Nottingham City Council

ADDITIONAL / TO FOLLOW AGENDA ITEMS

This is a supplement to the original agenda and includes reports that are additional to the original agenda or which were marked 'to follow'.

NOTTINGHAM CITY COUNCIL
HEALTH AND WELLBEING BOARD

Date: Wednesday, 30 March 2016

Time: 2.00 pm

Place: Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG

Governance Officer: Phil Wye **Direct Dial:** 0115 8764637

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NHS
Nottingham City
Clinical Commissioning Group

DRAFT

2016/17 Operational Plan

1. Introduction

In October 2014, the **NHS Five Year Forward View** was published. This sets out how health services need to change in order to meet the challenges facing the NHS as a result of people living longer and having more complex needs. In December 2015, **Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21,** was published. This sets out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. The guidance includes a requirement for the NHS to produce two separate but connected plans:

- A one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP; and
- A five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View

This Operational Plan has therefore been developed by NHS Nottingham City Clinical Commissioning Group in response to both the NHS Five Year Forward View and Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21. It describes the CCG's approach to delivery against the requirements as detailed in the above documents across a number of key areas during 2016/17.

1.2 NHS Nottingham City CCG

NHS Nottingham City CCG was authorised as a statutory NHS organisation by NHS England on 23 January 2013, officially taking on our statutory responsibilities from 1 April 2013. Reporting to NHS England, we are a membership organisation, comprised of local GP practices, and accountable to local people. We maintain our authorisation by demonstrating to NHS England how we are meeting our responsibilities through a detailed assurance process.

NHS Nottingham City CCG has 57 member practices, comprising more than 260 GPs. Our practices are organised into four groups known as 'GP Clusters', which are based partly on geographical location and partly on pre-existing inter-practice relationships with similar interests and approaches. The Clusters provide a framework through which we engage member practices in developing and delivering the CCG's commissioning strategy and priorities, and to channel the knowledge and experience of member practices into related service redesign and quality improvement.

Our vision and values

Our vision statement underpins everything that we do. It encapsulates our long-term vision and aspirations for future local healthcare as outlined in the introduction to our strategy.

It defines our purpose and what we aim to achieve for the benefit of local people and local healthcare services.

"We will work together with compassion and caring to improve health outcomes and end health inequalities through the provision of high quality, inclusive and value-for-money services that are patient-centred."

- When we say that we aim to **work together**, we mean that we will work in partnership with our patients, carers, the wider population, Nottingham City Council, providers of health services within Nottingham City, and other organisations that plan and buy NHS services within the region.
- When we refer to **health outcomes**, we mean a change in the health status of an individual, group or population.
- When we refer to **health inequalities**, we mean the differences in the state of health between different population groups.
- When we talk about **high quality services**, we mean services that ensure that patients are safe, have a good experience and receive the best possible treatment for their condition. This includes timely and equitable access to services, choice of how and where to be treated, and prioritising privacy, dignity and respect for all.
- When we talk about **inclusive services**, we mean services that recognise and value difference regardless of age, disability, gender, race, religion or sexual orientation.
- When we talk about **value for money**, we mean services that deliver the best possible health provision and outcomes for our local population within available resources.

- When we say that services will be **patient-centred**, we mean that they will be clearly focussed on our patients' requirements and that patients will be given a real voice in all decision-making processes. We are fully committed to being open, transparent and accountable to our population.

Our values describe the approach we will take to all of our commissioning activities. We believe that harnessing a culture which embraces these values, both within our organisation and extending to partners and others who work with us, will stand us in the best possible stead to achieve our ambitions.

Our values also reflect what member practices, staff, partners and local people have told us are the aspects most important to them. They will therefore enable us to be an organisation which operates in a way that best meets the expectations of the population we serve.

Involving others
We will actively involve patients and the public, carers, community groups, clinicians, and partners in everything that we do

Being responsive
We will understand and respond fairly to the changing needs of our diverse population

Improving quality
We will continually improve the quality of services through collaborative, innovative and clinically-led commissioning

Promoting education and development
We will support and encourage the education, training and development of the local workforce

Securing value for money
We will secure high quality, cost-effective and integrated services within available resources

1.3 Greater Nottinghamshire

Nottingham City CCG works as part of the larger geographical area of Greater Nottingham.

The population of Greater Nottingham (c700,000) is increasing and ageing (5% increase in the population size with an 11% increase in the over 65s expected by 2021). Citizens are asking for new and more holistic models of care which will support the maintenance of independence wherever possible and will provide more joined up care that is closer to home when needed. The current reactive and bed based model of care is no longer financially viable with financial gap of at least £140m forecast by 2018/19.

In line with the rest of England, Greater Nottingham has experienced a year-on-year increase in the demand for acute services and a shift is now needed from high-cost, reactive and bed-based care to a care model that is preventive, proactive and based closer to peoples' homes, focusing as much on wellness as responding to illness. New service models must focus on innovative clinical and social interventions in primary and community care. In order to achieve this, it is recognised across the system that the organisational landscape is likely to change significantly, with resources re-allocated away from reactive and bed based acute care to a model of preventive, proactive and care based close to citizens' homes.

Across Greater Nottingham commissioners and providers from health and social care have therefore come together to co-ordinate a response to the challenges facing the system. There are 12 Commissioner and Provider Partners within Greater Nottingham:

- NHS Nottingham City Clinical Commissioning Group
- NHS Nottingham North and East Clinical Commissioning Group
- NHS Nottingham West Clinical Commissioning Group
- NHS Rushcliffe Clinical Commissioning Group
- Nottingham City Local Authority
- Nottinghamshire County Local Authority
- Nottingham University Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust including County Health Partnerships

- Nottingham CityCare Partnership
- Circle Partnership
- East Midlands Ambulance Service NHS Trust
- Nottingham Emergency Medical Services

Diagram One: Map of the Greater Nottingham Area

The Vision

A shared vision has been agreed:

"We will create a sustainable, high quality health and social care system for everyone through new ways of working together, improving communication and using our resources better"

Partners are ambitious and have plans to create a profoundly different system which will meet the needs of the population. These ambitious plans have the attributes of an accountable care system which will improve health and wellbeing and deliver integrated person centred care.

The Partners have agreed a shared understanding of the ways in which this strategic vision and desired future state will change the landscape in health and social care in Greater Nottingham, Partners will:

- Integrate / join up care where it is fragmented
- Deliver services sustainably at lower system cost
- Support a shift in the location of care from acute and residential care settings to care closer to home
- Support a shift from reactive care to prevention and proactive care

The development of these strategic objectives has been informed by the views of local citizens and patients, clinicians and partner organisations. All Partners have endorsed these objectives at Board level (through a Partnership Compact).

The approach agreed is to focus on prevention and proactive care, delivering care closer to home, and reducing the use of hospitals and residential care settings, whilst maintaining a sustainable provider environment.

The Commissioning Partners have developed a compelling case for change for a new model of commissioning, which has been endorsed by the Chairs of the Health and Wellbeing Boards. The proposed approach is to move to payment for outcomes that matter to citizens, fixed budgets for a population's care, include incentives for preventive, proactive and whole pathways/systems of care, along with long-term financial envelopes that enable providers to invest and innovative upfront achieving better value over the longer-term.

The emerging ambition is to move to a new model of commissioning, at least in shadow form, for the adult population from April 2017. The Partners have agreed to take forward work on new provider delivery, commissioning and contracting models as well as future payment mechanisms as part of a sustainability planning piece of work. There is commitment is to design services which are truly person and population centric and then to solve the professional and organisational challenges that may present. The Partners operate in accordance with a comprehensive Accountability and Governance Framework which confirms the vision, aims, responsibilities, principles and scope together with the organisational model, roles and responsibilities, governance arrangements, programme management approach, benefit and risk sharing arrangements, resources, assurance and approvals process as well as approach to system development.

