STP FULL FEEDBACK REPORT

Appendix to STP Feedback Summary (June 2017)

The Nottingham and Nottinghamshire
Sustainability and Transformation Partnership

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1. Introduction

The Sustainability and Transformation Plan (STP) is the five year plan for health and social care in Nottingham and Nottinghamshire. We published our draft STP in November 2016. We will refer to it from now in this document as 'the Plan'.

The draft Plan looks at how we can best improve the quality of care and the health and wellbeing of local people. Local health and social care services intend to work even more closely together to achieve this. Demand is growing for these services and we need to deliver them differently so that we can achieve our aims based on what is affordable.

With increased demand and significant financial pressure across the health and care system there is no option but for us to work differently to achieve better value for the resources we have available and ensure the future sustainability of local services.

We set out five priority areas where we will focus our efforts over the next five years:

1. Promote wellbeing, prevention, independence and self-care
2. Strengthen primary, community, social care and carer services
3. Simplify urgent and emergency care
4. Deliver technology-enabled care
5. Ensure consistent and evidence-based pathways in planned care

Other key aspects of the plan include opportunities to improve housing and the environment, strengthen acute services, and make services more efficient and effective. We also want to make sure that we have the right workforce in place to deliver this plan and that staff are properly trained and developed to deliver services in the future. We want to make sure we are using our buildings in the best way and want to talk to local people about how we take some of these changes forward to make the necessary improvements happen.

Since November 2016, we have been listening to the views of local people, key stakeholders and staff through meetings, events and written feedback:

- 395 people came to our public events
- 80 people attended the voluntary and community sector event
- 69 written responses were received.

We asked for feedback on the five priority areas, the strategic direction of the draft STP and for general comments on the contents of our Plan.

This *Full Feedback Report* is published as an appendix to the *Feedback Summary* (June 2017). It provides a full breakdown of the feedback received and our response to the themes, comments and concerns raised. Our response to the feedback has informed an update to the five-year Sustainability and Transformation Plan (STP) for Nottingham and Nottinghamshire in the form of a revised executive summary, published in July 2017.

All documents relating to the STP and the feedback we have received are available on our website at www.stpnotts.org.uk. To request printed copies or alternative formats please contact us at:

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2. Comments on specific areas of the Plan

Theme 1 - Prevention, self- care and independence	
SUMMARY OF FEEDBACK/CHALLENGES	**RESPONSE**
<u>**Making prevention happen**</u> – How can STP **deliver** its aspirations on Public Health and prevention? – How are we going to help the population to improve their own health? – Putting money in Public Health for obesity, drink and smoking has been happening for years and only smoking has improved. – What is going to make the difference now?	The STP provides our local system with an opportunity to move from talking about prevention to embedding it and realising all the associated benefits to our citizens. Studies show that 49% of the diseases that contribute to low healthy life expectancy can be linked to the following factors: • Diet: 15.8% • Smoking: 15.5% • Overweight/ obesity: 14.2%. • Other risk factors which can be influenced by primary prevention include alcohol and drug use (7.3%), low levels of physical activity (4.3%), occupational health risks (2.6%) and air-pollution (2.3%). Having a fully engaged system focusing on promoting independence and building resilience in communities will generate better outcomes for the health of our local population. Increased information and support, personal goal setting and care planning will support people in making healthier lifestyle choices and an holistic approach to mental and physical health and wellbeing will better address barriers to behaviour change.

Theme 2 - Community services	
SUMMARY OF FEEDBACK/CHALLENGES	**RESPONSE**
<u>Quality of community based care</u> – Community system not currently fit for purpose/ care in community **does not exist**. – People want to be cared for at home when and if they can rely on the same **quality of care** as they would see in hospital. – How can the quality of care plan implementation be improved?	The aim of the Plan is to improve the quality of services available outside hospital to ensure that people get the right help at the right time. We will develop co-ordinated teams to support people in their homes and increase the support to people in care homes. This is part of the wider plan to shift care and resources into the community across the health and care system where appropriate to do so.
<u>Community beds</u> – Lack of slower stream rehabilitation beds. – Clinical risk in using care home beds. – Make community hospitals stronger. Will expect to see more investment in Newark Community Hospital as this is 'care closer to home'	The aim is for care to be delivered at home where appropriate but there will be a need for some bed-based care in the community. The analysis to determine the capacity needed will be carried out locally as part of the next steps. There is a role for community hospitals but we need to ensure clinical safety about what can/cannot be done there and make best use of our combined resources. We also know that care in people's own home, is preferable where possible.
<u>Carers</u> – Carers need more **skills** to deal with complex conditions. – **Not enough** carers, especially for ageing population. Impact of rising retirement age for women in particular – Parents/carers feel **pressured** to take on responsibilities that are not theirs – Carers' special **needs** not being met by health and social care services. – Educate people about carer's role – those that take responsibility for relatives and need financial support –	We recognise the role of unpaid carers and acknowledge that the detailed plans to support them need to be more explicit within the Plan. One scheme that we are now delivering across the whole STP area is a Carers Hub. The Carers Hub provides information, advice and support through a single point of contact for carers, including a staffed phone line and access to carers groups and befriending services. We will work closely with carers to develop how they can contribute to the delivery of improved services.

No mention of **management and care of the dying**	Although there is not a specific focus on end of life care in the detailed plan, the STP is a 'life course' plan which includes the management and care of the dying. High impact area 2: Strengthen primary, community, social care and carer services will address the unwarranted variation in care in end of life services with the ambition to "Increase the quality of end of life care planning so that more people die in the place of their choosing and fewer die in hospital."
Joined up care (integrated care) – Health and social care impossible to separate for older people – 90% of whom need services from both. – **Integration** of health and social care is the way to **improve** the service to patients and at the same time tackle the **duplication** and **confusing** administration surrounding both providers. – Need to speed up integration of services and teams. – More focus on **holistic care** needed.	Integrated and holistic care is at the heart of the STP. We aim to bring health, social care and housing together to provide joined up care focused on people's needs and helping people to maintain their independence, especially for older people, children and young people, and adults with complex needs. We are at the start of this journey, with further work needed to meet the ambitions in the STP. There are a number of initiatives that we will continue to develop during the course of the STP, including: • Integration between primary, community and secondary care, for example through the work of the Vanguards which are testing new models of care in Mid Nottinghamshire and Greater Nottingham • Integration between health, social care and housing – our Better Care Fund plans have been in place since 2014 with a focus on working across the system through the pooling of funds to deliver more joined up services • Integration between primary and community care (including mental health and social care), through programmes such as 'PRISM' (Mid Nottinghamshire) and Care Delivery Groups (Greater Nottingham) and as part of the national 'Integration Pioneers' programme. • Testing the joining up of health, social care and other services at the level of each individual (such as education for children and young people) as part of the Integrated Personal Commissioning Programme.

<u>Access</u> – More community care needed for older people who live a long way from hospitals and find it difficult to get to appointments. – Community hospitals with day service are very Notts central and not accessible to all. – Less support in **rural** locations from home care. – Proper care at home needed at **weekends** too. – The word "community" occurs frequently in the Plan. However there is **no definition** of the geographical area. Anyone living in Beeston at the moment has a short trip to QMC. Those living in Eastwood have a greater distance to travel.	We acknowledge that access to services can be more difficult for those who live in rural areas and that travel times vary across the County, and we will take this into account when planning / redesigning services. We are committed to the principle of delivering local services closer to home although care models need to be cost effective and make best use of the system's collective resource.
<u>Appropriateness of care in the community/ at home</u> **BME women** (and others)– fear of social isolation if care in the home There are circumstances when you cannot care for people with **mental health** needs in community **Complex needs**: often told that they cannot be dealt with in the community Care at home does not work if patient **aggressive** or **non-compliant** Hospital **outpatient appointments** have kept me out of **the Emergency Department** and **hospital beds** by giving me safe tailored care and continuity	We acknowledge that the model of care for services closer to home or delivered in the home needs to be sensitive to the needs of specific communities and groups. Implementation plans will consider the needs of specific groups and the appropriateness of care models for them, and will include the production of quality impact assessments (QIAs) and equality impact assessments (EIAs) as part of service specifications and re-design.

