by reviewing outcomes over a three-year cycle. Our Equality, Diversity and Inclusion Framework, Annual Equality Assurance Report, and a paper on the outcome of the grading process for 2014/15 are all available on our public website.

The NHS Standard Contract for 2015/16 includes a requirement for all providers to implement EDS2, and to meet the requirements of the national Workforce Race Equality Standard (see section 3.6 below). We will be looking at how we can determine our overall grade for the EDS2 outcomes that are more relevant to provider organisations, based on the aggregate grades of our main providers. Further key areas of focus for 2015/16 have been agreed as follows:

- The enhancement of patient engagement arrangements and feedback mechanisms.
- Continuation of embedding equality requirements within provider Quality Schedules and service review processes and the provision of comprehensive training to relevant staff to ensure that they have the knowledge and skills required.
- Completion of a more detailed analysis of our recruitment process.
- Provision of specific training for each of the newly nominated GP Equality Champions, in accordance with the specific focus of their roles.
- Review of the process for reporting equality performance to the Quality Improvement and Risk and Performance Committees, both of which have responsibility for the ongoing monitoring of our equality performance.

3.6 Workplace Race Equality Standard (WRES)

This national standard will, for the first time, require all NHS organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation.

Detailed guidance has been published in March 2015, which will enable us to compare our performance against the nine metrics defined within the standard. These include ensuring fair opportunities and representation for BME staff, discrimination, bullying and harassment, equal access to career promotions or progression, and ensuring that our Governing Body is broadly representative of the population we serve. Once current levels of performance have been identified, plans will be prepared to enable us to demonstrate sustained progress against the standard.

From April 2015 onwards, we will also work with our providers to agree action plans with clear milestones against the standard, with progress monitored as part of our existing contractual management arrangements.

4. Achieving parity of esteem

We are committed to achieving parity of esteem for those with mental health problems in the communities that we serve. In 2015/16, we will increase funding of mental health-related services by £1.38m to enable us to achieve parity of esteem. This represents an increase of 2.8% on last year's budget, and will mean a total investment this year of just over £50.5m in mental health contracts and continuing healthcare packages across Nottingham City.

Following a review of Children and Adolescent Mental Health Services (CAMHS) in December 2014, we launched a Children's and Young People's Behavioural, Emotional or Mental Health Needs Pathway. This is a two-year pilot, delivered in conjunction with a number of health and care partners, including Nottingham City Council, Nottinghamshire Healthcare NHS Trust, CityCare Partnership CIC, and Nottingham University Hospitals NHS Trust. The new pathway aims to respond to the findings of the CAMHS review as well as to patient feedback received. It will improve access as a result of having an integrated single point of access, provide online information for parents, and deliver co-ordinated, evidence-based care which ensures that no child or family is left unsupported. This will improve outcomes for children, young people and their families who are affected by behavioural, emotional or mental health problems. A performance management framework has been developed to assess the success of the pilot pathway against our objectives.

With the support of colleagues at Nottingham City Council and within healthcare services, we will continue to raise the priority of a joint approach to addressing the physical and mental health needs of local adults and children. Owned by the Health and Wellbeing Board, a partnership mental health strategy – *Health in Mind* – has been agreed, and a steering group has been established to oversee its implementation. Furthermore, a development session on mental health was held for members of the Health and Wellbeing Board in July 2014. This has enabled a better understanding of the issues by all parties, and will help to support the effective roll out of plans in 2015/16 to improve mental health, which is one of our four shared priorities. All reports presented to Health and Wellbeing Board meetings are now required to include an introduction which describes how both mental and physical health have been considered.

We remain focused on reducing the 20-year life expectancy gap for people with severe mental illness. We will continue to focus on improving the physical health of patients with serious mental illness, through a partnership approach between primary and secondary

care. For more than two years the CCG has had in place a 'physform', which is a physical health checklist to support the assessment of patients with serious mental illness. In 2015/16, this will also include bowel cancer screening and targeted smoking cessation support where appropriate. Undertaken within secondary care, this is an annual screening test covering indicators such as blood pressure, smoking, Body Mass Index, lipids and alcohol intake. The resulting summary is sent to primary care for action, where the patient is supported to improve their physical health. We have also implemented the national CQUIN, which focuses on improving the physical healthcare of patients with serious mental illness. Patients with mental ill-health can also refer to our Wellbeing+ Service, which offers a range of support, including physical health assessments and advice.

5. Enabling convenient access

We have a range of initiatives underway to improve access to all local services, including GPs, community and mental health services.

Primary Care

Results from last year's outcome measures (see section 1) showed that Nottingham City's performance had deteriorated significantly in relation to the number of patients able to access GP services. We have responded, and will continue to respond to this in 2015/16 supported by the CCG having delegated authority to commission primary care services from April 2015. Over the next year we will work directly with practices to deliver the following measures, which respond to insight from the national *Better Together* patient experience programme, a survey of more than 700 Nottingham City patients, and feedback from our local population.

We will encourage practices to review their booking systems, and look at innovative ways in which we can improve access to primary care, one of these may be to consider introducing a form of clinical triage before appointments are offered. This approach has been tried and tested in other areas and has had a direct result of freeing up capacity, so that patients with more pressing needs will be able to gain faster access to a primary care clinician. It will also ensure that all patients receive the appropriate levels of care to meet their needs. This work will help us to respond to the increasing number of appointments requested as well as mitigating a recognised shortage of General Practitioners in the primary care workforce.

In accordance with the GP contract, all practices must ensure electronic access to appointments. This facility will be promoted to patients, and we will support practices in taking a consistent approach to the marketing and management of these appointments. We will also provide technical support to ensure that mobile phone appointment bookings, reminders and cancellations are also available.

The role of medical receptionist is a core function within any GP practice. Over the years, it is clear that many Nottingham patients perceive the receptionist as the 'gate keeper' to the GP's time. This was substantiated by our recent patient survey, and we are now keen to address this. We will provide intensive training to *all* receptionists and front-line staff, helping to develop them into healthcare guides. Receptionists will learn more about how the healthcare system works, the importance of their role, and how they can help patients by

steering, guiding and supporting them through complex, confusing and sometimes frustrating situations. This training package will be bespoke to Nottingham City, and all practices will send their receptionists and other relevant staff to at least one of the four courses available.

The *Home Visiting Service* will support GP practices by providing rapid access to acute care at home, so reducing the need to attend hospital for urgent treatment. Operating from 9am to 1pm Monday to Friday, the service aims to reduce inappropriate emergency attendances and admissions as a result of better access management. It will make better use of existing services and help to achieve better patient satisfaction. Visiting clinicians are all local and therefore familiar with local services and care pathways. They will aim to visit patients within 60 minutes, supported by a basic clinical history provided by the patient's GP, to include practice and named contact details, information relating to the presenting complaint and relevant history, and a list of any repeat medication. Where a GP is required to attend, they will carry out a full appraisal within the patient's own home, supported by mobile technology to access notes and enable the documenting of vital information.

We will review and realign *Local Enhanced Services* (now known as *Primary Care Contracts*), aiming to ensure that they are fit for purpose and commissioned in as transparent and simple a way as possible. We will do this through continued engagement with all interested parties. By Spring 2015, we will be in a position to ensure that all patients have better access to, and a choice of local primary care services, such as wound care and phlebotomy.

Having agreed care pathways in place is proven to help healthcare staff to deliver and patients to access care which is safe, person-centred, and both clinically and cost-effective. It is well documented that the combination of targeted action within primary care, as well as informing and empowering individuals with certain conditions, can also help to improve the patient's sense of wellbeing and control over their condition. In turn, this helps to avoid repeat admissions to hospital. In the first instance, we will focus on pathways where the behaviour of primary care has the greatest impact on both secondary care, and on the health service as a whole.