Partners have agreed a desired future state focused on:

- Care organised around individuals not institutions
- Services based on the real needs of the population
- Resources shifted to preventative, proactive care closer to home
- Hospital, residential and nursing homes only for people who need care there
- Removal of organisational barriers enabling teams to work together
- High quality, accessible, sustainable services

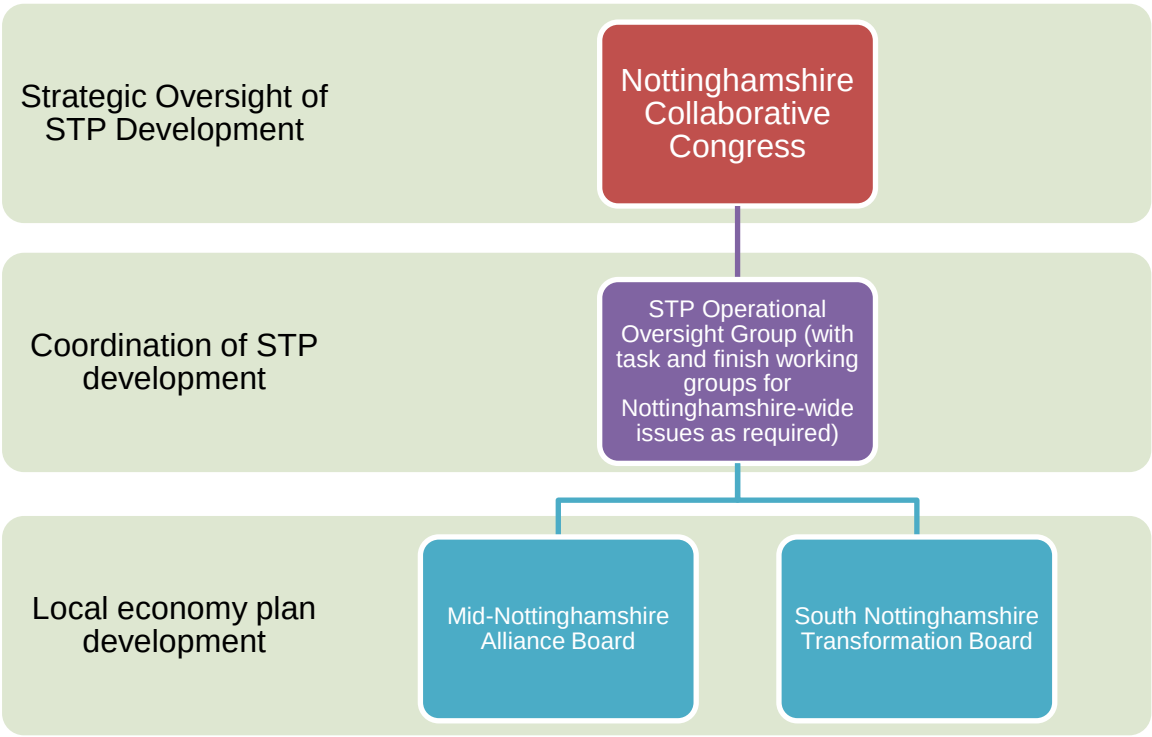
The Partners have also confirmed the need for a new philosophy based on:

- **Outcomes**: moving from process measures and targets to improving outcomes that matter to the population
- **Populations**: moving from institutional care (primary, secondary) to a focus on whole pathways for defined population groups
- **Value**: moving from volume to value with a focus on preventive and proactive care, closing the financial gap by delivering services sustainably at lower system cost
- **Integration**: moving from fragmented care organised around professional groups and organisations to joined up services organised around the needs of service users
- **Accountability**: To service users/citizens, to each other and to the success of the system.

Work has commenced on measures of success/benefits realisation and there are plans in place to progress this.

1.4 Nottinghamshire Sustainability & Transformation Plan

Wider system transformation will be progressed under a 'transformation footprint' which brings together CCGs in the Greater Nottingham Health and Care Partnership with the Mid Nottinghamshire CCGs (NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG).



This wider footprint will:

- support planning and delivery across a wider area where this will best meet the needs of citizens and
- support operational sustainability, for example the sustainability and potential reconfiguration of acute services
- better align to the County Council and NHS providers who deliver services across the County and support transformation in areas such as Learning Disabilities and Children's services
- provide an umbrella for the continuation of the transformation that has been started in Greater Nottingham and Mid-Nottinghamshire, recognising different models and pace
- provide an opportunity to share learning from the four Vanguards across the transformation footprint that are testing different new models of care.

2.1 NHS England National Planning Requirements

Delivering the Forward View; NHS Planning Guidance requires all NHS organisations to address nine national 'must dos' in 2016/17. The following describes these along with the actions that Nottingham City Clinical Commissioning Group will take in 2016/17.

Requirement 1

Develop a high quality and agreed Sustainability and Transformational Plan and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the Forward View.

The current NHS planning footprint is based on the four Clinical Commissioning Groups in Greater Nottingham. Over the next few weeks the Greater Nottingham Health and Care Partners will work with the Mid Nottinghamshire CCGs to agree how to develop the Sustainability and Transformation Plan (STP), building on the significant progress which has already been made in each area. This will be informed not only by national emerging guidance and approaches but by the four Vanguard programmes within Nottinghamshire, as it is recognised that these have the potential to unlock changes and benefits across the system beyond the initial boundaries of the focus of their work.

Requirement 2

Return the system to aggregate financial balance. This includes secondary care providers delivering efficiency savings through actively engaging in the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. Clinical Commissioning Groups will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

Commissioners, providers and local authorities are working together under the Greater Nottingham Health and Care Partners arrangements (GNHCP) in recognition of the financial and efficiency challenges facing the health and social care system over the next planning period. The partners have formed a Finance Directors group, and this group has undertaken work modelling the financial gap that the system faces. This work is under refresh given the recent Comprehensive Spending Review and subsequent allocations announcements, and the impact on CCG QIPP and provider deficits will be collated and consolidated over this current planning period.

The GNHCP recognises the need for transformation, and has a number of work streams in place as well as the three Vanguards. These high level work streams are Urgent care, Primary and Integrated care, and Elective Care. In addition there are several enabling work streams. Discussions are underway with acute provider via the GNHCP and via contract discussions and the System Resilience Group to reduce bed base and costs where feasible and re-provide capacity in more efficient and appropriate settings, for example home care. Through the GNHCP discussions there is recognition of the need to take costs out of the system.

The detailed CCG financial plans built up using prudent and transparent activity growth (both demographic and other) indicators and assumptions. These assumptions are shared with NHS England local teams and aligned with providers where jointly owned activity planning models informs they key acute provider financial plan.

The CCG has a local process in place to utilise the RightCare data to tackle unwarranted variation in demand contributing to a more financially sustainable system.

Requirement 3

Develop and implement a local plan to address the sustainability and quality of general practice including workforce and workload issues.

The CCG has developed its primary care vision and has been working to implement the following five essential objectives:

- Integration of Primary, Community and Social Care
- Standardise and improve access to Primary Care
- Utilise and adapt innovative technology and best practice

- Develop a shared workforce
- Promote shared responsibility of health

As part of the work to implement the vision in 2016/17 the CCG plans to undertake a sustainability and workforce review of primary care; introduce a standardised primary care offer; redesign primary care weekend opening services to further refine the most appropriate model and gain further patient feedback via a 'mystery shopper' initiative.

The CCG continues to work with Health Education England (HEEM) working across the East Midlands to ensure that the Primary Care workforce for the region is sustainable and has the right skills, values and behaviours, at the right time and in the right place. In working directly with HEEM we are able to flag up and highlight the particular needs of the city while future planning workforce needs, retention and development.

The CCG has supported the GP Fellowship programme which offers individuals the opportunity of working within Nottingham to gain insight and experience of working within a primary care setting. Nottingham City was fortunate to receive 3 fellows within the City, enabling an increase in a scarce workforce, but also giving trainee GPs the opportunity of seeing how an inner city primary care practice operates with the view of encouraging more GP trainees to consider an Inner City practice as a potential career path.

Requirement 4

Get back on track with access standards for A&E and ambulance waits, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

Greater Nottingham SRG is committed to developing and implementing a sustainable and resilient urgent and emergency care system. This will require us to transform our services, our commissioning and our delivery. During this period of transformation we must continue to provide the Urgent and Emergency Care that our system requires now.