<table>
<tr><th>Theme 3 – Mental Health</th><th></th></tr>
<tr><th>SUMMARY OF FEEDBACK/CHALLENGES</th><th>RESPONSE</th></tr>
<tr><td>Lack of plans specifically around mental health. Lack of parity of esteem.</td><td>We acknowledge there is insufficient focus on mental health in our Plan. We intended to include mental health and wellbeing into all parts of the Plan rather than create an artificial separation between physical and mental health, but accept this has resulted in mental health not being sufficiently prominent as a priority. Our focus will be on meeting the ambitions set out in NHS England’s Mental Health Forward View. Mental health is an integral part of this plan.</td></tr>
<tr><td><u>Prevention and early intervention</u>

– Opportunity to prevent long-term mental health issues from age of 18.
– Plan does not recognise needs of Children & Young People especially ethnic communities to reduce mental health issues and minimise future crises in adulthood
– Need to include aims around prevention and early intervention, access to emergency care and collaborative working on mental health issues, drawing on Concordat plans.
– Need quicker identification of those at risk of developing depression and access to psychological therapies</td><td>We recognise that our detailed plans for mental health are not clearly set out in the plan.

As an STP we aim to meet the ambitions set out in NHS England’s Mental Health Five Year Forward View which includes the following as a priority:
• to increase access to specialist perinatal care
• to reduce the number of out of area placements for children, young people and adults through the provision of more care closer to and at home
• to increase access to crisis care liaison services in emergency departments and inpatient wards
• suicide prevention
• improving physical health care and life expectancy for patients with serious mental illness</td></tr>
<tr><td><u>Dementia</u>

– Dementia is not in plan.
– How will you reach the 57,000 dementia sufferers not getting the diagnosis and services that they need?</td><td>Dementia is acknowledged in the plan as one of the key challenges facing us. In the plan we state that we will increase early identification of dementia (p28) and use technology to sustain independence for people living with dementia (p33).</td></tr>
</table>

– What is the plan for a better way of dealing with dementia patients? Lack of focus on dementia and Alzheimer's, especially inappropriate admissions to hospitals and care homes; and end of life care pathway. 30% of people presenting at ED have dementia**.** – Need better understanding around needs of people with dementia and that there is not a 'one size fits all'. – Earlier diagnosis with consistent follow up service across City and County (e.g. City has Jackdawe service and County has nothing similar). Lack of specific dementia services.	There are about 13,000 people in Nottingham and Nottinghamshire living with dementia (source: Notts County dementia strategy; Nottingham City Joint Strategic Needs Assessment). Annex C of the STP outlines dementia diagnosis rates for our footprint showing that they are in the top quartile (76.5%). Our ambition is to maintain this status. Local work plans are already in place and there are a number of integrated teams in place to support those with a diagnosis and their carers.
<u>Emergency care</u> – There are circumstances when you cannot care for people with mental health needs in community must have emergency care for mental health in community as a back up – Include timely access to mental health triage, assessment and specialist advice in **ED** in the plan. – Lack of **training** to ambulance crews on mental health leads to more pressure on the Emergency Department. Mental health nurses should go out with paramedics (e.g. in Leicester). – Impact on local **policing** – cross partner challenges. Lack of emergency care means people end up in ED or, worse still, a police cell. Notts Police very good at dealing with mental health.	We will focus our efforts on delivering the Mental Health Forward View which includes increasing access to crisis care liaison services in emergency departments and inpatient wards. Our specific plans include: • A Mental Health navigation service, incorporated within a single point of access for clinician to clinician conversations to provide GPs with senior clinical advice and patients with urgent follow up locally to reduce demand on urgent care services • Improving the acute mental health pathway by building our home treatment teams to enable people to stay well and reduce the demand on acute inpatient services and the need for out of area placements. • Should people have a crisis episode, we will ensure a robust approach to supporting the person to remain safe and where ever possible in their home setting. We will continue to embed our Street Triage service and work to improve access to acute clinical assessments and Section 136 suites. • Expansion of our acute psychiatric liaison services across Nottinghamshire to ensure that a

	Lifespan Liaison Psychiatry service is in place to cover 24/7.
Children and young people – How can there be improved access for **younger people** when mental health services have been cut? Explain approach to young people and mental health. – Mental health and **education** – how link people into their communities. Children's mental health affected by pressure at school – extend prevention philosophy to schools.	Our plan is to improve access for children and young people to the crisis and urgent care service and open a new inpatient service for children and young people so that they can have the inpatient care they need closer to home. By 2020/21, 70,000 more children nationally will access evidence based interventions. A major capital scheme is already under construction to ensure that we have improved access to Tier 4 CAMHS beds across Nottinghamshire with the aim of eliminating out of area placements for children and young people. Working across sectors is key to delivering outcomes for children and young people and we will build upon schemes already in place involving schools such as the Encompass Nottinghamshire scheme which informs schools about domestic abuse incidents which have been reported to the police so that children and young people can get the right support that they need quickly.
– Ensure plan covers **adult** mental services and rehabilitation as well as younger people. – Can you ensure that **adult** acute mental health provision and services and community crisis teams are provided for in the plan? – How are waiting times for adult mental health going to be reduced?	Our focus will be on meeting the ambitions set out in NHS England's Mental Health Forward View, which includes adult acute mental health provision and services, and community crisis teams. We aim to take a 'whole lifespan' approach rather than focusing on specific age groups. We are exploring different ways of working to improve services, for example integrating primary, community, mental health and social care services to provide people and their GPs improved access to evidence based mental health services. This will also offer much needed support for carers, reduce the pressure on general practice and reduce the number of people requiring hospital services.
– Current services fall short of what is needed – inpatient care, community services, school psychological services, urgent care. – Do not make any further cuts to **inpatient beds** before all processes sorted. Reminiscent of failed 'Care in the Community' plan 25 years ago	There is a clear expectation in the Mental Health 5 Year Forward View that there should be sufficient inpatient beds in Nottinghamshire so that no individual will be denied access to a local bed when they need it. Ensuring that there is enough bed capacity in the right place is a key objective of our plans.

– Suggest **peer support networks** that can improve self-esteem and confidence – No reference to **employment** in terms of improving health outcomes (mental health Five year Forward View). Benefit system causing mental health problems.	Priority area one (promote wellbeing, prevention, independence and self-care) includes plans to work with the voluntary sector to develop self-care approaches with community groups. We will aim to use education rather than treatment to help people to help them to be more in control and manage their own lives. We continue to focus on using peer support networks to help people, rather than treatment. By using an educational approach, people are able to choose the courses best suited to help them be in control and manage their own lives. Courses are put together and delivered in partnership with those who have lived experience of mental health challenges (e.g., the peer trainer/learning support advisor) and those who have professional experience (for example, an occupational therapist or consultant psychiatrist). In this way, people develop peer support networks, increase their confidence and manage their own health and well-being. NHS England's Mental Health Forward View includes an objective for 2020/21 around doubling access to individual placement and support to enable people with severe mental illness to find and retain employment.

Theme 4 – Primary care	
SUMMARY OF FEEDBACK/CHALLENGES	**RESPONSE**
<u>GPs</u> – Will increase GP workload when already overworked and it is difficult to fill GP vacancies – Will there be merged practices and larger scale?	We understand the big challenges facing general practice and the need to support them both locally and nationally. We will work as a system where appropriate but reflect the diverse needs of the area. We will develop services based around 'clusters' of practices working together, which may be supported by federations or alliances that will allow practices to achieve the benefits of operating together. Geographical clusters of GPs will be encouraged to work closely with other primary and community care providers, including sharing premises, to provide a more effective and efficient service. The aim is for teams to support these clusters in which mental health, social care, and community teams will be key members. By working in an integrated way we will improve services. Local people can also play their part in reducing pressure on GPs by making sure that they cancel their appointment if they are not able to attend, to release GP time for other patients.
<u>7 day services in primary care</u> – Blanket 8-8 not sensible – suggest opening hours following patterns of need of local practice population. Open extended hours – Not enough GPs so opening longer won't help. How will you deliver 7 day GP services? Will you merge GPs?	The availability of extended and weekend services in primary care is national policy and will be rolled out across the county. In Nottingham City and Nottinghamshire we will be working with our local GPs in discussion with local people to determine how to do this in the way that best meets the needs of local people. This does not require every practice to be open each evening or weekend, but it does mean that patients anywhere will be able to book appointments when they need them. To provide these additional services, general practices will increasingly co-operate with other practices in formal or informal networks as described above.