Whilst we are committed to delivering the improvements outlined above for the benefit of patients, we also acknowledge that the pace of change will be dependent on the ability of practices to adopt new approaches. We will therefore develop a one year 'responsiveness contract' to encourage practices to adopt and migrate to the change programmes described within this plan. An incentive payment will enable practices to use funds to backfill GPs, or for engagement and training, so that they can make the leap to new ways of working.

Service redesign to improve access

Enabling convenient access for patients now forms a key requirement of our service improvement programmes. Here are some examples of how we have improved, or are improving access to community services:

- The Integrated Diabetes Service, currently being piloted, is looking at how to improve access for patients. The service is available through a variety of clinics across the City, and patients can choose which clinic is most convenient for them.

- We are also redesigning the reablement service. One of the measures to improve access will see the hours of operation change from 8am to 10pm, to 7am to 11pm.
- Following service redesign, our Integrated Respiratory Service now offers a service from 8am to 10pm, 7 days a week.

Mental Health

From the 1 April 2015, a 24/7 enhanced crisis and home treatment service will be in operation. The service will ensure that patients in crisis receive an assessment, and ongoing support if required. The aim is to treat people in the community, and to minimise the number of transfers to hospital as well as inpatient admissions.

We have commissioned a new BME community mental health service, which will be in place by the end of June 2015. The service will provide one-to-one support, including care plans that focus on a patient's recovery, in addition to training and educational opportunities. It will also offer group activities, including training on mental health issues, support sessions, and peer support. Access to the new service and performance targets will be monitored and evaluated to ensure that the intended improvements are delivered.

A new personality disorder service will increase access for patients, provide targeted interventions, prevent emergency attendances, reduce in-patient admissions and increase community-based support. Based on the 'developmental model of personality' this integrated service will offer a range of treatments and interventions tailored to each individual's stage of personality development. Services include Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT) and Mentalisation Based Therapy (MBT).

All these services will improve access to mental health and other services, and will complement the services already in place, including the *Rapid Response Liaison Psychiatry Service*.

We also commission third sector services to increase access for people with mental ill health, for example, Wellbeing+ Service. Based in primary care, this is a non-statutory service which enables individuals, including carers, to refer themselves to mental health support services. These include one-to-one support sessions, counselling, stress management, developing assertiveness skills, training, employment, physical health assessments, and self-care to promote recovery by helping people to thrive physically, mentally, socially and spiritually.

Our two-year, award winning pilot street triage project will continue in partnership with Nottingham Police and mental health nurses. This helps people with mental health and learning disabilities to gain immediate access to the right care and treatment in an emergency situation, rather than being arrested or taken to a place of safety under section 136 of the *Mental Health Act*.

5.1 Improving access to services for minority groups

This plan sets out many initiatives to help improve access to services from those within minority groups. Here is a summary of just some of these, together with section references where readers can find further information.

- Delivering structured education programmes for patients with diabetes who speak Polish, Urdu or Punjabi, as well as for those who are deaf or have disabilities (section 1.2).
- Commissioning of a BME outreach worker who will work within the community to improve and wellbeing (section 3.3).
- Our *New Leaf* stop smoking service caters directly for cultural differences, and programmes have been tailored to address the various methods for chewing or smoking tobacco (sections 3.3 and 3.4).
- Introducing the 'Hear Me Now' service to raise awareness of prostate cancer awareness and screening for Black African and Black Caribbean men (section 3.3).
- Researching lower rates of bowel cancer screening take-up by BME groups (sections 3.3 and 4).
- Commissioning of the Wellbeing+ Service, which engages directly with minority communities and homeless people (sections 4 and 5).
- Undertaking a research study to improve uptake in services, particularly respiratory and diabetes, by BME communities (section 3.3).
- Introducing of a new BME community mental health service (section 5).

5.2 Plans to improve early diagnosis for cancer

Improving the overall cancer pathway is one of our key strategic priorities, and many of the measures we are taking are outlined in sections 1.2 and 3.3 above. Of the various activities described above, the following are key to enabling earlier diagnosis for cancer:

- Various initiatives to increase awareness will encourage people with symptoms of cancer to seek medical advice earlier. These include the New Leaf smoking cessation services to be delivered within Nottingham Hospitals and Nottingham Healthcare Trust, and the 'Hear me Now' project to promote awareness of prostate cancer to Black African and Black Caribbean men.
- The Early Diagnosis of Cancer Project, to include a dedicated project manager funded by Macmillan and backfill payments for GPs so that they are able to participate.
- Enabling better access to, and availability of, screening services, including the initiative to provide mobile CT scans to communities with high levels of smoking, the in-reach programme to support GP practices with low uptake rates, and implementing the national screening programme for over 55s.
- Direct access to CT scans for GPs who still suspect a patient may have lung cancer after receiving a 'normal' chest x-ray result.
- Education for GPs to improve diagnosis and referral in partnership with secondary care.

5.3 Tracking one year cancer survival rates

Across healthcare in England, national statistics currently establish overall measures of survival for local populations. As these are tracked annually, it is not possible to monitor progress throughout the year and so we have recently developed a local cancer dashboard, which is updated monthly and helps to provide evidence of change and improvement across all of our cancer initiatives. The dashboard itself is also reviewed each month for its effectiveness, and it continues to evolve so that it can reliably inform the commissioning process. The responsibility of reviewing the dashboard and its indicators falls to our Internal Cancer Programme Group. This brings together project leads and GPs with special interest in cancer who discuss the metrics and assess whether projects are making the desired difference. From March 2015, progress will be reported through to our Governing Body.

5.4 Meeting the NHS Constitution Standards

We are currently meeting most of the NHS Constitution Standards, and progress is well underway to address those where improvement is needed. The following describes our performance against each standard, and the action planned for 2015/16 and beyond.

18 week referral to treat – Our performance continues to be strong, and we have commissioned various activities with NHS Trusts to ensure that current performance is maintained.

Diagnostics – We continue to meet our obligations for diagnostics. However, we are conscious that demand continues to increase, particularly for MRI and CT scans, and so we have commissioned additional activity in 2015/16 to ensure that our strong performance is maintained. This will be provided by existing hospitals as well as by independent providers.

Increasing Access to Psychological Therapies – Actions are underway to improve access to services and enhance recovery rates. A new provider was recently commissioned to increase access and choice for patients and ultimately to reduce waiting times. We are confident that we will meet the quarter 4 2014/15 target of 15% of the eligible population accessing treatment.

Dementia – We are hitting all our targets for dementia and do not foresee any issues.

A&E / Winter resilience – The System Resilience Implementation Group brings together partners from across the Urgent Care Pathway to identify and agree the priority issues, as well as the actions required to address them. Meeting every week, its members are all, without exception, very senior representatives of local organisations. This group has signed up to a system-wide action plan, which considers changes that need to be made across the entire pathway, including prevention and demand management, management of Emergency Department attendances, bed management, accelerating the flow of patients leaving hospital, and supporting them to stay in their permanent residence. The plan is reviewed weekly to ensure delivery and to assess the impact of the various activities underway. Members of the group discuss which interventions are working, and whether any further actions are required to deliver the desired result. There is significant scrutiny of this plan across all agencies, and it has high-level visibility across the entire health and care system.

Cancer – The number of GP referrals to cancer services increases by 10% each year. We are developing plans to ensure that we meet and sustain both the two-week wait, and the 62

day standards. These will be implemented this year, and will help to improve the management of demand, and the flow of patients coming through the system. GP webinars with secondary care clinicians and decision toolkits will help to ensure that GP referrals are undertaken in accordance with best practice. We are also addressing the common issue of delays for tertiary patients in relation to cases where they are diagnosed at cancer units and then visit hospital for specialist treatment. We are working with Nottingham University Hospitals to manage the flow of patients better, with a particular emphasis on those with suspected or confirmed lung cancers. Activities will help to improve capacity and minimise delays.