In order to achieve the local system must do – get back on track with access standards for accident and emergency, ensuring more than 95% of patients wait no more than four hours in accident and emergency - the SRG has committed to achieve the standard in April 2016. The actions have been evaluated and a realistic system recovery plan produced that will deliver improved performance. The recovery plan is monitored through the fortnightly system resilience implementation group. To support achievement of the plan we have a Remedial Action Plan in place with our main acute provider.

Significant planning has already commenced through SRIG with all system partners on how the system will manage the identified pressure points throughout the next 12 months to ensure that once we have achieved the 95% performance is maintained. Partners will work with their respective organisations and boards to develop detailed plans which will be brought back to SRIG 2 weeks following Easter for a confirm and challenge session to ensure that robust plans are in place across the system and any gaps in capacity highlighted and mitigations in place.

A key piece of work, commissioned through SRIG, is to achieve a greater understanding of whether as a system we have sufficient community and acute capacity for the local health economy to ensure safe, effective flow so that care is delivered in the most appropriate setting. This work will help inform our urgent and emergency care Vanguard workstreams particularly focusing on the timely transfer of care of patients from acute to community based care.

The Keogh Urgent and Emergency Care Review details how new models of care can be achieved through a fundamental shift in the way services are provided. The Greater Nottingham SRG successfully bid to become an Urgent and Emergency Care Vanguard. The Vanguard Programme is focused on the delivery of a simplified, integrated system of urgent and emergency care that wraps care around the patient, is easier for patients and staff to navigate and blurs organisational boundaries. The current system is overly complex, containing a number of different entry and exit points and multiple hand overs. The Vanguard Programme seeks to implement the recommendations of the Keogh review and simplify the urgent and emergency care system Transforming Urgent and Emergency Care services in England (NHS England, Aug 2015) sets out a compelling evidence base for ‘what works well’ in urgent and emergency care systems. The Greater Nottingham Urgent and Emergency Care Vanguard is aligned to these evidence based principles and also the new commissioning standards for Urgent Care published in September 2015.

We have ambitious plans that will impact the whole of the system, to create a sustainable and resilient urgent and emergency care system that is fit for Greater Nottingham citizens. The Urgent and Emergency Care route map outlines high level expectations as to how the Urgent Care Review can be successfully delivered.

The Vanguard will accelerate the implementation of our local urgent care strategy. In the short term we will focus on the development and implementation of new models of care to achieve our vision, underpinned by changes in workforce, information / technology and contracting.

In 2016/17 our Vanguard will support clinicians, system leaders and wider stakeholders to lead the way in strengthening the evidence base against two of the five key changes in the Urgent and Emergency Care review:

- Helping people who need urgent care to get the right advice in the right place, first time
- Providing responsive, urgent physical and mental health services outside of hospital every day of the week so people no longer choose to queue in our hospital emergency department

We will be concentrating on the following new models of care

- Integrated Urgent Care (111) clinical hub – this has a direct link to the national must do - Improving access to out of hours care by achieving better integration and redesign of 111, minor injury units, Urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital.
- Primary Care hub at the front door of the Emergency Department
- Clinical Navigation
- Post hospital discharge and transfer to assess
- Mental Health

Ambulance Services

The Nottinghamshire Division of East Midlands Ambulance Services is implementing a new clinical delivery model in order to respond to the ongoing performance pressures and the key themes from the urgent and emergency care review, there will be: enhanced clinical triage within the Emergency Operations Centre to increase the delivery of hear & treat and see & treat services whilst also providing enhanced clinical advice to patients achieving an ambulance disposition via NHS 111; a new model of response to better match the response to the needs of the patient and the needs of particular communities; increased provision of community first responder schemes. Commissioners will continue to work with EMAS to address the operational issues that are adversely impacting on performance: staff vacancy and abstraction rates, handover delays at hospital, resource drift from Nottinghamshire to other divisions.

The implementation of the relevant “high impact changes” will be monitored through the SRG and the CCGs and EMAS are aware of the work of the ambulance response programme and prepared to implement the outputs as they emerge.

During 2016/17 the CCG will:

- Performance manage ambulance response via the EMAS recovery action plan (focus on staffing & deployment)
- Work with EMAS and NUH to improve ambulance turnaround times
- Review ‘drift’ and loss of resource from Nottinghamshire

Review green calls through the clinical hub to reduce demand pressures on the service

Requirement 5

Deliver the NHS Constitution Standard for waiting times. Improvement against and maintenance of the NHS Constitution that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment, including offering patient choice

The CCG and its major providers have provided a sustained high level of performance to its patients in respect of the delivery of the RTT standards set out in the NHS Constitution. This has been achieved through a number of mechanisms including innovative pathway design, strong relationships, close performance management and the shared understanding of a projected demand.

Requirement 6

Deliver the NHS Constitution Standards for cancer. Deliver the NHS Constitution 62 day cancer waiting standard including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission

During 2016/17 the CCGs in Greater Nottingham will work collaboratively with NUH to support maintenance of delivery of the cancer waiting standards. Cancer is the biggest cause of premature mortality within the City and accounts for around one in four deaths in Nottingham of which half are from lung, bowl, breast and prostate cancer. City specific actions being taken during 2016/17 include;

- Identifying specific clinical leads to support and champion the cancer agenda within the city.
- Lung Cancer Health checks
- Bowel Cancer screening uptake improvement programme
- Implementing NICE guidelines including Direct Access to diagnostics
- 'Hear Me Now' - Community Prostate Cancer Clinics
- Implementing electronic Cancer Decision Support Tools (eCDS)
- Piloting a multi-disciplinary diagnostic pathway project.

The following actions have been identified as necessary in order for the system to achieve the 62 day performance target.

Provider Processes

- Capacity and demand modelling tool being applied which has resulted in NUH achieving the 2ww standard in October and November
- Pilot of GP direct referrals to endoscopy for UGI tests commences 25th January 2016
- Trust commissioned private sector endoscopy capacity
- Standard Operating Procedures and key performance indicators (KPI's) for admin processes at NUH to be completed by 31st January 2016 to support consistent practice, escalations and prevent delay in pathway
- The IST visited NUH in Autumn 2015 to review MDT processes - report published in December and recommendations implemented as part of the on-going service improvement process
- Commission 5% additional cancer diagnostic capacity to support delivery of NICE guidance and move to 28 day referral to diagnostic target by 2020
- Reduce diagnostic waits from 6 weeks to 4 weeks.

Tertiary Activity

- Monthly information report on numbers of tertiary patients referred to NUH sent to COO's of referring trusts and CCG's
- Met with Lincoln CCG and hospital leads on 11th January - identified potential to develop revised pathways in UGI that reduce the number of attendances and remove several days off the pathway. New terms of reference to be agreed at the Lincoln Board meeting in January to embed robust MDT decision making process

- Monthly performance meetings in place with Treatment Centre and Sherwood Forest Hospitals

The delivery of the cancer performance is monitored via the Quality and Performance workgroup of the Contract Executive Board, individual CCG performance is shared with CCGs on a fortnightly basis via a performance portal. Additional monitoring and management is carried out via:-

- Recovery Plan monitored on Trust PMO system
- Weekly Corporate PTL established
- Bi-weekly Cancer Management Group established (NUH and CCGs)
- Clear line of accountability for performance in Cancer & Associated Specialties Division

Requirement 7

Achieve and maintain the two new mental health access standards, more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a dementia diagnosis rate of at least two-thirds of the estimated number of people with dementia

Plans are in place to increase growth in mental health budgets in line with the overall CCGs allocation. The CCG is also developing plans to ensure that it meets new mental health access targets in 2016/17, working collaboratively with other CCGs in Nottinghamshire. Improved Access to Psychological Therapies (IAPT) waiting times are on track for achievement. Additional capacity is expected to be available from April 2016, following a procurement process which is currently underway.

Access to Early Intervention in Psychosis (EIP) services that are in line with NICE standards within two weeks of referral are currently being developed for 2016/17.

The CCG has agreed an interim measure with the Trust from December 2015 in order to prepare for the introduction of the target. Commissioners are in the process of securing an external review of the EIP service against recently published standards. This review will identify the gaps and if any additional resources are required within the context of the overall funding of the service and value for money. Terms of reference are in the process of being drawn up and shared with the Trust.