Primary care teams Building teams of professionals around general practice will require change and can only be implemented over time.	We know that it takes time to build teams of professionals around general practice. We have already started to do this as part of transformation in Greater and Mid-Nottinghamshire: **1. Care Delivery Groups - an integrated model of care (Nottingham West CCG)** Nottingham West's alliance contract for community services drives the integration of health and social care by bringing together a range of services within its Integrated Community Hub Care Delivery Group (CDG) model. The CCG has continued to rapidly expand the range of services within this model during 2016/17 – with a focus on proactive care, reducing avoidable hospital admissions and improving support following discharge from hospital. Over the last year the model has been extended to include a range of professionals working together to support frail older people, patients with long-term conditions and those most at risk of hospital admission. The integrated team uses a range of 'risk stratification' tools to assess individuals' health and frailty in order to identify patients who may be at risk of deterioration or exacerbation. These patients can then receive the early intervention, proactive treatment and additional support needed to prevent crisis or unplanned admission to hospital. The multi-disciplinary team (MDT) in each CDG includes specialist nurses for long term conditions and end of life, specialist consultant and GP clinical supervision, therapeutic re-ablement at home, respiratory and cardiac rehabilitation, level two and three mental health talking therapies and dedicated social workers. Care navigators co-ordinate MDT meetings and liaise with clinical care co-ordinators and a range of additional local services, including those provided by the voluntary sector. Community matrons, district nurses and allied health professionals also support case management and risk profiling as part of the MDT. **2. Improving care for patients with long-term conditions (Mid Nottinghamshire)** The PRISM Programme (Profiling Risk, Integrated Care, Self-Management) is an ambitious and innovative change programme designed to improve care and outcomes for patients with long-term conditions. It uses a specific risk profiling software known as the Devon Tool to help health professionals to identify the most vulnerable patients in the community. Multi-disciplinary teams of health care and social care workers are meeting in GP practices to discuss specific packages of care to

	prevent a crisis from occurring. GPs, social workers, physiotherapists and community nurses are meeting regularly, together, to put in place practical support so people can remain as independent as possible within their own homes where appropriate. In Mansfield and Ashfield and Newark and Sherwood practices, GPs and other health care workers and social care workers are working as one team, meeting regularly together to meet the needs of people in communities. These teams are being led at practices with GPs taking a lead. The learning from these teams will shape similar models of care across the STP area.
Other services that can support GPs – How can we encourage GPs to refer to social activities to reduce need for medical intervention? – Do GPs know what is available in their areas to alleviate pressure on the Emergency Department? – Need to involve community pharmacists to reduce pressure on GPs and Emergency Department. Why no community pharmacist on the panel?	In recent years locality-based social prescribing services have increasingly been developed by health and social care commissioners to provide a means for linking patients in primary care with sources of social, therapeutic and practical support in the voluntary and community sector; for example, Nottinghamshire County Council's Connect Service signposts older people and people with long term conditions to a range of services including local voluntary and community groups and clubs. We plan to build on the existing professional clinical navigation service for GPs, Ambulance Service (EMAS) and other clinical staff within the Nottinghamshire and Nottingham STP. These services help and support clinical staff with urgent patient care by putting them in touch with appropriate services and providing support directly to patients. Nottinghamshire has a number of practices participating in the national Clinical Pharmacist in GP practice scheme. In addition, a locally funded pilot involving 3 practices in Nottinghamshire involves community pharmacists working in general practice, taking on additional clinical work to help ease GP workload. Community pharmacists are now represented on the STP Advisory Group

Theme 5 – Technology	
SUMMARY OF FEEDBACK/CHALLENGES	**RESPONSE**
Access – Many people do not have **access to computers.** May have it but don't know how to use it. Trying to get people in their 90's to look after their health using a **smartphone** is not realistic – More British Sign Language within that – much better for the deaf community	We know that not everyone has access to computers or smart phones. Where we feel there are benefits we will provide training and education to people on how to use technology to support their own health needs, in some cases providing specialist equipment. This may support them in their care, help them to live independently, monitor their condition or have access to information.
Human contact is an essential element of healing, so technology should not be seen as an alternative but an **additional tool.**	The intention of using technology is not that this should replace quality and compassionate clinical care but be an additional tool, and in particular to give people earlier support.
How will the required **investment** in technology be supported given financial constraints?	Investment will come from NHS England through our bids for various sources of national funding from the Government, including to support our 'Local Digital Roadmap' (LDR). The LDR sets out the way in which we will deliver national commitment to use information and technology and make sure patient records are digital and can be shared across organisations by 2020.

Theme 6 – Workforce	
SUMMARY OF FEEDBACK/CHALLENGES	**RESPONSE**
Staff morale – **Staff at wit's end** – increased sickness absence and posts /people not being replaced. – Make wards and departments **less stressful** and a better place to work. Value motivated staff more effectively.	We acknowledge that staff are working under growing pressure because of staff shortages or the increasing demands on health and care services. Health and care providers are working together to position Nottinghamshire and the organisations within it as attractive places to work. Employers are using their staff forums and newsletters to keep people informed about the STP and teams will be involved in designing new ways of working for new service models. Employers have a range of employee support and wellness at work schemes in place.
Workforce plan Will we have the **workforce** to deliver the plan?	Redesigning our workforce is essential for the successful delivery of our Plan. Our Workforce and Organisational Development Strategy describes how we will bring our staffing information together so that we can plan the workforce that we need to meet the needs of local people in the most effective and efficient way. We will strengthen the current workforce by introducing new roles to support areas where there are staff shortages.
GPs – Moving services from secondary to community care will increase GP workload when difficult to fill GP vacancies and GPs overworked. – Is Plan achievable given chronic shortage of GPs? – How will you recruit and retain GPs in the areas that need the most? – Change the way GPs work and don't expect them	We understand the big challenges facing GPs and the need to support them both locally and nationally. We will work as a system where appropriate but reflect the diverse needs of the area. We will develop services based around 'clusters' of practices working together, which may be supported by federations or alliances that will allow practices to achieve the benefits of operating together. Geographical clusters of GPs will be encouraged to work closely with other primary and community care providers, including sharing premises, to provide a more effective and efficient service. The aim is for teams to support these clusters in which mental health, social care, and community teams will be key members. By working in an integrated way we will improve services.

to solve all problems	We will support the GP workforce by building the skills and capabilities of those who work with them in their multi-disciplinary teams, including prescribing pharmacists, advanced practitioners and new support roles.
<u>Specialised care in community</u> – How can you provide specialised care currently available in hospital in the **community**? Are GPs trained for mental health etc.? – **Staff in community** not properly trained (e.g. ambulance crews on mental health). – Where is the plan to skill up workers providing care in the community? – Where will all the trained professionals from hospital go? Do frontline staff want to be moved (into the community)?	We are working with clinicians and managers to model the future skills and staff that will be needed and developing workforce and training plans to make those changes over the next five years. We are delivering training in urgent and emergency care skills to staff in primary, community and secondary care through our training hubs. We are working with Health Education England to develop new education programmes to meet the skills needs across the workforce. Our Human Resources Collaborative is looking at potential employment models to enable people to work more flexibly.
– **<u>Home care</u>** – Home care services have been cut back so given the considerable increase in home care outlined in the STP is it likely there are sufficient numbers of suitable personnel can be recruited and trained within time span envisaged? – Given the increase in elderly people can we make domiciliary workers more of a career? – Carers are [i.e. home care workers] paid too little and treated badly – need to look after them. – Community services not of high quality, with local authorities employing cheap and poorly trained **staff** with little motivation to provide a good	Local Authorities are working in partnership with providers to support recruitment and retention of home care staff. We plan to prioritise building capacity and capability in this workforce through our holistic worker model to support our ambitions in delivery of out of hospital care. Some of the additional funding for social care announced by the Government in the March budget will be used to stabilise the social care provider market. This includes attracting and retaining the workforce in home care services and improving the quality of services provided.