Early intervention – Infant mortality is line with national expectations, and we have in place proven, effective processes to review all child mortality. However, we do have challenges relating to higher levels of smoking during pregnancy and lower rates of breastfeeding, when compared with elsewhere. We are working with other partners – public health, local authority, community and acute hospitals – to deliver improvements in these areas. Some of the actions include:

- Joint working with public health to ensure pregnant women have easy access to stop smoking services throughout their pregnancy. This includes an 'opt out' referral system where all women with high CO2 readings are automatically referred to services.
- Provide intervention training for midwives, and other training to key staff to raise their awareness of the dangers of smoking in pregnancy.
- Implement stop smoking services within antenatal clinics.
- Provide a targeted one-to-one breastfeeding service for women aged less than 25 years.
- Provide extra support to breastfeeding women in commercial and community settings, and when returning to work.
- Offer a breastfeeding support and guidance service in line with UNICEF Baby Friendly Standards and NICE guidance.

5.5 Preparing for the new mental health access standards

We are assessing current performance against the four new mental health access standards, which are described in more detail below. A Service Development Improvement Plan will be agreed with each provider by the end of March 2015, and will detail key milestones to ensure achievement of all standards by the 1 April 2016.

Standard 1: Early intervention in psychosis *– More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved package within two weeks of referral –* We already commission an *Early Intervention in Psychosis Service*, and a preliminary review indicates that this waiting time standard is not being met. We continue to work with the principal provider to agree actions to improve performance. Due for sign off in April 2015, this plan will ensure the standard is met by April 2016. Additional funding will be made available to increase capacity, if required.

Standard 2: Improving access to psychological therapies (IAPT) *– 75% of people referred to the IAPT programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral –* Work is being undertaken to assess performance against this

standard across the three current providers. We will then agree measures to ensure delivery of the access targets. Plans will be in place by December 2015. In the meantime, we continue to monitor actions to improve waiting times for IAPT, including increasing the provision of on-line resources, e.g. *SilverCloud,* an online application that helps individuals to learn techniques to overcome symptoms of low mood and anxiety. Additionally, we are increasing the number of providers who deliver services. Each provider is responsible for the systematic review and sharing of exception reports relating to long waits for psychological therapies. In addition, we regularly review a plan that sets out the specific actions being taken by providers to improve access to these services. This includes the assessment of staff productivity levels and recruitment plans, increasing awareness of services in primary care, and the promotion of self-referral.

Standard 3: Liaison Psychiatry *– By 2020 all acute trusts will have in place liaison psychiatry services for all ages appropriate to the size, acuity and speciality of the hospital –* An acute liaison service - *Rapid Response Liaison Psychiatry* - is already in place at Nottingham University Hospitals. This service will be reviewed by the end of September 2015 to ensure that it meets the required standards. We will also assess whether it is operating in the most effective way, diverting patients away from the acute trust and into mental health services where appropriate.

Standard 4: Eating Disorders *– A national access and waiting time target will be developed for eating disorders during 2015/16 –* We have funded a community eating disorder service for children and young people, which will be evaluated by the end of September 2015.

6. Improving quality

6.1 Responses to the findings of national reviews and reports

We have ensured that our plans reflect the key findings of all national reports published, including Francis, Berwick and Winterbourne View. This has helped us to ensure that high quality, compassionate, safe and clinically effective care is delivered to residents living within Nottingham City.

All reports identified that the NHS needs to be open and transparent, and more focused on both patient needs, and improving individual patient outcomes. They advocated continuous learning, effective leadership and fundamental standards and measures of quality, and emphasised the importance of listening to patients and staff and acting on feedback received.

Francis and Berwick Reports

The report of the *Mid Staffordshire NHS Foundation Trust Public Inquiry*, known as the 'Francis Report', was published in February 2013. Following its publication, six further independent reviews were commissioned by the Government to consider some of the key issues identified by the Inquiry. These include the *Cavendish Review of Healthcare Assistants and Support Workers in the NHS and Social Care Settings*; *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England* by Professor Don Berwick;

and a *Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture* by Rt Hon Ann Clwyd MP and Professor Tricia Hart.

We created an action plan to address the recommendations made by all reports, and these actions are at the heart of our commissioning decisions. They underpin our plans and contracts with providers, and have informed the nature of information that we request from them. We have specified the standards and improvements that we expect from providers, and how we will measure achievement against them to assess the quality of care being delivered. Providers are also required to update us every six months regarding both compliance against the recommendations of the national reports, and the steps they will take to continue to meet standards. The action plan has also helped to determine behaviour and competency frameworks for CCG staff.

We have now developed a comprehensive framework of indicators to serve as an 'early warning system'. This allows us to monitor performance and identify if further action or investigation is required. It is split into five key areas listed below:

- Preventing problems
- Detecting problems quickly
- Taking prompt action
- Ensuring robust accountability
- Ensuring staff are trained and motivated

During 2015/16, reports detailing performance against the early warning system indicators will be presented to our Quality Improvement Committee on a quarterly basis. This will enable us to demonstrate ongoing compliance with the recommendations made and to take early action to address any concerns identified.

Winterbourne View

We remain focused on reducing the number of people with learning disabilities or autism staying in hospital or residential homes where it is inappropriate, and we are committed to ensuring the safe care of all our vulnerable patients who do reside in these settings, whether temporarily or permanently.

In conjunction with NHS England, the Local Authority and healthcare providers, Care and Treatment Reviews were undertaken on an individual basis to ascertain whether people were in the most appropriate setting, receiving safe and high quality care, and that they had proper future plans tailored to their needs. These were completed in December 2014 for all appropriate individuals, and a number of changes to care and settings were recommended a result. Any changes will be completed by June 2015.

Our review programme will continue during 2015/16 and beyond, and will involve service users, advocates and family members in ensuring that these vulnerable people are cared for in the best environment available to meet their needs.

The Governing Body regularly receives progress reports to ensure that recommendations and actions are delivered, and to ensure an appreciation of the latest requirements to undertake care and treatment reviews for eligible individuals, both nationally and locally.

6.2 Patient Safety

We have in place a variety of robust arrangements to ensure that we can understand and measure any harm that may occur in healthcare services. We use the quality, information and CQUIN (Commissioning for Quality and Innovation) schedules of the NHS Standard Contract to gain the information that we need in relation to quality, including metrics and indicators for patient safety and harm. This enables us both to share and to act on the information we receive to increase awareness and to drive further improvements. This section sets out some of the arrangements either already in place or underway, together with details of how we will increase the reporting of harm to patients.

We will continue to expect providers to report promptly and investigate all incidents robustly, including serious incidents and never events. They must have in place systems to identify themes and trends and to facilitate the sharing of learning from incidents. We regularly scrutinise incidents and discuss them with providers, including how learning might be expected to impact on future practice. As a CCG, we review the themes and trends from reported incidents and use them to inform decisions relating to service provision. One such example is the identification of suicide and self-harm as a key area of focus, which led to a transformation of crisis services. Learning also informs CQUINs, for example, where we developed an indicator to ensure that patients have comprehensive crisis plans in place so it is clear what should happen if individuals need to access services.

We also use information reported via the NHS Safety Thermometer to measure harm and to assess the number of patients who have harm-free care. The Safety Thermometer is a point-of-care survey that is carried out on patients on one day each month only. In October 2014, we rolled out the latest versions, which cover areas of care other than acute, including mental health and maternity services. We have collected information from the Safety Thermometer and have already targeted our intervention to those areas where data showed that harm was occurring. One such example relates to pressure ulcers, where we have focused on ways to reduce avoidable pressure ulcers through training, education, different ways of working for staff, and robust performance management with provider organisations. We will continue with this programme in 2015/16, and this will include a piece of work to measure healing rates and sizes of pressure ulcers to improve patient safety and experience.

Reducing the rates of suicide and self-harm amongst adults and children within Nottingham City has been a focus for us. Self harm is one of the indicators included within the new safety thermometer for mental health services and we will use this data, together with that gained from implementing the actions required within the *2014-2016 Suicide Prevention Strategy for Nottingham City*, to identify groups at high risk of suicide and self-harm and improve timely data capture.