The dementia diagnosis rate has been significantly above the national target of 67% in 2016/17. Plans are in place to continue close monitoring and improvement of performance in this area to ensure that dementia diagnosis and treatment is integrated.

Requirement 8

Deliver actions set out in local plans to transform care for people with learning disabilities, including enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

Nottinghamshire was selected to be a 'Fast Track' site for Transforming Care for people with learning disabilities and a local transformation plan completed in September 2015 incorporates the following:

• A systems approach across all commissioners (CCG, NHS England and Local Authorities) for people in Nottinghamshire with a learning disability and/or autism and challenging behaviours

• Care and support redesigned to ensure that inpatient care is only used when it is the best place for the person concerned e.g. when it is mandated by the courts or for respite or assessment and treatment when community provision not possible

• Person centred care and support planned and delivered to individuals consistently by providers

• An increased focus on the voice of the carer, relative and service user

• A ‘whole life’ preventative approach needed for care and support with a much greater emphasis on reducing the severity and frequency of challenging or offending behaviours from a young age and beyond into adulthood

• Greater liaison and influence at a national level about the use of new style inpatient service models and bed numbers in Nottinghamshire

• Significant market development and provider liaison to achieve the changes required by building the skills and capacity in the market whilst not destabilising it unnecessarily.

Six workstreams and an overarching Transforming Care Board have been established to oversee local progress. These workstreams are county wide. Engagement events have been held with existing and potential new providers led by CCGs in partnership with Local Authority and NHS England. Service gaps have been identified. Commissioners are exploring the most appropriate procurement models to address service gaps focusing on preventing admission and timely step down. Robust care and treatment reviews are in place, including Blue Light reviews in an emergency situation. Lessons learned are gathered and these inform the overall local plan.

Requirement 9

Maintaining and improving quality

The CCG will continue to work with providers (across all sectors) to ensure that standards of quality are maintained and areas where it could be improved are identified. To support them with this we will continue to triangulated and analyse data and information from a wide range of information including clinical and patient outcome measures, patient and staff experience measures, indicators of safety (for example harm free care) with findings from CCG and regulator quality visits and inspections and any other intelligence we receive.

We will continue to drive and incentivise continual improvement using CQUIN indicators; targeted quality schedules requirements and the opportunities available to us as a vanguard site for care homes and urgent and emergency care.

During 2016/17, using the data we already triangulate we will establish and trial a framework which demonstrates improvements in care across the care home sector. If successful this will be replicated across all sectors.

We have developed quality dashboards for care homes, mental health and community services which combine process and outcome measures across the range of quality indicators venture with the local authority, and will be piloted in 2016/17.

In particular we will focus on achieving the following:

- Reduction in avoidable mortality for our population
- Improved recognition and management of the deteriorating patient in all sectors including sepsis
- Reduced incidence of avoidable harm including HCAIs, pressure ulcers, falls and self-harm and suicide
- Transformation of the experience of care for people with a learning disability (see section on Learning Disabilities for further detail)
- Improved choice for patients requiring end of life care
- Improvements in maternity care (see section on children and young people for further detail)
- Delivering our offer for the expansion of personal health budgets
- Making safeguarding personal and improving outcomes for individuals who are in receipt of safeguarding interventions
- Delivering our plans to improve outcomes and the safety for residents in care homes
- Supporting and improving the emotional wellbeing and mental health of children and young people via our Future in Mind plans
- Improvements in antibiotic prescribing and general medicines management across all sectors
- Improving the percentage of staff stating that they are likely or extremely likely to recommend their organisation to their friends and family as a place to receive care

- Improving the percentage of patients stating that they are likely or extremely likely to recommend a service to their friends and family
- Improving the percentage of staff stating that they are likely or extremely likely to recommend their organisation to their friends and family as an employer
- Improvement in the timeliness of complaint handling and complainant satisfaction with the process and outcome
- Improving workforce indicators e.g. reduced sickness, reduced turnover/ vacancies, increased fill rates
- Improvements in staff cultural barometer findings and evidence of effective staff health and well-being strategies

We will continue to work collaboratively with regulators to share intelligence and information in relation to the quality of commissioned services 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.

For those providers who are deemed 'inadequate' or in 'special measures' we take immediate action to ensure ourselves that there is a safe environment for patients in whilst improvements are being made and will terminate contracts if improvements cannot be achieved.

We will continue to expect providers to report promptly and investigate all incidents robustly, including serious incidents and never events. All providers 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.

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 for example using recognised tools to measure organisational safety culture and maturity e.g. Manchester Patient Safety Assessment Framework (MaPSAF) and the National Patient Safety Agency (NPSA) Seven Steps to Patient Safety to identify areas for improvement and facilitate the development of strategies to improve reporting rates, reduce levels of harm, facilitate learning from incidents and develop a mature safety culture.

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.

We will also work with the Patient Safety Collaborative to develop and deliver root cause analysis training for clinicians to further improve the learning from incidents and ability to identify and implement harm reduction strategies. This will also include training in human factors in healthcare which will increase staff understanding of how and why things go wrong and what action can be taken to prevent recurrence.

We will ensure that mechanisms for staff and patients/ carers to raise concerns about the quality or safety of services are accessible and effective ensuring that appropriate action is taken in response to concerns and that this intelligence is triangulated with other sources of information to provide a comprehensive picture of the quality of services being delivered. We will ensure that providers have appropriate systems and processes in place to support patients, their families and carers, as well as staff who have been involved in incidents and will monitor compliance with the Duty of Candour.

Following the publication of the findings of the 'Francis Report' and the six subsequent independent reviews commissioned by the Government, including the Cavendish, Berwick and Clwyd reviews Nottingham City CCG created an action plan to address the recommendations made by all reports, and put in place a framework of indicators which serve as an early warning system against which we monitor provider performance. This underpins our plan to commission for improvements in quality across all the priority areas listed above by ensuring that there is:

- Clearly defined fundamental quality standards and ways to measure these within contracts, frameworks and service specifications
- A focus on continuous improvement of outcomes (clinical and patient reported)
- Use of best practice and learning in other areas to support learning and change

- Transparency and candour with service users via being open policies and using the duty of candour
- Hearing and acting on the experiences of patient/ carers / families in terms of how it feels to receive care in an organisation

Hearing and acting on the experiences of staff in terms of how it feels to deliver care in an organisation

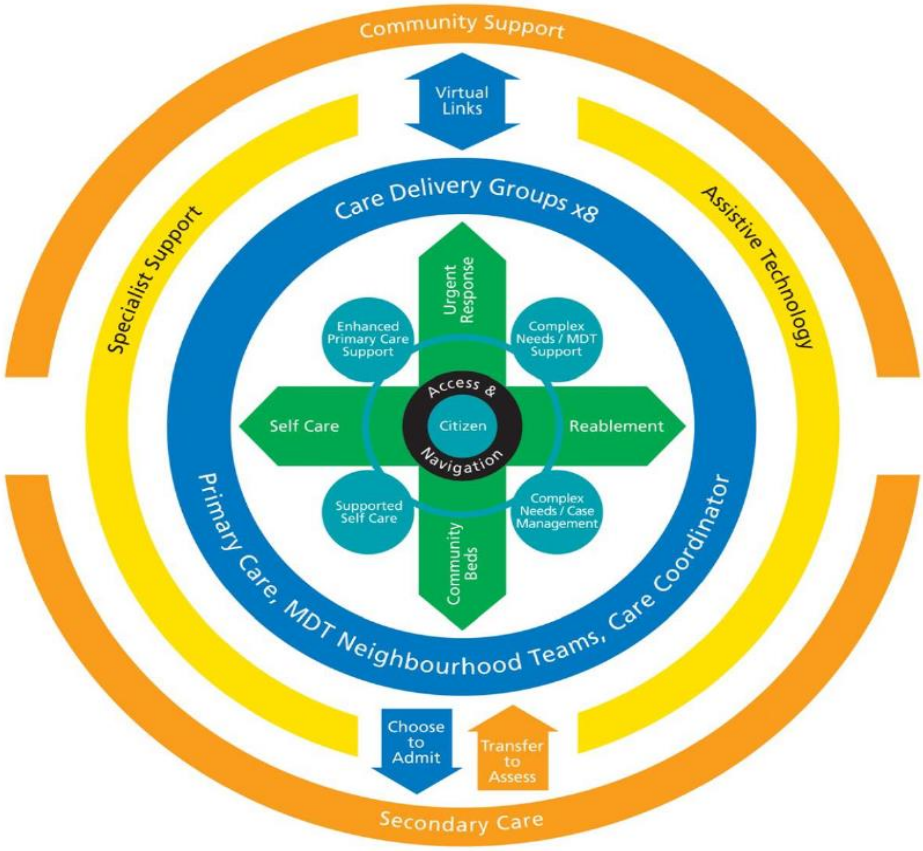
2.2 Better Care Fund (BCF)

The BCF involves the creation of a pooled health and social care budget, the value for Nottingham City is £25.8million.