service. Not enough staff.	
– **Training** – Lack of trained staff. No mention of future training plans – No mention of training around mental health/dementia. – Training in community now is not good. How people in busy jobs to do training? – Need to train to support culture change in relation to self-care and proactively managing risks of independent living; respond to early signs of disease and social isolation. – How are you going to deliver all of the **support and training** to meet culture gap, support integration and fill skills gaps? – Increasing **technology** – need to ensure the workforce is trained and supported	We are working in close partnership with Health Education England to ensure future training needs are identified and education programmes are in place. All staff will have training in mental health and dementia awareness as part of induction and mandatory training programmes. We are developing innovative ways of delivering skills training to our staff in their place of work through our training hubs, particularly in urgent and emergency care and community settings. We are developing a faculty of educators who will support the development and practice of advanced clinical skills. We are working with colleagues in public health to ensure all staff have the skills to promote independence and intervene early in diseases that can be prevented by people changing their lifestyle behaviours. We have identified the need for both staff, carers and patients to develop the skills to behave and work in new ways as part of the focus on preventing disease and enabling people to stay well and independent in their own home. Frontline staff are directly involved in developing the technology from the beginning. There are a number of different projects focusing on different solutions to help support the aims of the STP. For example, through Connected Nottinghamshire, organisations are working together to develop solutions which will enable staff to make better use of the technology that they already have, as well as sharing information more effectively so that services can be fully integrated. For each new development, there is a full programme of work behind it to design, develop, test and implement digital technology. This includes working with the organisations to support staff to work in different ways enabled by the technology available. Updates and further details about this work in Nottinghamshire can be found on: www.connectednottinghamshire.nhs.uk

Ideas to address staff supply – Start promoting NHS Careers at school age – Make most of mature population and encourage mature students. Fund people locally to do 1 year access course	We are developing a Nottinghamshire-wide 'Talent Hub' to focus on this. We are working with the Local Enterprise Partnership, D2N2, on the Nottinghamshire Employment & Skills plan that will work with young people to attract them into careers in care and provide entry routes. These will include work experience, traineeships and apprenticeships in health and social care employers. We are also looking at ways of developing our own staff to address the problem of staff supply, for example Nottingham City Council Children's Integrated Services are currently scoping and leading on a 'Grow Our Own' programme where internal staff will be given the opportunity take a degree in social work.
Unions Ask for early discussion with **unions**	David Pearson, our STP Lead, has met the East Midlands Social Partnership Forum and will continue to liaise with them. Organisations are using their internal staff side forums to keep colleagues up to date with STP development.
Pharmacy Proposal to cut funding from pharmacies – how will this work with less staff? Could ease pressure on GPs	Funding decisions on pharmacies are a national decision. However we are working locally with pharmacists across all sectors to make sure that we can meet the pharmaceutical needs of our population. Our projects include community pharmacists linking to GP practices, and pharmacists being part of projects on improving support to care homes and to primary care teams. A number of our practices are participating in the national pilot bringing pharmacists into general practice.

Theme 7 – Voluntary and community sector	
SUMMARY OF FEEDBACK/CHALLENGES	**RESPONSE**
– **Role of the voluntary and community sector** – Greater **collaboration** with CVS. Harness **knowledge and experience** of CVS – Explore CVS potential **role** to support implementation of plan: e.g. helping people to access social activities; self care; support prevention agenda; support to isolated communities; education of young people through transition; protected learning time for GPs; BME women; communication. Support for **minority** community usually falls to voluntary sector. Use voluntary sector to identify vulnerable people (isolated). – There are a whole set of services delivered by VCS that aren't being used. How will you support communities and volunteers? – How do we educate primary care about the role of voluntary sector – Utilise the experts in 3rd sector for societal change in the **culture** in the community – Connects **voluntary sector** and providers and local authorities and health which is positive but it needed more **timely involvement** of voluntary sector – always an afterthought. – Better **integration of voluntary sector and social care**.	We know that the voluntary and community sector (VCS) has a valuable and cost-effective role to play, in particular in supporting isolated communities, working with seldom heard groups and vulnerable people, and in the area of prevention, independence and self-care. We have started to talk to the community and voluntary sector and plan to continue to work with them to maximise their contribution to the delivery and awareness of the Plan across all services.

– £1 spent with NHS = £10 of **value** in VCS. Many VCS organisations change people's lives from the start, if properly funded. – Plenty of organisations, within the voluntary sector, are struggling for cash; there is a risk that quality will be lost due to lack of money. Our local society could be poorer because of the changes. What will we see that is different to what we have today? – Plan focuses on **funding gaps** but should look at what **investment** is needed for **voluntary and third sector** involvement. – Many of the **voluntary organisations** change people's lives from the start if **properly funded**	

Theme 8 – Communication and engagement	
SUMMARY OF FEEDBACK/CHALLENGES	**RESPONSE**
<u>Communication with the public</u> – How to **promote this to the public** - average person on the street has never heard of STP. Be creative, forward thinking and joined up about **delivering the message, especially.** – Information and communication needs to be more **clear and concise.** Needs to be articulated in layman's terms. Voluntary sector could help. – Also need more **inclusive and accessible communication -** not all communication by computer. Communication barriers experienced by deaf people. STP needs to be BSC compliant - DVD/ pictorial presentation.	We have had an initial conversation with the public through our 4 public events and asking for written comments on the STP. We produced a summary guide which explained the plan in a more straight forward way. However we acknowledge that we have more to do, including making sure that we communicate in a range of formats and in a way that everyone can access. We are committed to an ongoing conversation with local people using a variety of methods and using accessible language. We will use case studies and real stories from across all our partners to tell the story of how we are taking our plan forward. We will also talk to local people as we develop our detailed implementation plans ensuring changes to services are produced together.
<u>Groups not reached by communication so far</u> – The people not here [at events] are the ones to be engaged with (**younger generation/ working population**). Employers could play a role. – Proactive searching out of **seldom heard** groups. 90% of people not covered by these changes i.e. obesity /alcohol etc. How will we target this message to **those who don't think they have a problem.** – What specifically has Notts NHS done to consult with **carers** face to face? – How do we engage and communicate with the **housebound**? – What engagement will you have with people with	We acknowledge that the people who attended the events do not represent the wider population and that there is more we need to do to hear the views of certain groups in our community. We commit to extending our communication to these groups, using existing networks and groups run by partner organisations and by the voluntary and community sector; for example, we have recently had a conversation with the Deaf Wellbeing Action Group and will be taking forward ideas for improving the experience of deaf people through the STP. We will also involve people in changes that directly impact on them.

dementia regarding what they want/ need?	
Patient voice Need more of the **patient voice.** We need patients to be involved to influence the next phase, patient leaders need to help with communications to the wider public.	Patients and the public have been involved in developing many of the proposals in the plan, but we realize that we need to extend this and make full use of patient leaders and other local groups (e.g. voluntary and community sector) to communicate with the public.
Keeping the public informed – People feel the process around STP to date is not inclusive, well publicised and that events are just 'tick boxes'. How can this be addressed? – Questions about how public will be kept informed of **progress**. When will final plan be published? How is it going to be tracked and evaluated to the public?	We acknowledge that we will need an ongoing conversation with the public over the course of the next five years, and we commit to doing this. In addition to talking to local people as we develop our plan, our intention is to keep the public updated on an annual basis on progress against the plan.
Public consultation Implementation of the STP plans should be halted until a proper **public consultation** has been undertaken. The **time scales** don't look like there will be space to do this.	Some aspects of the plan were based on proposals that have already been discussed with the public (Health and Wellbeing strategies of Nottingham City Council and Nottinghamshire County Council; Better Together programme in Mid Notts). Any significant changes going forward will be subject to public consultation following national guidance
Staff engagement – Consultation on the Plan appears to have been limited so far (e.g. **GPs** do not all know about it). – Timescales do not look like they provide time for **consultation** with workforce – disgruntled people not a good start (learn from dermatology).	Frontline staff have been involved in the development of our Plan. With over 40,000 staff working in health, care and housing we have a great opportunity to get ideas from them but we also understand the challenge of ensuring we can involve and energise them in helping us to deliver our ambitious plan. We will use our current mechanisms for talking to and listening to staff. We will share consistent

– Consult with **frontline** clinical staff- sometimes the best ideas come from the frontline clinical staff. How we are getting **staff** involved? – Are the staff within statutory services being offered the same level of communication and engagement regarding the STP? Are there any people here from **home care providers**?	information about the Plan and give staff the opportunity to shape the detailed delivery plans.

3. Summary of feedback on what is missing from the plan

<table>
<tr><th colspan="2">Summary of feedback on what is missing from the plan</th></tr>
<tr><th>FEEDBACK</th><th>RESPONSE</th></tr>
<tr><td>1. Mental health

Lack of plans specifically around MH. Lack of parity of esteem.