In addition to requiring information from organisations, we will also continue to undertake annual quality visits to all commissioned services, linking in with the regular service reviews that already take place. We have a schedule of visits and set criteria are used to measure standards of care provision, which include listening to the views of staff and patients during the visit. All information gathered is used to inform future commissioning decisions or to target areas requiring further exploration; for example, improving the understanding of confidentiality in relation to safeguarding children. In addition, to our own programmes of audit and visits to services, we work cooperatively with the Care Quality Commission (CQC) to provide relevant information and intelligence prior to inspection. Following inspection,

providers are expected to supply an early summary of areas requiring improvement to commissioners and produce actions plans for CQC demonstrating how they intend to achieve compliance against standards, which are also shared with us and monitored through to completion.

The Patient Safety Collaborative has a key role in understanding and measuring harm across the local health and social care economy. We will continue to work with them on a number of projects, including reducing harm from pressure ulcers, reducing healthcare associated infections, and improving safety in care homes. The data gathered, together with evidence of what works in practice, enables us to identify the actions required to make further improvements to patient safety.

National and local CQUIN indicators, which are set to incentivise improvements in quality, also enable us to identify and measure harm that may occur. For example, we developed a scheme to provide us with benchmarking data relating to individuals who had fallen, or were at are at risk of falling, and targeted assessments and interventions to help reduce the resulting harm. This work will continue in 2015/16, and we will monitor and evaluate the impact that it has had on patient outcomes.

We will continue to work in partnership with Nottingham City Council to understand and measure harm within care homes. We have established a dashboard of metrics to identify homes that are at risk of failing, and we will use this information to ensure that support is available to them through an Early Intervention Team. This new approach is a joint venture with the local authority, and will be piloted in 2015/16.

6.3 Increasing the reporting of harm to patients

We recognise that improvements can always be made as a result of increasing the reporting of patient harm. We have a number of mechanisms and tools to allow us to improve reporting on a continual basis. Working with the Patient Safety Collaborative, we intend to review whether there are any further areas where we might benefit from collaboration. This might include the delivery of root cause analysis training for clinicians to improve the identification of learning from incidents, as well as solutions for reducing harm. We also want to identify the support that clinicians need to encourage them to report incidents, as well as to explore the barriers that may prevent them from doing so.

To help promote the benefits of incident reporting, we will continue to share case studies taken from incident reporting, investigation and lessons learned in our quarterly newsletter *Quality Matters*. This includes examples from all sectors, and is distributed to providers across primary, secondary and community care, and care homes.

Primary Care – We undertake annual practice visits, during which we review a range of indicators linked to performance and quality, to support practices in improving their standards. We consider findings at our Primary Care Quality Steering Group, and we share examples of good practice identified with other practices. As we have not been responsible previously for commissioning general practice, we have focused on sharing learning, following incident investigation to facilitate improvement, rather than on the rates and numbers of incidents (which cause harm to patients) being reported. However, now that we have been granted delegated authority, during 2015/16 we will work with practices to

increase incident reporting and demonstrate the value of a positive safety culture with regard to patient care. We will do this by using established tools, for example, Seven Steps to Patient Safety in General Practice (National Patient Safety Agency) to benchmark current practice, identify areas for improvement and generate actions plans to support the changes required at a CCG level. We will work with practices to understand what would support an increase in reporting within primary care as well as exploring barriers to reporting so that we can understand how reporting rates could be improved on a sustainable basis. This can be fed into the wider piece of work with the Patient Safety Collaborative. At individual practice level, we will identify current rates of reporting, benchmark these appropriately and target practices with lower than expected level of reporting.

Secondary and Community Care – During 2014/15, we set trajectories for an increase in the reporting of medication-related safety incidents along with a number of other areas, including falls. These are in line with national quality premium guidance for all providers of community and secondary care. We will continue to include these targets in 2015/16 contracts, and have set clear expectations that there will be an increase in the proportion of incidents reported that result in 'no or low harm', and a decrease in the number causing 'moderate or severe harm'. We will continue to monitor the uploading of incidents onto the *National Reporting and Learning System.* Providers will be expected to detail the actions they are taking to address any areas identified within their organisational reports, and to provide evidence to show that these have been implemented.

Care homes – New contracts are being issued to care homes with effect from 1 April 2015. These include a contractual requirement to report incidents directly to the CCG. During the consultation and engagement period, we have highlighted this requirement to care homes. At the same time, we have promoted the new CQC regulations, which set out fundamental standards of care that come into force on 1 April 2015. These include regulation 20 (the duty of candour) which will require incidents to be reported and investigated appropriately.

6.4 Tackling sepsis and acute kidney injury

For our acute provider, we are developing CQUIN schemes which relate to two areas: to ensure that staff are able to recognise acute kidney injury and sepsis at an early stage; and that there is consistent assessment and treatment, both of which are evidence-based, to ensure prompt rescue and improved outcomes for patients. We will measure outcome data, e.g. mortality and unexpected admissions to intensive care, and triangulate findings with compliance against the sepsis care bundle, early warning score monitoring, and the national acute kidney injury algorithm.

Within community and mental health settings, we are also exploring how staff should be both trained to recognise acute kidney injury and sepsis at an early stage, and able to maintain their competence. We are also reviewing pathways for care and referral to ensure that they are clear, provide sufficient information, and support staff in dealing with what may be infrequent events within their sphere of clinical practice.

For primary care, again we will focus on recognition, diagnosis and treatment, and targeted education and training for sepsis in both adults and children. This also responds to the failings in care highlighted by a recent case in Nottinghamshire.

We will review these plans when the new nationally mandated CQUIN schemes for 2015/16 are published, to ensure that we are doing everything required.

6.5 Improving antibiotic prescribing in primary and secondary care

Updated, antimicrobial guidelines for the health community have been developed in collaboration with primary and secondary care. These will be signed off formally at the Nottinghamshire Area Prescribing Committee, and will ensure consistency in antibiotic prescribing recommendations across the Nottinghamshire health community. They will also help to ensure the appropriate use of antibiotics.

Antibiotic prescribing indicators are in place within GP practices, and are monitored quarterly. The findings are discussed at annual prescribing visits, or more frequently should a practice become an outlier. In this instance, outlying practices receive individual practice support, and are audited regularly to monitor progress and ensure that changes are implemented effectively.

Antibiotic prescribing across primary and secondary care is further strengthened through links to district-wide Health Community Acquired Infection groups. This helps to facilitate a collaborative approach across the health community. We also work closely with the Infection Prevention and Control Teams from community health providers to share results and learning from audits, incidents and root cause analysis. Key messages are then identified and disseminated to prescribers within primary care.

7. Improving patient experience

7.1 Setting measurable ambitions to reduce poor experience of inpatient care

We have access to a wealth of data and information relating to experiences of local healthcare services. Sources include complaints, patient feedback, CQC and provider survey findings, comments left on websites - for example, *NHS Choices* and *Patient Opinion*, Friends and Family Test results, targeted engagement work, and quality visits. We will continue to monitor and triangulate this data to identify areas of concern and to set improvement targets. So that we can make further improvements in how we use data, we will review how we categorise the complaints and enquiries we receive and manage. We will consider changing our coding system to reflect NICE quality standards 14 and 15, so that we can monitor this against information received from providers. These standards relate to patient experience in adult NHS or adult mental health services. We will also review how information about patient experience is triangulated with other data sources, for example patient safety, staffing levels and service performance indicators, to provide a more representative picture of how patients truly experience the care and services they receive.

Providers are required to monitor and triangulate their own patient survey data, and demonstrate to commissioners how this has improved or impacted on both practice and service delivery. We request that a minimum of four examples are identified and shared with us each quarter, so that we can track the effect of patient feedback received.