The BCF continues the work of the Adult Integrated Care Programme. The Programme supports our vision to enable people living in Nottingham to live longer, be healthier and have a better quality of life, especially in the communities with the poorest health. Our aim is to remove organisational barriers and ensure that teams from different sectors work together seamlessly. Citizens will receive care in their home or the community; by shifting resources from hospitals to primary and community care we will be able to reduce unnecessary hospital admissions and shorten hospital stays. The integrated care model is a whole system model with the citizen at the centre. It includes simplified access and navigation, equitable access to re-ablement, an effective response in a crisis situation and Care Delivery Groups offering a proactive/multi-disciplinary approach including primary care and social care.

We will continue to monitor and assess progress on achievement of the Better Care Fund against performance metrics which also align and will demonstrate progress against our STP;

- Avoiding permanent residential admissions
- Increased effectiveness of reablement
- Reduced delayed transfers of care (DTOC)
- Reduced non-elective admissions to hospital
- Non – elective activity by Care Delivery Group (CDG)
- Increase in the uptake of citizens supported by Assistive Technology
- Improvement in citizen's health and social care outcomes



2.3. Urgent & Emergency Care Vanguard

The NHS Five Year Forward View (5YFV) sets out the need to redesign urgent and emergency care services for people of all ages with physical and mental health needs. Urgent and emergency care (UEC) is one of the new models of care outlined in the Five Year Forward View.

The proposed shifts in provision in UEC described within 'Transforming Urgent and Emergency Care Services in England' (NHS England, Aug 2015) detail how to improve the system so patients get safe and effective care whenever they need it. The guidance focuses on five particular elements of change:

i. Providing better support for people to self-care
ii. Helping people get the right advice in the right place, first time
iii. Providing responsive urgent care services outside of hospital
iv. Ensuring those with life threatening emergency care needs receive treatment in centres with the right facilities and expertise
v. Connecting all urgent and emergency care services together so the overall system is more than just the sum of its parts.

The Greater Nottingham U&EC Vanguard is aligned to these evidence based principles and also the new commissioning standards for Urgent Care published in September 2015.

Eight UEC vanguards have been selected to accelerate delivery of the elements of change, acting as test beds for new UEC initiatives including clinical decision support hubs, implementing a new payment model, testing new system outcome indicators, and delivering seven day services.

The Value Proposition has been developed by the Greater Nottingham System Resilience Group (SRG). The SRG benefits from mature system relationships that have already enabled collective responses to the ongoing challenges faced by urgent and emergency care services locally. However, sustainable gains can only be secured by developing new models of care that build on the foundation (and evidence base) of successful collaboration during 2015.

Our Vision

"To create a sustainable and resilient urgent and emergency care system that is fit for Greater Nottingham citizens"

Citizens, commissioners and providers will work together to transform the models of care, we will
Ensure citizens who need urgent care to get the right advice in the right place, first time.
Provide responsive, urgent physical and mental health services outside of hospital every day of the week so people no longer choose to queue in our hospital emergency department
Through a series of areas of change, citizens will have improved outcomes and a positive experience of care whilst supporting the short and long term sustainability of our health and social care system.

Achieving our Vision

The Greater Nottingham Urgent and Emergency Care Vanguard is an integral part of the collective approach to system resilience under the Greater Nottingham System Resilience Group (SRG). Health and Social Care partners (commissioners and providers) share the oversight responsibility for urgent and emergency care across the system. Working together building on relationships and a history of innovation and delivery we will plan, resource and implement programmes of change to advance our new care models.
We are committed to meaningful and effective communication and engagement with patients, carers, the health and social care workforce and key stakeholders, this will be crucial to achieving our vision. Giving impacted individuals and those with potential/future interest in service change the opportunity to share their experiences, co-design new ways of working and develop new service models will ensure that we establish urgent and emergency care services that are able to respond to the needs of individuals and are fit for purpose now and for the future.

The scope of our Vanguard

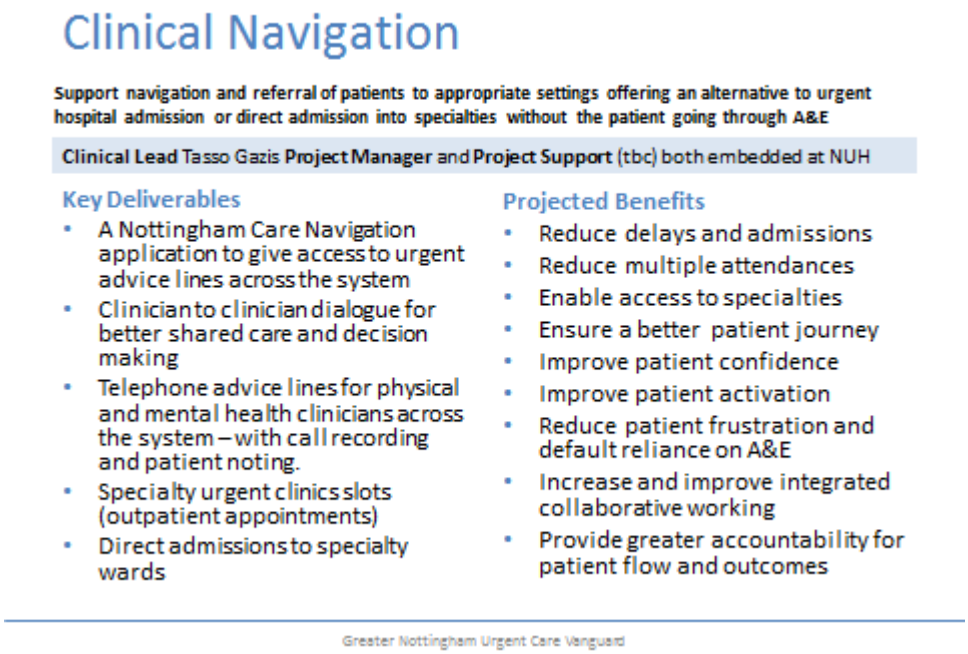
We have ambitious plans that will impact the whole of the system. Our experience and proven successes in partnership working will enable us to do this working across organisational structures, commissioners and providers together.

Our Vanguard will accelerate the implementation of our local urgent care strategy. We will focus on the development and implementation of new models of care to achieve our vision, underpinned by changes in workforce, information / technology and contracting.