See Theme 3 for detail</td><td>We acknowledge there is insufficient focus on mental health in our Plan. We intended to include mental health and wellbeing into all parts of the Plan rather than create an artificial separation between physical and mental health, but accept this has resulted in mental health not being sufficiently prominent as a priority. Our focus will be on meeting the ambitions set out in NHS England’s Mental Health Forward View. Mental health is an integral part of this plan (see Theme 3 for detail)</td></tr>
<tr><td>2. Children and Young people

– The focus on children and young people needs to be explicit rather than implicit. Children and young people need more of a voice and need to be clearly represented within this plan. An example of an area that is taking a truly system-wide approach can be seen here – what is stopping us using the STP as a vehicle for this? http://www.cyphp.org/about-cyphp .

– We would like more information on plans and collaboration and partnership opportunities that we can support our young people’s health and wellbeing.

– Not enough on younger age group, especially around prevention (maternity, early years and adolescent health) and self- care.

– Explain approach to young people and mental health

– Children with long-term conditions need more care and support at home

– Need to include transition.</td><td>We acknowledge that there is not enough focus on children and young people in the plan. We will publish and updated STP executive summary we and include a section on children and young people and their needs, in particular around prevention, self- care and mental health.</td></tr>
</table>

<table>
<tr><td></td><td></td></tr>
<tr><td>3. Carers

From Theme 2: Community services

– Carers need more skills to deal with complex conditions.
– Not enough carers, especially for ageing population. Impact of rising retirement age for women in particular
– Parents/carers feel pressured to take on responsibilities that are not theirs
– Carers special needs not being met by health and social care services.
– Educate people about carers role – take responsibility for relatives that need financial support

From Theme 8: Communication and engagement

What specifically has Notts NHS done to consult with carers face to face?</td><td>We recognise the role of unpaid carers and acknowledge that the detailed plans to support them needs to be more explicit within the Plan. We will work closely with carers to develop how they can contribute to the delivery of improved services.</td></tr>
<tr><td>4. Impact on specific groups (e.g. homeless, LGBT, deaf community)

Need representation from protected groups – e.g. further information about how the plans will impact on specific groups of people and whether their needs and requirements are clearly understood, and whether we are differentially affected.</td><td>We will consider the needs of specific groups of the population as part of our detailed delivery plans. This will then be taken forward by health and social partners, working with the voluntary and community sector</td></tr>
<tr><td>5. Voluntary and community sector

– Greater collaboration with CVS.
– Harness knowledge and experience of CVS
See Theme 7 for more detail</td><td>We have started to talk to the community and voluntary sector and plan to continue to work with them to maximise their contribution to the delivery and awareness of the Plan across all services.</td></tr>
</table>

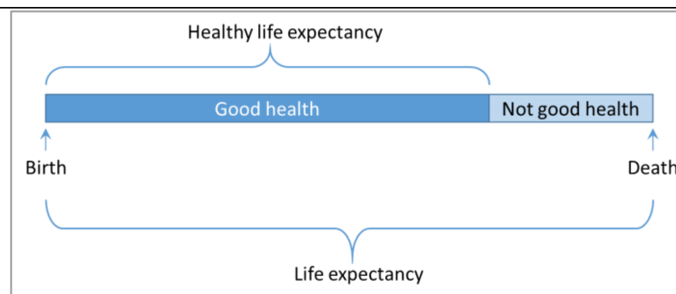
6. Transport No mention of ambulance service or reimbursing people for long journeys. Ensuring appropriate transport to enable access to services	Transport and ambulance services are important parts of the wider health and social care system and will continue to be managed and developed through existing mechanisms and individual workstreams.
7. Schools and education The STP does not appear to have involvement with the wider system, and particularly schools. Education adds to the health and care landscape that characterises adult services, but appears to be missing completely within the plan despite developments in relation to EHC plans etc. Work is progressing, but not recognised or prioritised.	The STP describes a five year plan focused on five areas where we believe we can make the biggest impact. All the themes apply to children and young people as well as adults and in the new executive summary we will include a section on children and young people
8. Lack of focus on Learning Disabilities Little in the plan about learning disabilities, services and support	Our approach to Learning Disabilities is described in Annex C of the Plan 'How our STP meets key national priorities' on the STP website. www.stpnotts.org.uk Nottinghamshire is home to an NHS England Transforming Care Partnership. Our local plan aims to transform care and support for individuals with a learning disability and / or autism who also have, or are at risk of developing, a mental health condition or behaviours described as challenging so that their care is focused on keeping people well and supported in their local community and that in-patient services are only used where community settings cannot provide safe and suitable alternatives to admission.
9. Social care Very little in plan about social care and what will happen in social care.	We have included approaches that come from social care, for example promoting independence, and it is an objective of the Plan to strengthen social care. However, this will be enhanced in the updated STP executive summary.

4. General comments on the plan as a whole

<table>
<tr><th>Theme 9 - Evidence, rationale, overarching plan and realism</th><th></th></tr>
<tr><th>SUMMARY OF FEEDBACK/CHALLENGES</th><th>RESPONSE</th></tr>
<tr><td><u>Evidence base of plan</u>
– The desire to produce change needs to be based on evidenced-based research and I feel that you have not done this.
– What is the evidence that can move patients from hospital beds into communities?
– Integration - what is the evidence this will work?
– Similar to other plans what is the evidence it will work.
– What evidence is there that previous plans worked?
– Talked about these plans for years – what is the evidence these are working?</td><td>Case for change:
Our gaps and the underlying drivers are set out in section 2 of the full Plan on our website. The schemes and initiatives set out in our Plan are based on addressing these gaps.

Most schemes in our Plan and detailed project initiation documents (PIDs) are based on evidence or national direction, for example, schemes to implement NICE guidance.

Our Plan also contains schemes which Nottinghamshire is testing such as the innovative new models of care being developed through the national Vanguard programme. Our Vanguards have been operating since 2015, with two of our local schemes leading nationally. We have committed to spreading evidence-based learning across local organisations so that we can benefit from the emerging evidence. This means that everyone will benefit from improvements in one area.</td></tr>
<tr><td>– Your assumption about life expectancy/health life expectancy seems impossible to achieve in the next 3 years and will probably fail. Is there any hard evidence.
– It is claimed that Healthy life expectancy can be increased by three years within a period of two to three years. Is there hard evidence which shows this</td><td>Healthy Life Expectancy:
The headline ambition for our Plan is to increase healthy life expectancy by 3 years for males and females by 2020. Healthy Life Expectancy (HLE) means how many years a newborn baby might expect to live in good health.</td></tr>
</table>

goal is realistic	 *Figure 1 Healthy life expectancy and life expectancy* Nottinghamshire's HLE is significantly worse than the England values of 63.4 years (males) and 64.1 years for females. The ambitions for the Nottinghamshire and Nottingham STP are based on increasing healthy life expectancy to be among the best in the peer group. The proposed improvement will take HLE in Nottinghamshire for males and females to the level currently experienced by similar local authorities. It is an achievable but stretching ambition.
Rationale for bed closures – **Additional** services needed in **community** before hospital services are **cut** (learning from MH). – Need proper **investment** in **community services** before close 200 beds – How can hospital services be cut with **ageing population**? Best would be stand still in number of beds. – Where is the evidence this (bed closures) will work? – Why close 200 beds – has this been worked through in proper manner. Why was it not 500 or 50?	The feedback from the public highlight a lot of concern about the proposal to close beds at NUH. The number of beds identified in the Plan has been calculated from the number of patients who are admitted to our hospitals who did not need to be there for a clinical reason if suitable support were to be available at home or in the community; or who stay in hospital longer than they should because the necessary support cannot be provided in the community to enable them to be discharged safely. The concern that the public have in relation to bed closures has been recognised by NHS England and from 1 April 2017, local NHS organisations will have to show that significant hospital bed closures meet one of three new conditions before NHS England will approve them to go ahead: • Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or • Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat

– How can hospital beds be cut with ageing population? – Need to embed self-treatment side of plan before you close beds. – Need additional services in community **before cutting hospital services** (apply learning from MH). For MH the money was never transferred to the community. Reminiscent of the failed 'Care in the Community' plan for reorganising MH services 25 years ago. Resist cutting further inpatient MH beds before all aspects of processes ironed out. – Concern over proposed closure of NUH beds - evaluate outcomes before closing beds. Could be left in a worse provision if current provision has been dismantled to make way for the new. – Closure of beds not viable until after investment – Criticism over **bed closures** in NUH by 200 when many of the problems of the NHS result from **ill-advised bed closures** in the past. – Endorse **reducing size** of hospital if services go back to the community. – The authors of the STP need to understand that **our hospital** is a **community hospital** it is as the name says part of our community. – Has Nottingham City Council and	strokes, will reduce specific categories of admissions; or • Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme.) Locally we have evidence that it is possible to improve patient experience and care, whilst reducing the number of hospital beds (see example below). The bed closures in the Plan relate to a specific group of patients but our hospitals will continue to assess the capacity to support other groups of patients e.g. specialist surgical, cancer. New technologies and drugs will continue to have an impact on the number of beds needed and will be part of the organisational efficiencies made by our hospitals. An example of how we are approaching improved patient experience and reducing number of beds can be seen at Sherwood Forest Hospital. Mid Nottinghamshire local Integrated Community Teams have been developed which can provide more care closer to home and prevent hospital admissions or allow people to be discharged sooner. During the past two years that these measures to better co-ordinate and integrate care among NHS and social care providers have been implemented, Sherwood Forest Hospitals NHS Foundation Trust has been able to: • Move to become one of the top performing Trusts in England for the four-hour urgent care standard (to treat and discharge or admit 95% of Emergency Department attendances within four hours). This is against a backdrop of a 15% rise in Emergency Department attendances • Reduce length of stay by almost 2 days, resulting in a reduction of 60 beds and annual savings of £6m, thanks to improved flow through the whole NHS and social care system. Mid Nottinghamshire local Integrated Community Teams have been developed which can provide more care closer to home and prevent hospital admissions or allow people to be discharged sooner. During the past two years that these measures to better co-ordinate and integrate care among NHS and social care providers have been implemented, Sherwood Forest Hospitals NHS Foundation Trust has been able to:

Nottinghamshire County Council actually agreed the STP plan which suggests that there should be a reduction of 200 NHS beds in our local hospitals?	• Move to become one of the top performing Trusts in England for the four-hour urgent care standard (to treat and discharge or admit 95% of Emergency Department attendances within four hours). This is against a backdrop of a 15% rise in Emergency Department attendances • Reduce length of stay by almost 2 days, resulting in a reduction of 60 beds and annual savings of £6m, thanks to improved flow through the whole NHS and social care system.
<u>Economies of Scale</u> – Economies of scale – cost effectiveness of care in the community – The plan to **shift care from secondary** to primary and to integrate care whilst still making efficiencies. I am concerned around the concept of **economies of scale**. This would not maximise the value of concentrated resources as we would divide services up and devolve in various establishments. From a **business perspective** this is a more **expensive** option. – Not necessarily **cheaper** in the **community**. – Care at home not **cheaper** – carers paid too little and treated badly – **Community care** should require more **staffing** it is to run well – may be more **expensive** than concentrating resources in **hospital.**	This is a difficult area and needs to be considered for each individual service. It is true for some services that outcomes and timeliness are improved if services are brought together at scale. However, for other services such as the care of the frail elderly and those with complex long-term conditions there is evidence that more co-ordinated support at home helps people to manage their care more effectively and reduces cost. The Project Initiation Documents (PIDs) in Annex B to the Plan contain initiatives that we have identified from partners within the STP, from the wider NHS or internationally. These initiatives have shown improvements in care at the same or lower cost or have retained the same quality of care at a reduced cost. The Plan sets out our early approach and will be developed into detailed plans and business cases to test the proposals robustly and engage with local people and staff. As we progress the plan some schemes may change or not happen and others may be added.
<u>Approach and style of Plan</u> – much **jargon** in detailed plan.	It is difficult to comment on the feedback on the overarching plan as we are not clear on which document the comments were made. The summary Plan was written to give the public a flavour of the priorities and plans. The detailed Plan was written for submission to NHS England and unfortunately the document did

– The plan isn't **SMART**. – behind each action? – **Principles** good but we need **specifics**. – The **decisions** are made **already** and this is a **PR exercise.** – Agree with **principles** and aims of **saving money** and providing **better service** to patients but not enough **detail** to make useful comments. – It is largely **irrelevant** to **Notts** and it is just what the **government** has said to do. – **STP** plan feels very **top down** – This should be about **mortality and health** i.e. public health but seems to be about **business risk.**	contain jargon. We chose not to amend it in the light of our desire to be open about our submitted plan. The Plan brings together existing and new plans and priorities, so some of the initiatives are already being implemented through the local Vanguards. In Nottinghamshire we have 5 Vanguards where we were given national resources to develop new models of care. These schemes have already been subject to engagement with services users and the public. In many cases these were developed in small areas and the ambition of the STP is to spread this best practice across Nottinghamshire so every resident benefits from them. Our plan was built from existing plans and ideas, particularly using the experience and benefits identified through our Vanguard programmes but also reflects national NHS policy in some areas such as urgent care where some of the models are nationally required.
Realism/optimism of plan – Plans may include some good ideas but overall they are **unrealistic** about funding and include **untested assumptions**. – Too much **optimism** about **achievability** of plan and not enough critical thinking. – Some of your assumptions are **unrealistic** and this predicates all your desires to save money. – Very optimistic and ambitious – a **gap** between **rhetoric** and **reality.**	The Plan recognises the level of challenge particularly in relation to continuing to deliver services under pressure whilst we make the changes. Many of the assumptions are based on evidence, both local national and international, but some ideas will be tested and developed locally. We will evaluate outcomes and costs and use the results of our evaluations to change our plans if a new idea is not working. The Plan is ambitious but as it is built from evidence from elsewhere we do not believe it is over optimistic. We recognise the cultural shift that will be needed for us to deliver. We will monitor delivery and share progress with the public on an annual basis. The concerns expressed in the public feedback are mirrored in some of the national reports from independent research/ policy organisations such as the King's Fund and Nuffield Trust. These highlight issues relating to the plans for integrated care but also how such change is planned and delivered. We will

– Plan **very ambitious** particularly in relation to **timescales** – if they don't work with a big outlay we would be left in a worse position because provision will have been dismantled to make way for new. – **Unrealistic and over-optimistic** many of the factors which are critical to success are a) **outside your control** or b) **trending in the wrong direction** for example funding per capita for the NHS and Social care, recruitment and retention of medical staff, capacity in the social care system. – **STP** is a wish list a mish mash of **good and bad** ideas **designed** to meet the **government's** target of **cutting over £600** m from local health care budgets. It is the need for cuts that underpins every proposal and the claimed savings are widely optimistic. – The STP is full of **laudable aims** and good intentions; in the present context in which health and social care services operate it is **hopelessly optimistic** and indeed **unrealistic**. – Clearly **better core prevention** measure and pro-active steps can **reduce** the clinical burden in theory but I believe the plans are **unlikely** to produce the **savings** in the plan – Concern **plan** will be **scrapped** because the benefits will not come **quickly enough**.	learn from these reports and ensure that we apply the learning from them and our Vanguards in how we develop and implement change, monitor progress and identify and manage the risks.