Based on the information we have to date, the following ambitions have been set for 2015/16. Each of these will have measurable targets for achievement, appropriate to each organisation:

- Increased numbers of complaints received from seldom-heard and vulnerable populations.
- Reduced numbers of complaints relating to the attitude of carers or staff (nursing, allied health professionals and medical), dignity and respect, and care and treatment.
- Reduced number of complaints accepted for investigation by the Parliamentary and Health Service Ombudsman.
- Reduced number of complaints upheld by the Parliamentary and Health Service Ombudsman.
- Reduced percentage of patients who would not recommend services to others.
- Increased response rates to all forms of patient survey.
- Increased numbers of patient survey respondents from seldom-heard and vulnerable populations (providers' own surveys).
- Increased number of complaints acknowledged and responded to within timeframes agreed with the complainant.
- Increased numbers of patients who agree that their experiences of care align with the statements within NICE Quality Standard 14 or 15.

7.2 Assessing and improving the quality of care for vulnerable patients

The methods of evaluating the quality of care as set out within section 7.1 above apply equally to the care provided to vulnerable people.

Equality Delivery System – We have continued, and will continue to assess our performance against the Equality Delivery System (EDS2) outcomes for both goals one (better health outcomes) and two (improved patient access and experience). These relate to the nine protected characteristics and inclusion health groups within Nottingham City, whom we know to be vulnerable for a number of reasons. This assessment allows us to establish how vulnerable groups fare compared with the general population, and to determine where further focus is required. As set out within their contracts, in 2015/16 we will continue to require providers to report information on patient experience measures and complaints by protected characteristics. We then review information received, and work with providers both to target areas where experiences vary between different groups, and to agree improvement objectives.

Care homes vanguard – We know that some of our most vulnerable patients are in care homes, are elderly, or may have mental health conditions, learning, or physical disabilities. We have recently submitted an application to NHS England's *New Models of Care* programme to become a vanguard site. This has been developed in conjunction with a number of our partners, including Nottingham City Council, acute and mental health providers, and Age UK. With support from the structured national programme, we would

like to commission a care home model that is seen as a beacon of best practice and fit for the future. Over the course of the next year we plan to review the effectiveness of our current arrangements in meeting the needs of care home residents. Findings will inform improvements and the development of new services, and we would look to start introducing new ways of working from October 2015.

Clinical accountability – We will continue to work towards embedding the practice of clear clinical accountability, with a named doctor responsible for each individual patient's care, within and across different care settings. In 2014/15, as part of the commitment to more personalised care for patients with long term conditions, all patients aged 75 and over were assigned a named accountable GP. During 2015/16, we will continue to focus on vulnerable adults through implementation of a local and a national Enhanced Service to reduce unnecessary emergency admissions to secondary care. This will require proactive case management of at-risk patients using a risk stratification tool to identify vulnerable older people, high risk patients, patients needing end of life care and patients who are at risk of unplanned admission to hospital. Personalised care plans will be developed for patients on the case management register by a named accountable GP within their practice.

7.3 Demonstrating improvements from complaints and feedback

Complaints and other sources of feedback, including comments, concerns and survey data help commissioners to identify problem areas by giving an insight into the services that we commission and provide a barometer of quality and standards of care. Above all, they help us to take action to prevent similar problems occurring in the future and to allow services to continually improve.

As outlined in previous sections, we already expect our providers to monitor and triangulate their own patient survey data and demonstrate to commissioners how this has improved or impacted on practice and service delivery and to ensure that this can be linked to vulnerable groups via analysis by protected characteristic and this will continue in 2015/16. We will also monitor progress against the patient and staff experience ambitions identified to ensure that improvements are being seen.

7.4 Meeting NHS Constitution patient rights and commitments

All providers are required to supply an annual declaration to commissioners that they are i) compliant with the rights and commitments of the NHS Constitution with respect to patients and staff; and ii) have plans in place to address any areas of concern identified. This declaration is scrutinised and reviewed against patient feedback and other information received during the year.

7.5 Ensuring that Caldicott Review recommendations are relevant to patient experience

We will use the general condition, included within the NHS Standard Contract, to ensure that our providers adopt and implement all recommendations from the Caldicott review (including those relevant to the patient experience) and conduct an annual audit of their

practices against the quality statements relating to data sharing, as set out in NICE Clinical Guideline 138.

In 2014/15, we implemented a CQUIN relating to information sharing. This targeted a number of areas for improvement, including information sharing protocols and preparing technical solutions for sharing data appropriately. There was also a requirement for providers to improve information sharing and as part of this a survey was conducted to ascertain patient views on how information is handled. Providers will need to present the results of this survey to commissioners, together with an action plan to address any gaps or weaknesses identified. We will require providers to repeat this survey in 2015/16 to ensure that actions implemented have been effective. We expect patients to report better experiences and greater confidence in the way in which their data is managed and handled. In addition, the CQUIN scheme has been developed to focus on implementing the technical solutions created in 2014/15 to improve handovers between professionals during episodes of clinical care.

8. Compassion in Practice

Compassion in Practice, the national strategy for nurses, midwives and care staff, was launched in December 2012. Since that time, a significant programme of work through six action areas, known as the '6 Cs', has gained a momentum across the country which has recognised the very crucial role that organisational culture plays in determining the experience of patients and users of our services. Our role as a commissioner is to assure that providers are delivering against the 6Cs, which are: care; compassion; competence; communication; courage; and commitment.

We have recently completed a review of the assessments undertaken by providers of how well *Commission in Practice* has been implemented within their organisations. As a result, we are assured that provider plans are delivering against the 6 Cs, and no concerns have been identified. This review has highlighted examples of good practice and has demonstrated the extent to which activities to date have directly benefited patients and staff. The 6Cs are being rolled out to all staff in a number of ways, including incorporating them in recruitment approaches, induction programmes, and ongoing training, appraisal and supervision. We will continue to monitor progress against these implementation plans via existing contractual mechanisms.

9. Improving staff satisfaction

We have access to a range of information available to provide us with an insight into staff satisfaction locally, and how sentiment compares with similar organisations. This includes findings from the annual staff surveys, *Friends and Family* tests and quality visits; staff sickness and absence rates, staff appraisals, safe staffing returns and other workforce indicators; complaints; patient surveys; and feedback from student placements. The following provides an overview of satisfaction for staff working at each of our key providers.

Nottinghamshire Healthcare NHS Trust – Generally staff are satisfied with the organisation and would recommend it as a place to work or receive treatment. In the 2013 staff survey

published in February 2014, the overall score for staff engagement relating to their work, their team and the Trust, was amongst the top 20% of similar Trusts across England. The Trust scored well on issues relating to work pressure, although many staff reported that they had felt pressure in the last three months to attend work when feeling unwell, and this was in the worst 20%. The percentage of staff appraised in the last twelve month was also in the worst 20%, although the Trust scored 86% against a national average of 87%.

Nottingham University Hospitals NHS Trust – Generally, staff are satisfied with the organisation and would recommend it as a place to work or to receive treatment. In the most recent survey, published in February 2014, the Trust scored better than average for the percentage of staff appraised in the last twelve months. It was also in the top 20% for those considered to have well-structured appraisal systems. The Trust was in the worst 20% both for access to training, and for the number of errors, near misses or incidents witnessed in the last month. The results from the 2014 staff survey are due to be published in early 2015. We will review these to establish how performance has changed over the past year. Providers will be required to share their action plans with us, and we will monitor these as part of our contractual performance management process. We will also work directly with Health Education East Midlands to ensure that we can recruit and retain a motivated and skilled workforce. Furthermore, this workforce will need to meet the needs of both changing populations and the NHS landscape, as well as respond to the new models of care and working required for successful transformation.

9.1 Delivering improvements in staff experience to improve patient experience

We will continue to monitor and triangulate all the data and information we hold about experiences of health care and services from staff and patient perspectives. This will to identify areas of concern and set targets for improvements. The following ambitions have been set for 2015/16, against which we will develop measurable targets appropriate to each organisation:

- Increase general response rates to staff surveys
- Increase or maintain the position on overall staff engagement
- Increase or maintain the position relating to recommending the organisation as a place to work or to receive treatment
- Reduce sickness and absence rates
- Increase staff retention and reduce turnover

Once the results of the 2014 survey are known, we will set objectives to address areas where performance is worse than average, or where performance has deteriorated since the previous year.