The SRG Governance and delivery mechanisms are structured and resourced to develop and deliver both transformational change and operational delivery; recognising that urgent and emergency care services must continue to deliver during the programme of change. The Vanguard will enable acceleration of specific aspects of the implementation of our strategy to improve and integrate urgent care across Greater Nottingham. Specific areas of Vanguard focus are:

Clinical Navigation
Primary Care hub at the front door of the Emergency Department
Mental Health
Integrated urgent care (including clinical hubs)
Transfer of care

Our evidence base demonstrates that these areas of focus will achieve the greatest levels of impact, improvement and benefit. We will meet the needs of our population, enhance our urgent and emergency care system and contribute to the overall sustainability of the Greater Nottingham Health and Care System



Primary Care at Front Door of A&E

Primary Care management of ambulant users of A&E enabling patients to get the right advice / treatment in the right place in a timely manner

Clinical Lead Ben Pope **Project Manager** and **Project Support** (tbc) both embedded at NUH

Key Deliverables

- A primary care nurse sorter at the front door, Mondays to Fridays between 10 and midnight
- GPs at the front door Monday to Friday 6pm until 10pm, Saturday and Sunday between 10am and 10pm
- Direct bookings for urgent primary care clinic slots in A&E from 111
- 111 telephone referral to primary care clinicians at front door
- Website showing waiting times to include A&E, our urgent care centre and eye casualty
- An integrated alcohol model at A&E

Projected Benefits

- Reduce crowding in A&E & increase higher acuity/complexity capacity
- Enable patients to see the most appropriate clinician in the most appropriate location
- Ensure a better patient journey
- Offer safe and effective assessment, treatment and onward care
- Improve safety and efficiency for certain patient groups

Mental Health

Provide safer, faster better patient care with an equal response to physical and mental health for both all ages and age specific

Clinical Lead Chris Schofield **Project Managers** Clare Fox and (tbc) **Project Support** (tbc)

Key Deliverables

- Introduce a mental health navigation service
- Invest in an improved and more responsive liaison psychiatry service ('Lifespan Liaison Psychiatry') for all ages on a 24/7
- Enhance the early supported Mental Health discharge pathways, with improved collaboration across commissioners and providers
- Mental Health 111 will be used to help appropriately direct 111,999, police and ambulance calls to the most appropriate Mental Health Services
- Invest in ICT systems and processes to significantly enhance the way clinician's access electronic patient records and to provide management information for care planning and service performance management

Projected Benefits

- Improve system response
- Offer patients an equal response to physical and mental health needs
- Involved patients as much as possible in decisions about their care
- Improve access to information
- Reduce delayed discharges
- Reduce mental health admissions
- Reduce multiple transfers and attendances
- Reduce A&E attendances
- Provide more timely treatment

Integrated Care (including Clinical Hub)

Delivering an integrated urgent care pathway offering a viable alternative to A&E for patients supported by the development of a clinical hub function

Clinical Lead Christine Johnson **Project Manager and Project Support** (tbc)

Key Deliverables

- Develop and implement a clinical hub which will provide
  - Direct bookings to services
  - Warm transfers from 111 to hub
  - Clinical assessment of 999 green calls
- Integrated current admission avoidance approaches e.g. Nottingham Care Navigator
- Advance integrated urgent care commissioning standards

Projected Benefits

- Increase the number of patients accessing care through a booked appointment to an urgent care service
- Reduce time patients and professionals spend navigating the urgent care system and time spent in urgent care services
- Reduce the need face to face consultations through expert urgent telephone assessment and advice

Transfer of Care

Deliver a streamlined, coordinated discharge pathway that ensures the needs of frail and older patients are met in the most appropriate setting

Clinical Lead (tbc) **Project Manager** Adrian Matthews **Project Support** (tbc)

Key Deliverables

- Invest in tools, software systems and processes relating to patient information and flow
- Implement a trusted assessor model
- Invest in Ward to Hub and Transfer to Assess models
- Invest in a specialised Frailty Unit
- Invest in external services to support patients at home for as long as possible
- Implement 7 day services across Health and Social Care

Projected Benefits

- Maximise available capacity into community beds and services
- Reduce the Delayed Transfers of Care (DTOC) rate
- Reduce Length of Stay (LoS) LoS post medically stable for supported patients
- Reduce overall Length of Stay (LoS) for supported patients
- Reduce the number / % of permanent admissions to care homes directly from hospital
- Decrease the average number of outliers across campus
- Reduce duplicated decisions and speed up transfer process for patients returning to Care Homes
- Reduce the time a patient waits for Social Work allocation
- Reduce duplication of sign-off and review
- Speed up and improve the quality of the transfer of care from acute to community and from community to home
- Reduce readmissions as a result of poor discharge planning

2.4. Care Homes Vanguard

Background

Nottingham City has been selected as a Vanguard site for Enhanced Health in Care Homes, along with other CCGs in Wakefield, Sutton, Newcastle and Gateshead, East and North Hertfordshire, and Airedale Hospital Trust. The 'Care Homes 6' are expected to implement new models of care, at pace and sector-wide, across the care homes in their authorities, with access to transformation funding and specialist support from NHSE and partners.

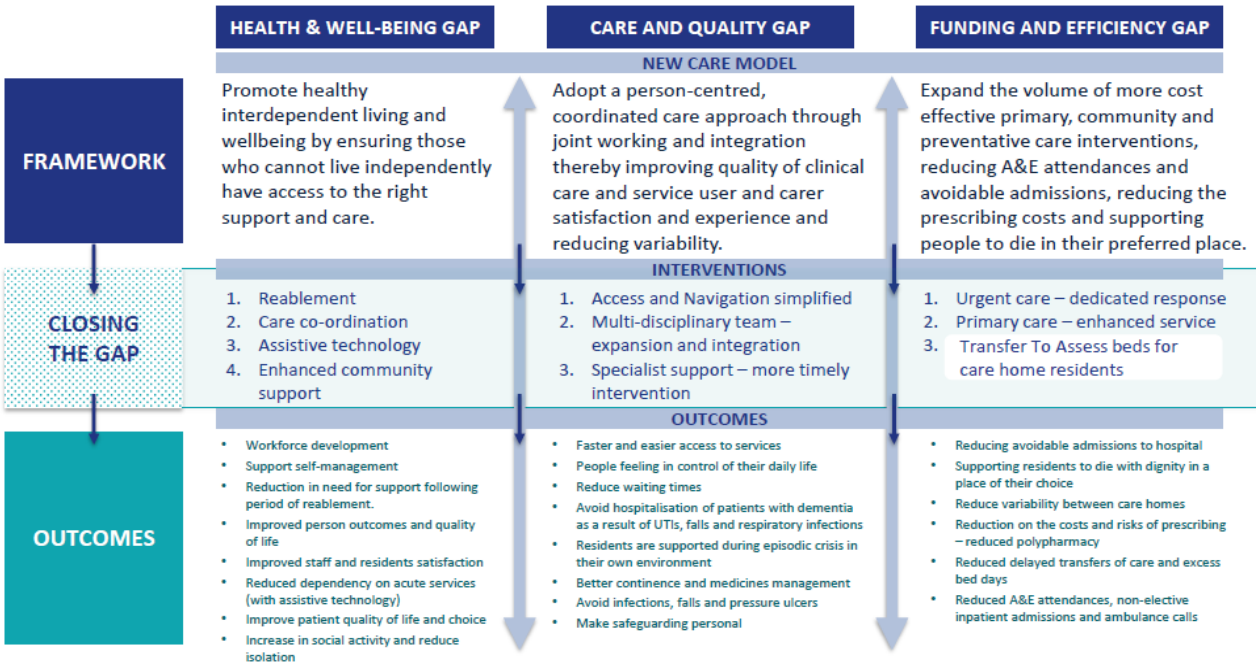
Care home residents have complex medical needs. The average resident has six diagnoses and takes eight medications. Currently, care homes residents are 0.5% of the city's population but account for 5% of all admissions to hospital. Many older people are cared for in hospital but best practice evidence indicates that care is most effective when provided at home or in the community. We are working to enable residents living in a care home to be healthier, have a better quality of life and to be treated with dignity and respect, focusing on residents' capabilities rather than their dependencies. To that end we have developed objectives and an ambitious programme of work.

Achieving our objectives

Our objectives, co-designed with our stakeholders via the Care Homes Vanguard Steering Group, the Care Homes Managers' Forum and the Care Homes Citizens' Group, are:

- ✓ **To ensure residents have an improved experience through high quality essential care**
- ✓ **To ensure all residents have agreed goals of care based on proactive multi-disciplinary review**
- ✓ **To ensure residents are admitted to secondary care only when they have a medical need and are discharged when that need is met**
- ✓ **To ensure residents have enhanced autonomy and involvement in decisions about care, place of care and place of dying**
- ✓ **To improve the quality of care for residents through well-co-ordinated, timely care and appropriate use of technology**
- ✓ **To ensure residents have reliable access to familiar health professionals and are supported by a workforce with the skills to meet their needs**

The Five Year Forward Plan sets out the challenges we face across all the Vanguards. We face a health and wellbeing gap that requires a radical upgrade in our preventative approach; a care and quality gap that requires efficient, joined-up new care models of person-centred care; and a funding and efficiency gap that requires us to make and evaluate system impact with each investment we make as Vanguards. How our Vanguard addresses these gaps and how achievement will be measured is described below:



Through these activities we anticipate realising a number of benefits – for care home residents, for the care home sector and for the health and care system. Residents will experience better quality care, improved support for long-term conditions, reduced risk of falls and injuries, reduced trips to hospital and improved end-of-life care. The care home sector will become a safer environment, working in partnership with clinicians providing better co-ordinated care around the clock. The health and care system will reap the benefits of operating a more efficient model, utilising resources more effectively and developing a greater skill mix among a more flexible workforce.