Theme 10 - Implementation and Delivery	
SUMMARY OF FEEDBACK/CHALLENGES	**RESPONSE**
<u>Culture gap and timescales</u> – Little detail given on how integration would work, given different cultures and political pressures of organisations in local authorities and NHS. What will be different this time? How do you propose to close the culture gaps? Bringing together culture of health (including primary care) and social care – there is a culture gap. Needs to be based on cooperation. – Plan looks **great** but when you put into **practice** will take a **long time** to mould together. – Plan talks about **integration** but little detail of how this would work given the different **cultures of organisations** – one highly political LA and the other political intervention from high level and at arm's length – Plan is **complex** and lots of **different organisations** involved – need to get the **governance** right and hear the voice of the **voluntary sector** and **people.** – Plan is laudable, **fantastic and aspirational.** Timescale (3 years to life by 2020) is incredibly difficult (many not invested in this). – This should not be all about the **money** but how we can work	The approach we are taking within Nottinghamshire is to develop proposals for Accountable Care systems (ACS) as set out in *NHS England: Next Steps on the NHS Five Year Forward View (March 2017)* An ACS is a system in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on collective responsibility for resources and population health. We believe this model will help us to manage some of the challenges we have in closing the culture gap as it will require us to work in a new way and reduce the focus on individual organisations. An ACS will also allow us to move away from focusing on single organisations risks and manage some of the disincentives to doing the right thing such as the split between health and social care funding. Work is taking place to develop the ACS in Mid Nottinghamshire and Greater Nottingham within our STP area. These transformation areas will be accountable for managing their individual approaches, although leaders will work across the STP and within an ACS to ensure alignment. Although not a full ACS model, the 'Better Together' programme has already delivered benefits in Mid Nottinghamshire using the approach of developing an alliance of key partners. We do not underestimate the challenge of delivering our Plan and as a System Leadership team we will be focusing energy on the organisational and leadership skills and capacity needed to deliver the plan.

together to **pull energy** back into the system. – **Competing priorities** and tough decisions are required by **individual organisations** but this lack of system wide life course **undermines** the STP aims. – The **aims and objectives** are **laudable** and have huge **complexity**, especially **culture change**.	Operating as a system, and particularly managing resources between organisations, should also support the delivery of integration and the shifts of work between providers without destabilising individual organisations.
<u>Detail and delivery of plans</u> – Whilst the STP explains **'what'** (aims and outcomes) clearly there is a substantial piece of work to be done on **'how'** together with **prioritisation and sequencing** for successful transformation. – **Implementation** plan is challenging and history shows the **NHS does not have a good track** record. However, the County C**ouncil** has delivered on its plans and has a **better track record**. – Is the Plan achievable within the timescale? – Clear principles and priorities - don't get a sense of **how** this is going to happen? 'Lots about the '**why**' little about the 'how'. – How are you going to put this theoretical plan in to action? – Where is the detail behind the 5-year plan (STP) that sets out what will happen? – How will services be taken forward and joined up locally? – Amazed by the **complexity** has it been properly thought out, what about the **planning** process and how it will be delivered.	There is particular concern expressed in the feedback about the details of the plans. There is a level of detail in the full plan but as this is a strategic plan it provides a direction of travel rather than definitive actions. The next stage of development and implementation will now move to our two transformation areas of Greater Nottingham and Mid Nottinghamshire and also to a number of STP wide workstreams. The Project Initiation Documents (PIDs) in Annex B to the Plan contain initiatives that we have identified from partners within the STP, from the wider NHS or internationally. These initiatives have shown improvements in care at the same or lower cost or have retained the same quality of care at a reduced cost. Quality Impact and Equality Impact assessments will be undertaken for each of these schemes. Some aspects of the plan were based on proposals that have already been discussed with the public (Health and Wellbeing strategies of Nottingham City Council and Nottinghamshire County Council; Better Together programme in Mid Notts).Any significant changes going forward will be subject to public consultation following national guidance. Each year we will review progress and develop our annual plan, this means there is never a 'final' plan as a plan of this nature will evolve over the five years. The transformation areas and STP workstreams will produce annual plans with performance measures and expected

– Explanation of **delivery of a high level plan,** how will public be advised on progress. – The Plan is **too vague**. Agree with aims of **saving money** and providing better services to patients but no detail on **how** this will be achieved and therefore difficult to make useful comments about the plan. It is difficult to see how there will be **significant savings** in less than two years – Agree in principle but need more detail about investment in community and primary care and sceptical because of what has happened in the past – Are the priorities areas in any order – what will make the most impact and how are you measuring this? Who is going to monitor delivery of all this? – Where is the plan these are statements how are we doing this? – Timely **disclosure** should be made for the areas of **significant disinvestment** and change. – Need to analyse our **full spend** and what it **achieves.** – How will quality be measured and progress fed back to the public?	outcomes based on the delivery of the plans. The STP Leadership Board and transformation areas will have robust but complementary governance structure to monitor and assure progress and identify and manage risks. It is proposed that we provide an annual report to the public on the progress we have made, our priorities for the year and any changes we propose to make to the plan in the light the progress and work we have undertaken. We are committed to review the plan if any of our current plans are not deliverable.
Performance and Monitoring – Some of the measures are a **little woolly** and trust that these will be refined and you identify the most appropriate **performance measures.** – How will the STP identify results, impacts and lessons to be	We have an agreed set of measures to monitor progress in delivering our plan, but this will now be developed further. Each of the transformation areas will agree a performance and outcome framework which will ensure the STP Leadership Board can monitor progress and issues are identified. The measures will include clinical quality measures as well as finance

learned and how will this be fed back to the public? – Measure what matters – Continuous **monitoring** of **quality** of care **out of hospital** – Check **discharge and care plan** being delivered. – We suggest that **data collection** and **analysis** should be undertaken on **inappropriate** referrals	and activity measures. It is not the intention to duplicate the performance monitoring that is required across the system for providers and commissioners but to identify the key measures to monitor delivery of the STP and to identify unintended consequences which may indicate schemes are having a detrimental impact of care or finances.
Risk and Contingency – What about **risk management** – how are you managing risks. – How are you ensuring that the plan is tested for risk, quality etc. health impact assessments etc. – Service and staffing **changes** may increase the risk of **abuse and neglect** perhaps in unforeseen ways if they are not considered but also provide opportunities for strengthening public and staff awareness of **safeguarding**, local arrangements and preventative interventions. **Safeguarding, risk and opportunities** ought to be an impact consideration across the work of STP. – **Safeguarding**: potential risks through promoting independence and self-care – Unable to find an **equality impact assessment** that gives assurances around the impact on **specific groups.** Assurances are needed on how it affects all **protected groups** as set out	The Mid Nottinghamshire and Greater Nottingham transformation areas and the STP workstreams will take responsibility for managing and monitoring clinical and operational risks for the parts of the STP that they are responsible for. The most significant risks and any identified by the STP Leadership Board will be monitored and managed at an STP level. There are safeguarding risks when people become dependent on services, for example the quality of care in residential settings. However, encouraging people to look after themselves and live more independently can create other safeguarding risks. We will ensure that clinical risk and safeguarding risks are considered and assessed as we move to implementation. The clinical and service risks which have the potential to impact on care, services and potentially safeguarding will be identified through our quality and equality impact assessments which require potential risks to be identified, reduced and monitored as more detailed plans are developed. These are recognised approaches which are routinely used across partners and will be undertaken when changes to services are planned.

within **Equality Act 2010**.	

Theme 11 – Money	
SUMMARY OF FEEDBACK/CHALLENGES	**RESPONSE**
<u>**National Funding Position**</u> – Need a proper **discussion** about the **government funding level** and the growing deficit – The **NHS** and **Council** should say **No** to making **cuts**. What is said in the Plan is OK it is what is not said is worse. – Lack of **money** shouldn't be the **driver** we should be doing this because it is the **right thing** to do but at least it is **happening** even if it is because of lack of money – **Leaders** of the STP need to request more **funding.** Main **driver** is to save money. Change is **expensive** – can we afford it? – The **bottom line** is there are not enough resources to fund **NHS and social care**. Nottingham County Council's s**ocial services cuts** are being felt and money is needed. The **NHS is in crisis** (to say it is facing a challenge is an understatement). **Senior leaders** in Health and social care should **request more funding** – The worse thing about the STP is it confuses people about the real issue **chronic underfunding** and therefore **disempowers people** and undermines their genuine experiences and concerns. – **Prevention and self care** being used to justify **cutting money** from	As senior leaders we raise concerns about national funding levels as we feel appropriate. The recent commitment to increase funding for adult social care has been as a direct result of senior leaders across social care and the NHS making a case to the Government. We have to live within our means, and this means spending only what we can afford and getting the best value for money. We believe the changes proposed in the plan will improve care and health outcomes, either improving care at equal or lower cost, or delivering efficiencies from services and support functions. We remain committed to increase our focus on prevention and self-care. We believe that given the necessary information and support most people would prefer to stay well or be in control of their own health managing their condition themselves where possible.