10. Achieving seven day services

There is clear evidence that patients admitted to hospital as an emergency at the weekend have an increased risk of dying compared to those admitted on a weekday. Because of this,

the planning guidance for the NHS for 2013/14 expressed a clear commitment to move towards making routine services available seven days a week, with an initial focus on hospital care. This included a clear recommendation that the NHS should adopt the following ten evidence-based clinical standards for urgent and emergency care.

- Standard 1 – Patient experience: health professionals and social workers actively involve patients, real time data collection and feedback.
- Standard 2 – Time to first consultant review: clinical assessment by consultant within 14 hours of arrival.
- Standard 3 – Multidisciplinary team review: MDT review within 14 hours of emergency inpatient and establish management plan and estimated date of discharge within 24 hours.
- Standard 4 – Shift handover: handovers between incoming and outgoing and led by a key decision-maker.
- Standard 5 – Diagnostics: seven day access to consultant diagnostic tests and reporting within 1 for critical, 12 for urgent and 24 hours for non-urgent.
- Standard 6 – Interventions/key services: timely 24/7 access to consultant led interventions.
- Standard 7 – Mental health: acute admission patients assessed by psychiatric liaison 24/7.
- Standard 8 – On-going review: High dependency area patients to be seen by consultant twice daily, and once moved onto general wards at least once daily.
- Standard 9 – Transfer to primary, community and social care: support services onsite and offsite to be available seven days a week to ensure next steps in pathway can be taken.
- Standard 10 – Quality improvement: review of patient outcomes to drive care and quality improvement.

We are working with our partners, particularly Nottingham University Hospitals NHS Trust to ensure that as a minimum, by 2016/17 the hospital will comply with five of the ten standards, with compliance against the remaining five standards from April 2017 onwards. During 2014/15, Nottingham University Hospitals NHS Trust was required to assess its current compliance and agree an action plan for implementing the standards. This has involved working with individual wards to determine their baseline positions against the national standards and all Directorates identifying how they are moving to seven day working as part of the annual planning process. For 2015/16, we will agree an updated Seven Day Plan with the Trust to ensure that significant progress is made towards implementation of the standards. Key priorities have been identified as Standards 2, 5 and 9, with plans in place to make progress on Standards 6 and 8.

In support of the work taking place in the hospital, particular focus will be paid over the next two years on developing seven-day community and mental health services where appropriate. For example, Standard 9 (transfer to primary, community and social care) is already the focus of local improvement efforts through the Better Care Fund plans. For Standard 7 (psychiatric liaison), the Clinical Commissioning Groups in South Nottinghamshire

will invest recurrent resources to further support capacity into the existing 24/7 Rapid Response Liaison Psychiatry Service and will review the use of the £30 million targeted investment announced nationally as soon as further information on this becomes available.

11. Safeguarding

11.1 Meeting our requirements to protect vulnerable people

We have robust arrangements in place to meet the requirements for CCGs within the NHS Commissioning Board's accountability and assurance framework: Safeguarding Vulnerable People in the Reformed NHS (March 2013). These include the following:

- Maintaining clear lines of accountability through both the Director of Quality and Delivery, and the GP Executive Lead for Safeguarding.
- Coordinating and overseeing all safeguarding activities through our Safeguarding Steering Group, with assurance being provided to the Quality Improvement Committee and the Governing Body.
- Actively participating in all sub-groups (both statutory and non-statutory) in addition to chairing a number of local Safeguarding Boards for both adults and children.
- Continuing to be a funding partner and vice chair of Local Safeguarding Boards for adults and children.
- Working in partnership with statutory agencies to Identify emerging areas of concern and work together to deliver improvements, for example historic abuse, child sexual exploitation and modern slavery.
- Maintaining ongoing membership of the Nottinghamshire/Derbyshire Safeguarding Forum.
- Ensuring that we have a designated doctor and nurse for children and looked-after children and a lead practitioner for safeguarding adults and the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Undertaking an annual assessment of safeguarding capacity requirements for both adults and children, to ensure that staffing levels and arrangements for safeguarding purposes remain appropriate and effective.
- Undertaking Section 11 audits and Markers of Good Practice (MOGP) and Safeguarding Adults Assessment Framework audits with all providers and for the CCG.
- Implementing all the actions required to complete the action plan following the Child Safeguarding and Looked After Children inspection undertaken by the CQC in June 2014.
- Operating appropriate policies and procedures to safeguard adults and children.
- Providing an annual report on safeguarding performance to both the Quality Improvement Committee and the Governing Body for assurance.
- Delivering a training programme for general practice and care homes in relation to safeguarding; to include adults, children, MCA, DoLS and the Prevent strategy.

- Developing and delivering training, as described above, to all members of the Governing Body to ensure ongoing compliance with any national requirements, including the intercollegiate guidance for children.
- Delivering training for all CCG staff for all areas described above.
- Learning from, and monitoring the impact on practice following Serious Case Reviews and other types of learning reviews.

The Care Act 2014 has been introduced since the publication of the Accountability and Assurance Framework. We will therefore work with Nottingham City Council and other partners to ensure that the requirements of phase 1 of this Act are introduced and implemented with effect from April 2015. This includes introducing the role of the Senior Manager and Designated Safeguarding Adults Manager (DSAM) within our CCG. We will also continue to support Nottingham City Council with implementation plans required for phase 2, which takes effect from April 2016.

11.2 Delivering improvements in the application of the Mental Capacity Act

The work to introduce the Care Act 2014 will support improvements in safeguarding adults and the MCA by ensuring that statutory processes are fully operational. We have already undertaken work to ensure that staff are adequately trained in relation to the MCA and DoLS. Following the receipt of funding from NHS England, we have also developed a suite of tools to support primary care clinicians with complying with the MCA and DoLS. This has involved the development of an 'App', an e-learning package and a number of workshops to improve education and understanding. We will continue to promote and embed these tools into practice and will provide one-to-one support and advice on individual cases as required.

We have reviewed our practices following the Cheshire West judgment and are reviewing all individuals funded by Continuing Healthcare Funding to ensure that they are not deprived of their liberty in care homes, supportive living or domiciliary settings. A number of these are being referred to the Court of Protection for a decision on their circumstances.

We will provide regular progress reports on all of these areas to the Safeguarding Steering Group, so that progress and quality improvement can be monitored.

11.3 Meeting the standards in the *Prevent* agenda

The *Prevent* strategy is one element of the government's anti-terrorism strategy with the aim of preventing people from being drawn into extremism or extremist activities. Although Nottingham is not deemed to be a high-risk area, we will ensure that these standards are met. In light of the latest guidance relating to the training and awareness required for this agenda, we will ensure that there is an increase in the number of accredited *Prevent* trainers across the health community. This will allow training to be delivered within the required timescales, whereby 90% of all staff requiring such training will have completed it within 12 months of starting in a role. The training will be supplemented with a communications strategy, together with policies and procedures to ensure that all staff are aware of how referrals should be made in the event of any concerns.

We will measure compliance with the requirements to have an executive and operational lead, access to accredited trainers, a *Prevent* policy, clear referral processes and completion of awareness-raising and the training requirements listed above. This will be measured using the Safeguarding Adults Assessment Framework for both the CCG and our provider organisations, and we will provide reports to the Safeguarding Steering Group. We will address any areas of risk, or non-compliance by providers using existing contractual mechanisms.

Providers will be required, through quality schedules, to provide information relating to the *Prevent agenda*. This will include regular returns, compliance against the training and competencies framework, and performance against the duties in the Counter-Terrorism and Security Bill (which are currently subject to consultation).

12. Research and innovation

12.1 Fulfilling our statutory responsibilities to support research

We remain committed to promoting and supporting research and innovation across local healthcare. This includes fulfilling three related statutory duties, which are described in the following sections.