2.5 Local Estates Strategy

Introduction

The NHS has been tasked by the Five Year Forward View to change the way that it delivers care – improving the quality of services by using its resources more efficiently. The NHS estate is a key enabler for achieving this objective – both through the support that estates provide for the provision of high quality care and their potential efficiency contribution.

The healthcare estate is an essential component of effective and efficient service delivery. Nottingham City Clinical Commissioning Group has therefore developed a Primary and Community NHS Estates Strategy 2015-2025 to ensure that the built environment contributes to high quality care within a sustainable resource envelope.

We have reviewed existing health and social care strategies at both the local and national level. We have conducted a comprehensive review of the existing primary and community care estate for the services that we commission. We have engaged with stakeholders on the future direction of health and social care services. We have listened to local opinions on what we do well and what does not work well and requires change. These activities have collectively served to create an estates strategy that reflects the current landscape and responds to the future direction for health and social care in Nottingham City.

Our Estates Strategy will be a key enabler in delivering our commissioning strategy to deliver more integrated care outside of hospital seven days a week, with self-care and technology playing an increasingly prominent role. The commissioning strategy is supported by our Primary Care Vision and aligned with our Better Care Fund plans development jointly with our local authority partners.

Strategic Context

The local NHS in Nottingham spends £168m annually (2014-15) on primary and community care, commissioned from almost 200 provider organisations delivering services to patients from more than 250 locations across Nottingham.

Activity pressures, budget constraints, workforce challenges, increasing focus on outcomes and enhanced compliance obligations are collectively putting significant pressure on general practice and community services.

The policy response to these pressures includes a shift towards more integrated service provision, new models of care, new ways of working and collaborative commissioning.

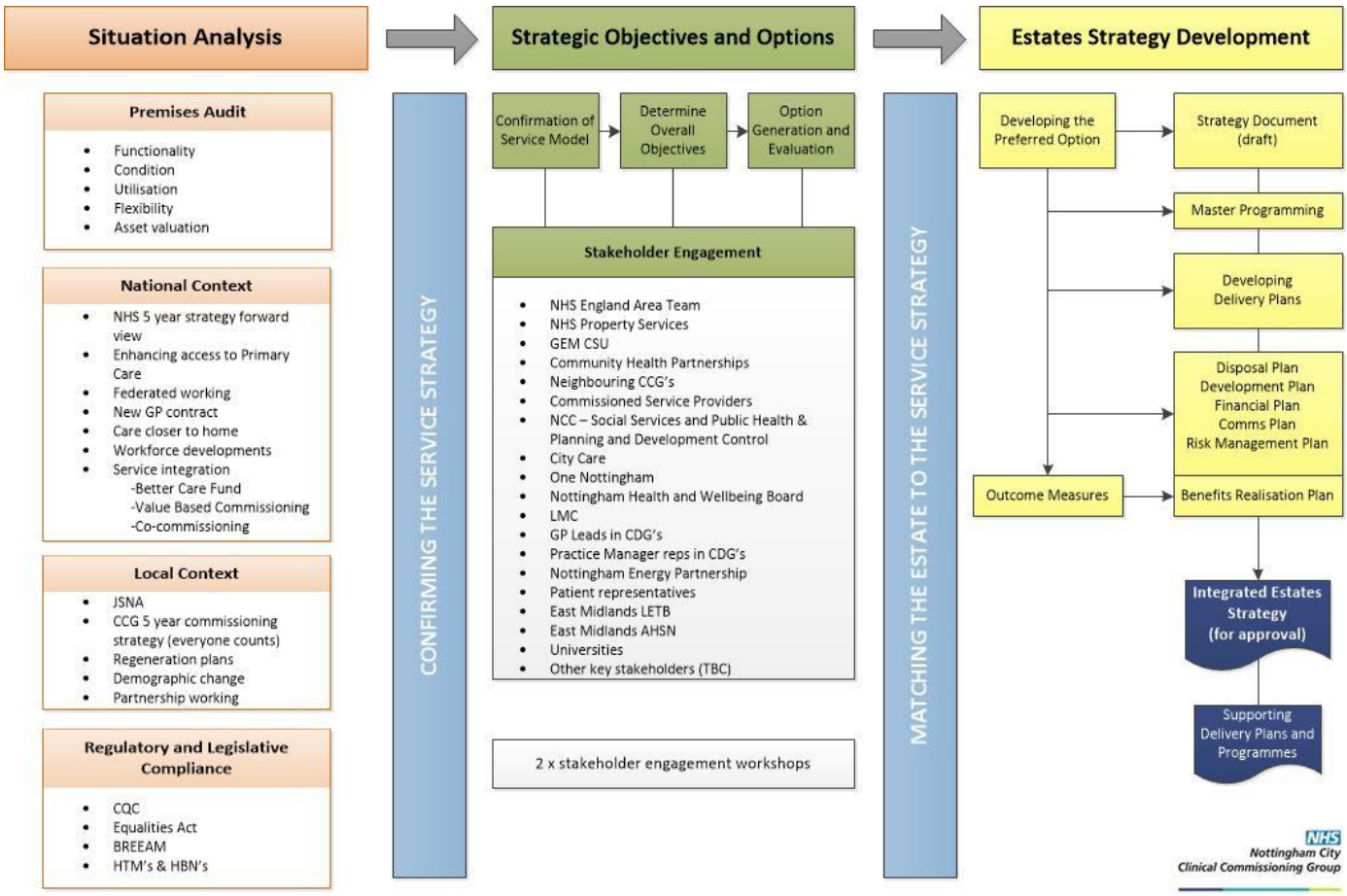
A key element of the Primary Care Vison is the CCG's member practices being aligned into 8 Care Delivery Groups (CDGs). The CDG model facilitates the establishment of productive

networks that align to the City Council's Neighbourhood Teams within Local Area Committees and facilitates a collaborative approach to integrated health and social care.

A new Urgent Care Centre from a single city centre location has been in operation from October 2015, with extended services including diagnostic x-ray facilities, a plaster room and suturing. The new service will relieve pressure on emergency services and provide an enhanced 'no appointment' service to patients who need to be seen urgently.

The approach we have taken

Supported by our Estates Advisors, we have taken a structured approach to information gathering, engagement with stakeholders, options development and assessment.



This process has included:

- Review of local context (service pressures, service response, population growth and current provider landscape)
- Interviews with key Stakeholders
- Surveys of 57 GP Practice sites
- Assessment of building condition, space utilisation and site development potential
- Development of a bespoke Estates Database with search and modelling capabilities
- Established strong links with the local 'One Public Estate' initiative, facilitating a 'joined –up' approach to estates strategy and planning across public sector organisations in the city.
- Worked with the national SHAPE team (Strategic Health Asset Planning and Evaluation) to develop SHAPE maps incorporating local estates information collected.
- Facilitated a successful Stakeholder Engagement event.
- Developed a draft Local Estates Strategy (LES) including CDG analysis.
- Established a Local Estates Forum (LEF) with representatives of commissioners, providers and asset managers to encourage information sharing on estates issues and plans.
- Developed strategic estates options for consideration and evaluation

As part of the development of the STP, we will work with partners across the health and social care community, combining our local estates knowledge to identify opportunities across the whole of the planning footprint.

3. Local Priority Areas

3.1. Primary Care

The Five Year Forward View emphasised the important role that GPs play in the system. It is acknowledged national and locally that primary care is facing unprecedented challenges which are impacting upon equality of access to and provision of high quality services for Nottingham City patients.