NHS –STP is a c**ost saving exercise**; not improving **health outcomes** – focused on the **funding gap** –There is not **too much demand** it is just **beyond** the **resources** politicians are willing to level pay taxes we need to fund them. –**STP** is another way of saying **cuts** to services	
Appropriate use of NHS – One way to address **shortage** for funds would be to consider making **fines** to patients who fail to turn up to appointments – There are too many **foreign people** using A&E because they are not registered with a GP or various other reasons. They have not paid into the system and therefore should be charged as when we go abroad.	NHS providers, commissioners and local authorities are controlled by law in relation to what and how they can charge for services. The NHS cannot charge patients for missing appointments but through the use of new technologies and more customer friendly systems we can reduce the impact on services. Examples of a new initiative that has significantly reduced the number of people who do not turn up for their GP appointments was described at one of our events and our intention is to ensure that such good practice is quickly spread across the system. Similarly the NHS has clear rules for when overseas visitors can receives services under the NHS and when they should charge. This largely relates to emergency treatment and in many cases we have reciprocal agreements with other countries where costs can be reclaimed.
Pump Priming – Prevention and self care: will need more **money** that commissioners do not have. – How are you going to ensure that prevention is properly **funded** and meets the **outcomes** – Appears to be no **upfront money** to run old and new service models side by side until changes **bedded in and tested**,	We understand the concern from the public in relation to investing in alternative services before we reduce existing services (pump priming). This is a major challenge for the area and one which the STP Leadership team will manage over the course of the five year plan. We are fortunate in Nottinghamshire as our Vanguards bring some short-term additional resources in 2017/18 for testing the extent to which our new ways of working benefit patients and provide good value for money and a return on investment. We have also been awarded some additional central Transformation Funds for specific priority areas.

– How are we going to **fund dual running** of services and we develop new services – Savings cannot be released before investment in **double running**. Some things will need **pump priming**. – How will **double running** be managed through the **transition**? – How is pump priming going to be financed?	However, there are areas where we don't have any easily identifiable resources and there is further work to do to fully address this challenge.
Financial Risks – **Efficiencies** cannot be delivered without **more funding.** – If services are going to be transferred to **community** there needs to be proper investments in community services. – Agree in **principle** with objectives but need more detail on **investments** to support people in the **community** – Funding should be **upstream** and not **reactive** – Notwithstanding the **savings** expected from the workforce strategy, some of the savings arising should be **reinvested** into other key groups such as urgent care staff, primary and community care. – **Investment** and **development** needed faster – Not convinced that **sufficient** money is being put in to make integration happen – There is no indication about **how figures** have been **worked out** or	We are confident that the savings in the Plan are net of the cost of services to re-provide care in the new setting; but there is a potential short term problem of double running. The Plan is a high level five year Plan and the next stage is to develop detailed business cases and implementation plans. Some of the plans may not come to fruition and new opportunities will emerge. The governance structure will ensure that the delivery and viability is reviewed at within transformation areas, STP workstreams and at the STP Leadership Board and, where necessary, contingencies will be agreed.

what will be happen if not achieved. – If this ambitious target is not being met will staff then be reduced and health services closed completely to fill the shortfall? – **New** is **not always better** huge leap of faith. Is there a plan B behind each action? – There is no **pilot period** to see if **transformation** will give the required savings while improving care	
Single Budget for Health and social care – There needs to be a **single budget** for **health** and **social** care funding. – How can we fix the **health and social care divide**? Is it really possible? Doesn't the **money** need to be **merged**. – **One budget** for **health and social** care. Take away from politicians – STP working to a **model** that is out of date **Health and social care** is impossible to separate for **older people 90%** of whom need services from **both.** – **Amalgamate** the **budgets** and take away from local politicians. – Interface between **health and social care disputes** especially on **CHC**. Lack of trust. **Competitive** funding environment.	There is a great deal of national debate on the advantages of creating a single budget for health and social care, but this would require legislation in Parliament and is not a decision that we can take locally. Our proposals for Accountable Care Systems will allow us to move away from focusing on single organisations and manage some of the blocks to doing the right thing such as the split between health and social care funding. We believe an Accountable Care System approach will enable us to work more flexibly and manage some of the risks raised by the public to deliver the changes required.
System Incentives/ Disincentives – The **financial incentives** in the current system make it **more difficult** to deliver change. Currently secondary care has incentives to see as many patients as possible which are the opposite of the plans objectives – need to **change** the way	An Accountable Care System (ACS) approach will allow us to ensure all our resources are used to deliver the greater good and reduce the sometimes unhelpful rules that apply to organisations. An ACS will potentially give us greater flexibility to manage disinvestment whilst supporting the clinical viability of critical services during the transition phase whilst the

secondary care is paid. – Should continue to **commission smaller contracts** so as not to lock out smaller organisations of force them into **resource intensive** and unequal consortia, subcontracting arrangements or SPVS – Suggested pharmacists can ease strain on **general practitioner** but NHS England are **reducing financial** support to pharmacies. – Proposal to **cut funding** from pharmacies – how will this work with less staff? – **Primary care** budget being **top sliced** to fund **social care** but doesn't appear to be being spent **Self-funders** have to **pay more** due to cuts.	remaining capacity is reshaped to meet the new demands on the services. We understand that this is a potential risk but we recognise the value of smaller health and care providers particularly in our high impact change relating to prevention, independence and self-care and the delivery of more integrated care community health and social care and support to carers. Our STP Advisory Group has been established to provide a forum for non-statutory provider representatives and the voluntary and third sector to engage We assume this comment relates to the Nottinghamshire Better Care Fund plan which has reported underspends in the Care Act allocation. This arose due to a national pause on implementing Phase 2 of the Care Act for which these funds had been allocated. This underspend will be been carried forward within the pooled fund as funding is ring-fenced for this purpose, and an action plan has been agreed. We are aware that some independent sector providers do charge a higher fee to self- funders than the fee paid by local authorities for people who require council funded support. The Councils have worked with providers to understand the actual costs of care and whether Council fees adequately meet these costs. This is a national issue relating to the overall funding for social care, and it is being actively considered at a national and local level.
<u>**Organisational savings plans**</u> – **CCG**s seem to be doing their own thing. **NNE Nottingham CCG** moving services to **community**. – Need to retain services to support people with Parkinson's' Disease through weekly sessions to prevent apathy and promote health and wellbeing	The Plan does not include all the plans and actions of commissioners and providers. The Plan identifies some priorities areas for system working and assumes that individual partners continue to deliver their organisational efficiencies. The STP Leadership Board will provide some oversight and the ability to challenge if organisational plans are compromising the wider STP Plan. These concerns from the public relate to a particular group of services which were reviewed

–No neuro-physiotherapist available in the community for **Parkinson's** patients [proposed closure of NUH Rehab Unit] –What is being done to reduce drain on resources e.g. repeat or unused prescriptions? –**STP** need to consider **impact** on people when make decisions to save money example of saving planned for **neuro-rehabilitation** which could increase falls and fractures.	as part of the South Nottinghamshire and Nottingham City CCGS undertaking clinical reviews on group of services which are historically provided at the acute hospital. The reviews were initiated because, whilst wishing to ensure a high quality care and services, there was a need to ensure the best value for money when commissioning publicly funded health services. A robust process was carried out in conducting the reviews, including engagement with clinicians, public health and patients (this has also included the relevant professional bodies, other system partners, and the Clinical Senates) to review the service models including the completion of Quality Impact Assessments and Equality Impact Assessments. Each service now has a clinically appropriate specification which supports the provision of cost effective, evidence based care in line with the principles and aims of the STP around best value care closer to home. As a result of this work these services have been or are being re-procured.
Privatisation –Fear that STP will **increase/is an excuse** to privatise NHS –STP will **increase involvement** from **private health care companies** who will load operations with **debt, fleece the taxpayer** and avoid responsibility for wrong doing. –**Privatisation** is already part of waste problem **causing** the problem **STP cuts** will lead to more privatisation in turn as NHS struggles to cope with the pressure. –The employment of **external consultants** such as Centene in Rushcliffe may lead to large sums of money being **paid to firms outside the health service**. Some of these firms have experience derived form a completely **different culture** of working. –Oppose the STP which will s**lash trash and privatise the NHS**	We do not believe the STP will either increase or decrease the use of the private sector to deliver health care. The NHS uses private partners where value for money, innovation and quality exceeds the service offered from the NHS. We will continue to do this as we must ensure we spend the money we have wisely. Some of the innovation we are looking for to support the development of services in Nottinghamshire may come from the private sector, both in technology and clinical services.

– Although David Pearson said he had never been asked to **privatise** services yet private companies already **increasingly involved** whose primary interest is **making profits** not providing healthcare – Plan is unworkable will not work in practice and will lead to an **increase in privatization** – Is this an excuse to privatise the NHS? – Will the STP increase privatisation?	