Duty to promote research – We have a dedicated Research Strategy Group to oversee our statutory duty to promote research. The Group is chaired by Dr Alastair McLachlan, GP Executive lead for Research, and meets quarterly. Group membership includes representatives from research-active GP member practices, commissioning managers, the Head of Quality Governance, a Public Health Consultant and the Deputy Director of the National Institute for Health Research (NIHR) Research Design Service East Midlands. We have in place well-established research partnerships with:

- University of Nottingham
- Nottingham Trent University
- NIHR Clinical Research Network East Midlands (NIHR CRN EM)
- NIHR Collaboration for Applied Leadership Health Research and Care East Midlands (NIHR CLAHRC EM), where Lucy Branson, Associate Director for Corporate Development, is a member of the Governance Board

We will continue to utilise NIHR Research Capability Funding, which is awarded to research-active organisations. This will provide ongoing support for the strategic development of high quality primary care research and research capacity, delivered in partnership with our GP member practices and local academics. We have commissioned two exploratory research studies with a view to increasing the uptake of Long Term Conditions and cancer services within primary and community care for Black and Minority Ethnic (BME) groups within Nottingham City. More about these can be found in section 3.3, and findings will inform the future commissioning and provision of services in 2015/16. We will also commission another research study this year to support the ongoing development and delivery of our commissioning strategy. We will work with our People's Council, GP leads and commissioning managers to determine the focus of the new study. We will continue to include research indicators within our provider contract quality schedules, where we are the

lead commissioner. Furthermore, we will develop and approve an Intellectual Property Policy within 2015/16.

Duty to promote the use of research evidence – Our Clinical Effectiveness Forum is the mechanism through which the CCG receives assurance of our statutory duty to promote the use of research evidence. This forum advocates and encourages clinical effectiveness and quality throughout all our activities. One of its duties is to review reports from local research studies and service evaluations, share learning, and make recommendations on the appropriate action to take. We are developing an *Integrated Impact Assessment Toolkit* to help us determine whether any new or changed activity will impact adversely or positively on service users, CCG staff or other organisations in relation to equality, quality and privacy. It will also assess whether planned activities are based on the best available evidence. To support the effective roll-out of the toolkit to staff, the Nottingham City Knowledge Resources Team will develop and deliver training to CCG staff, focusing on accessing and utilising evidence to support the commissioning process.

Duty to follow the Department of Health's policy on excess treatment costs for research – The matter of excess treatment costs for research is included within our detailed financial policies. We have an agreed a process for considering applications for excess treatment costs, which includes a dedicated budget. Our Head of Research and Evaluation has led a process to standardise the information required to support an application to commissioners for excess treatment costs. The resulting new form is now widely accepted by CCGs across the East Midlands and further afield.

12.2 Using Academic Health Science Networks (AHSNs) to promote research

Together with our health community, we are both actively engaged in, and benefitting from, the work of the East Midlands Academic Health Science Network (AHSN). This activity includes the development of evidence-based early supported discharge for stroke patients, community rehabilitation teams, and the Patient Safety Collaborative.

The *PINCER* initiative is a pharmacist-led intervention that will use information technology to address clinically important errors in the management of medications within primary care. The initiative will reduce prescribing errors, improve patient safety and reduce the number of unnecessary admissions to hospital. We are one of 17 CCGs in the East Midlands to take part in the PINCER initiative in collaboration with the East Midlands Academic Health Science Network (EM AHSN), Lincolnshire Community Health Services NHS Trust and the Universities of Lincoln and Nottingham. The initiative will be rolled out over the next two years to 150 GP practices across the East Midlands. Funding from both the EM AHSN, and a Health Foundation *Scaling Up Improvement Award* will enable partners to implement and evaluate the initiative.

The CCG is also in discussion with the EM AHSN regarding the commissioning of a SPARKLER (Spreading Applied Research and Knowledge – Longer Evidence Review) to support the transformation of urgent care. The SPARKLER is a pioneering service to help health organisations within the East Midlands to synthesise research from multiple sources. The evidence gathered provides the base on which to build rapid service improvements. During 2014, the South Nottinghamshire Unit of Planning asked the East Midlands AHSN to produce

a SPARKLER to identify the characteristics of three internationally renowned systems of care in Jonkoping, Sweden; Canterbury, New Zealand; and Alzira/Valencia, Spain. The findings will help to inform the development of new models of care for Nottingham City over the course of 2015/16.

12.3 Delivering Health and Wealth: accelerating adoption and diffusion in the NHS

The Department of Health's report, *Innovation Health and Wealth,* sets out a delivery agenda for spreading innovation at pace and scale throughout the NHS. We will continue to meet the requirements of this report with respect to our role and responsibilities as a commissioner. Here, we set out how we will do this.

Reducing variation and strengthening compliance – NICE Technology Appraisal – Where we are the lead commissioner, our Quality and Contract Review meetings will continue to monitor the quality reporting requirements compliance against NICE Technology Appraisals for providers. Our CCG has delegated authority, through the Medicines Management Team, to the Nottinghamshire Area Prescribing Committee to ensure the appropriate implementation of NICE Technology Appraisals and clinical guidelines relating to medicines used within primary care.

Leadership for Innovation – We are aware of our duty to seek out and adopt best practice, and to promote innovation. In 2015/16, we will hold a session on innovation as part of our Governing Body development programme. This will be based on NHS England's 2013 guidance: *Strengthening Leadership and Accountability for Innovation. A practical guide for Governing Bodies and Provider Boards.*

High Impact Innovations – Assistive Technology Programme – The Assistive Technology (AT) Strategy within the Adult Integrated Care Programme aims to secure increasing and more effective use of AT across health and social care. It also seeks to integrate the two separate services - Telehealth and Telecare - into one service. We will focus on key priority groups, such as adults with long term conditions, adults with learning disabilities and disabled children, with a view to preventing hospital admissions, supporting discharges, and preventing or delaying care home admission. Included within the Better Care Fund Plan, the AT programme has an overall target to support up to 10,000 local people by 2018. This incorporates an increase from 4,800 to 6,000 people within 2015/16. Feedback from both users and carers is very positive. 96% of users report that they feel safer at home with the equipment, and 75% of carers say they feel less stressed than before. Patients using Telehealth have told us that the technology has helped them to manage their condition, so reducing hospital attendances and admissions, as well as visits to their GP. Feedback forms part of the formal evaluation of the programme, and in 2015/16 we will also conduct a cost-effectiveness study to demonstrate the impact that using AT has had on the cost of providing services. Following the accolade of 'Highly Commended' at the 2014 Government Opportunities Award, there are also further initiatives planned for 2015/16. We aim to introduce Telehealth and video conferencing to support patients in care homes, together with virtual clinics to support respiratory patients to manage their condition and avoid hospital admissions through their Telehealth device. This will also provide more help to GP Practices in supporting their high-risk patients and in managing frequent attenders.

13. Delivering value

13.1 Meeting the business rules on financial plans

The CCG has a duty to deliver against a set of business rules for financial plans. For 2015/16, these are as follows:

- To deliver a minimum of 1% surplus on our total allocation (resource limit). This equates to a surplus of just over £4,230k.
- To ensure that at least 0.5% contingency is held by the CCG for in-year risk. This equates to £2,116k.
- To ensure that at least 1% of our programme resources are funded non-recurrently during the year. This equates to £4,230k.

Our 2015/16 plans successfully deliver against *all* of these metrics.

13.2 Developing credible, evidence-based QIPP plans

QIPP plans have been identified for 2015/16 to deliver efficiency savings of £6.5m in line with our targets.

In developing our specific QIPP priorities and initiatives, we have benchmarked our performance, data, services and activities with evidence gained from a number of sources and approaches, including *Commissioning for Value*, *Dr Foster*, deep dives and programme budgeting. Our *Better Care Fund* team has also met with a number of peer CCGs and other organisations to compare activity and to explore best practice. These include NHS Wolverhampton CCG (long term conditions); Leicester and Lincoln CCGs (smoking cessation); Torbay Care Trust (older people's services); and Manchester and Liverpool CCGs (cancer pathways and QIPP programmes in general).

Benchmarking has shown that the main opportunities for efficiency improvement across Nottingham City healthcare lie within urgent care, long term conditions, mental health, and emergency admissions. Prescribing also has a national focus, and whilst we perform well in terms of prescribing spend, there are still savings to be made. In accordance with these findings, our QIPP programme is divided into five core programme areas to align with specific pathways of care:

- Urgent care
- Planned care
- Long Term Conditions
- Mental health
- Prescribing

Representatives from our CCG have also attended national QIPP redesign conferences and workshops to gain best practice, develop further skills, and share learning in relation to various areas of care.

In many areas we are leading the agenda for service improvement; for example, giving GPs direct access to CT scans for suspected lung cancer patients, our orthopaedic community ICAT service, and our community diabetes service. Many of these initiatives are a direct benefit of the clinical commissioning approach, whereby GPs developed the ideas to respond directly to local challenges, and simply made it happen through the CCG. Thanks to this local innovation, a number of the QIPP arrangements we are implementing in full this year are as a result of successful local pilots.

We have worked, and will continue to work in collaboration with our providers to develop and to deliver QIPP plans across the local system. This ensures ownership of organisational plans, as well as commitment to their delivery. The process has involved 'confirm and challenge' sessions with finance, commissioning and clinical leads across the CCG, as well as the relevant leads from provider organisations. In turn, each provider has taken proposals through their own organisational governance processes.

All QIPP plans have an integrated impact assessment undertaken before being shared with GP Leads and signed off by the Risk and Performance Committee, and on to our Governing Body. Other partners, such as the local authority, are involved in this process where a scheme either involves, or impacts on them. Any initiatives requiring investment are referred to the Resource Allocation and Prioritisation Panel, and undergo a process of further assessment and scrutiny before funding is committed.

Our QIPP plans for 2015/16 will be available on our public website once they have been signed off by the Governing Body.

14. System Resilience

System Resilience Groups (SRGs) are the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. Nottingham City CCG is part of the Greater Nottingham SRG.

In the second and third quarter of 2014/15 Nottingham City CCG and its partner CCGs in Greater Nottingham received two separate allocations of non-recurrent money (totalling £9.2m) which was used to support 22 separate resilience and service improvement schemes across three key areas:

- Avoiding Hospital Admission.
- Internal Capacity and Flow with Nottingham University Hospitals (NUH).
- Effective Discharge and Rehabilitation.

With the increasing understanding that system resilience is not just an issue in the winter there has been a national decision to move away from ad-hoc funding and in 2015/16 every CCG in England has received a system resilience allocation on a recurrent basis. Whilst this allocation is considerably reduced from that received in 2014/15 (£4.2m across Greater Nottingham CCGs) the certainty of recurrent funding is hugely beneficial. However for 2015/16 it will require the system to reduce the number of resilience schemes that were in operation at the end of 2014/15.

The Greater Nottingham system has undertaken a detailed 'stock take' exercise to review all of the schemes put in place during 2014/15, understand their impact on system resilience and understand the risk should those schemes be reduced or stopped. Recommendations from the 'Stock Take' meetings were presented to the SRG meeting in March 2015 and the following investments confirmed utilising both System Resilience and alternative sources of funding.

- Additional clinical staff in the Liaison Psychiatry Service to support the Emergency Department at Queens Medical Centre.
- Additional diagnostics imaging capacity to support the Emergency Department at Queens Medical Centre.
- Additional Emergency Department Consultant cover to increase the number of consultants on duty during the evening and overnight period.
- Nottingham Care Navigator Service (a range of initiatives which enable doctors at the hospital to access alternative services for patients to prevent them from having to admit someone to a hospital bed).
- Additional nurses at Ling Bar Community Hospital to support the rehabilitation of patients and a reduced length of stay to improve flow through hospital.
- Discharge Coordinator for community facilities to improve flow through community in-patient facilities and eliminate delayed transfers of care and additional staff to coordinate discharges from hospital.
- Additional social worker capacity to achieve timely assessment and discharge of patients from hospital who require ongoing support at home or in the community.
- Resilience capacity for East Midlands Ambulance Service.
- GPs working in the Emergency Department (this will be trialled over the Easter holiday bank holiday weekend).

In addition to this all of the other resilience schemes that were in place as at the end of 2014/15 will continue to be supported during April 2015. This will provide additional resilience over Easter and will allow further work to take place to assess a safe way to withdraw from these schemes (which includes additional beds in the hospital) or alternatively to look at how they can be continued if this is deemed to be necessary.

Appendix 1 – NHS Outcomes Framework Performance

Domain	IndicatorName	Range	Increase / Decrease
Preventing people from dying prematurely	1.1 Potential Years of Life Lost amenable to healthcare - female	IQ Range	Sig Decrease
	1.1 Potential Years of Life Lost amenable to healthcare - male	Worst	Non-sig Decrease
	1.2 Under 75 Mortality from CVD	Worst	Non-sig Decrease
	1.6 Under 75 Mortality from respiratory disease	Worst	Non-sig Increase
	1.8 Emergency admissions for alcohol released liver disease	Worst	Non-sig Decrease
	1.9 Under 75 Mortality from cancer	IQ Range	Non-sig Decrease
	1.10 One year survival from all cancers combined	Worst	Non-sig Increase
	1.7 Under 75 Mortality from liver disease	Worst	Non-sig Decrease
	1.4 Myocardial infarction, stroke and stage 5 kidney disease in people with diabetes	Worst	N/A
	1.11 One year survival from breast, lung and colorectal cancers	Worst	Non-sig Increase
	1.17 Record of stage of cancer at diagnosis	IQ Range	
Enhancing quality of life for people with LTC	2.2 % of patients with long term conditions who feel supported to manage their condition	IQ Range	Non-sig Decrease
	2.6 Unplanned admissions chronic ACS conditions	Worst	Non-sig Decrease
	2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	IQ Range	Non-sig Decrease
	2.15 Health-related quality of life for carers	IQ Range	Non-sig Increase
	2 Health-related quality of life for people with long-term conditions	Worst	Non-sig Increase
Helping people to recover from episodes of ill health or following injury	3.1 Emergency admissions for acute conditions that should not usually require hospital admission	IQ Range	Non-sig Increase
	3.2 Emergency readmissions within 30 days of discharge from hospital	Worst	N/A
	3.3 Hip replacement casemix adjusted health gain	Worst	Non-sig Increase
	3.3 Knee replacement casemix adjusted health gain	IQ Range	Non-sig Increase
	3.3 Groin hernia casemix adjusted health gain	IQ Range	Non-sig Decrease
	3.4 Emergency admissions for children with lower respiratory tract infections	IQ Range	Non-sig Increase
	3.3 Varicose veins casemix adjusted health gain	N/A	Non-sig Decrease
	3.6.i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Worst	Non-sig Decrease
	3.6.ii Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital.	Best	Sig Increase
Ensuring that people have a positive experience of care	4.1 Patient experience of GP out-of-hours services	IQ Range	Non-sig Decrease
	4.2 Patient experience of hospital care	IQ Range	N/A
	4.5 Responsiveness to Inpatients' personal needs	Worst	
	4.4.i Access to GP services	IQ Range	Sig Decrease
	4.4.ii Access to NHS dental services	Best	Non-sig Increase
	4a.i Patient experience of GP services	IQ Range	Sig Decrease
	4a.ii Patient experience of GP out-of-hours services	Best	Non-sig Decrease
	4a.iii Patient experience of dental services	IQ Range	Non-sig Increase
Treating and caring for people in a safe environment and protecting them from avoidable harm.	5.4 Incidence of healthcare-associated infection - C.Difficile	Best	N/A
	5.3 Incidence of healthcare-associated infection - MRSA	Best	N/A

Key	
	Overarching indicator
Worst	Worst quartile nationally
IQ Range	Within interquartile range nationally
Best	Best quartile nationally