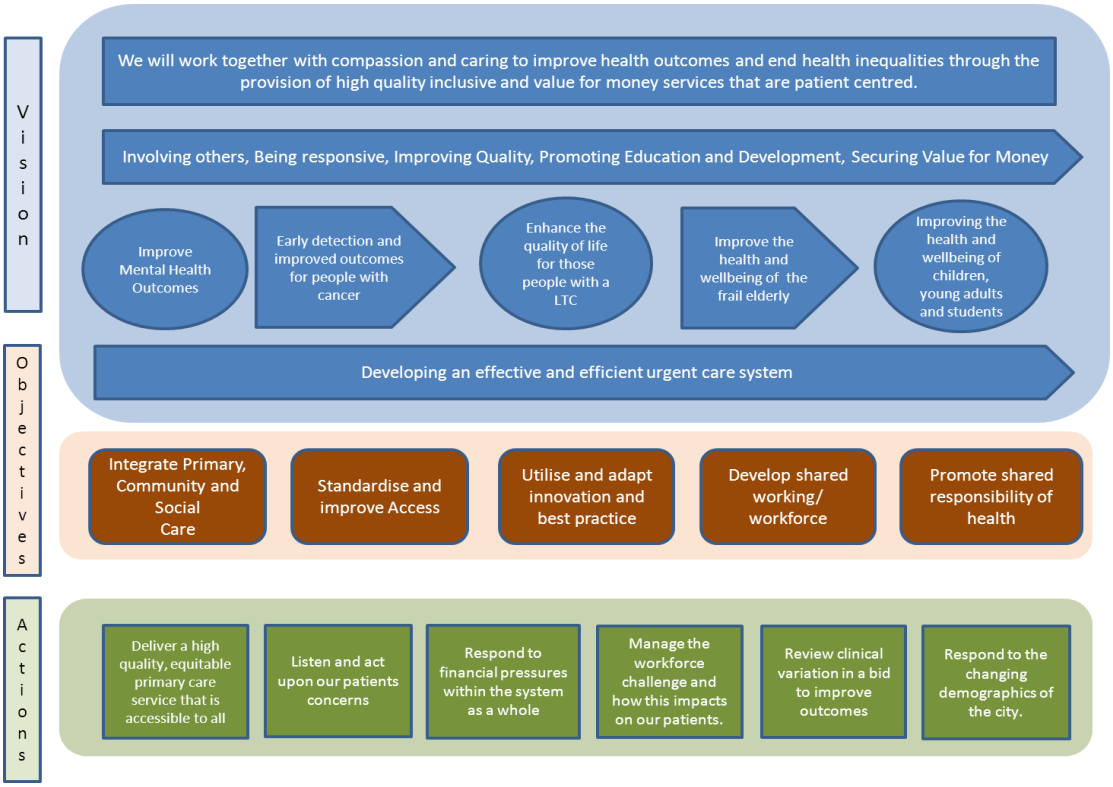
Workforce challenges are one of the top issues, in the East Midlands the workforce crisis for Primary Care is evident with 38% of training posts for the Vocational Training Scheme not being filled in 2015. Nottingham City has the highest percentage of GPs over 55years, the highest number of single handed practices and the highest list size per full time equivalent doctor than other local CCGs. To address this, general practice has increasingly been using Locum's to deliver core primary are services, however, the costs of this use are increasing and is unsustainable adding further to the pressures.

We therefore need to support and strengthen primary care in order to have positive influence and fulfil the aims of all other health care priorities. We want to have as many people managed in primary care as possible, so that people are being correctly treated in the right place at the right time for their needs.

The CCG has developed its primary care vision and has been working to implement the following five essential objectives:

- Integration of Primary, Community and Social Care
- Standardise and improve access to Primary Care
- Utilise and adapt innovative technology and best practice
- Develop a shared workforce
- Promote shared responsibility of health

As part of the work to implement the vision in 2016/17 the CCG plans to undertake a sustainability and workforce review of primary care; introduce a standardized primary care offer; redesign primary care weekend opening services to further refine the most appropriate model and gain further patient feedback via a 'mystery shopper' initiative.



3.2 Mental Health

The development of community-based alternatives to hospital care is an objective of the CCGs Integrated Care Programme. To date the programme has successfully rolled out integrated adult health and social care teams within the community to meet the needs of the local population. To further enhance integration, the city will review existing acute mental health services and look to develop community mental health into the Multi-disciplinary team format to enable patients improved and more equitable access to mental health services.

We will review and integrate mental health services with the aim of better management of the illness within the wider context of achieving a fulfilling life, this will be achieved by:-

- Developing a process of collaborative commissioning by ensuring service users and clinicians are at the core of service development, underpinned by newly designed services that supports integration
- Develop a liaison mental health services for all ages appropriate to the size, actuity and specialty of the hospital.
- Reviewing acute and community pathways in a bid to develop new services to reduce delayed transfer of care
- Commission Street Triage Services to provide an effective and timely intervention by police and CPNs for anyone believed to be suffering from a mental health disorder in a public place. (the Street Triage Team is an essential service to support the national mandate to stop people detained on a s.136 from going to Police Cells)
- Develop and integrate primary care mental health liaison and support teams within the community.
- Develop and implement acute Liaison for mental health element as part of the Urgent and Emergency Care Vanguard.
- Initial mapping against CORE 24 grading

3.3 Learning Disabilities

As described earlier in the plan, Nottinghamshire was selected to be a 'Fast Track' site for Transforming Care for people with learning disabilities and a local transformation plan, detailing the objectives for service change, was developed in September 2015 incorporates the following:

• A systems approach across all commissioners (CCG, NHS England and Local Authorities) for people in Nottinghamshire with a learning disability and/or autism and challenging behaviours
• Care and support redesigned to ensure that inpatient care is only used when it is the best place for the person concerned e.g. when it is mandated by the courts or for respite or assessment and treatment when community provision not possible
• Person centred care and support planned and delivered to individuals consistently by providers
• An increased focus on the voice of the carer, relative and service user
• A 'whole life' preventative approach needed for care and support with a much greater emphasis on reducing the severity and frequency of challenging or offending behaviours from a young age and beyond into adulthood
• Greater liaison and influence at a national level about the use of new style inpatient service models and bed numbers in Nottinghamshire
• Significant market development and provider liaison to achieve the changes required by building the skills and capacity in the market whilst not destabilising it unnecessarily.

Six work streams and an overarching Transforming Care Board have been established to oversee local progress. Engagement events have been held with existing and potential new providers led by CCGs in partnership with Local Authority and NHS England. Service gaps have been identified and commissioners are exploring the most appropriate procurement models to address service gaps focusing on preventing admission and timely step down.

Robust care and treatment reviews are in place, including Blue Light reviews in an emergency situation. Lessons learned are discussed and these will be used to inform the overall local plan.

In addition, all individuals with a learning disability will have an annual physical health check by their GP and be offered specialist support to overcome any access barriers in order to receive physical healthcare monitoring/treatment where appropriate.

In 2016/17 the CCG will:

- Support GPs to increase the number health checks undertaken
- Continue to review the performance of the Health Facilitation Nurses and ensure the number of health-checks increases each quarter
- To review the outcomes from health-checks and quantify an improvement for people with learning disabilities as a result of the health checks

3.4 Long Term Conditions

In 2016/17 The CCG aims to support people with long term conditions to create a more sustainable way of living, enabling, encouraging and facilitating better outcomes through self-management. Areas of focus for the CCG will be:-

- Diabetes
- Weight Management
- Respiratory
- Cardiac Rehabilitation
- Stroke

Diabetes

The CCG has secured an offer to be part of the first wave National Diabetes Prevention Programme. This requires working with NHSE to ensure behavioural programmes are available for our patients from March 2016. Monitoring is in place as part of the Integrated Diabetes Service Pilot (2013-15) and this will continue to be monitored via the contract. This programme and associated work will ensure that:-

- 85% of the diabetes population is diagnosed and receiving care for their condition.
- People with diabetes diagnosed less than one year will be referred to structured education
- Early intervention and management to reduce associated complications with diabetes including diabetic ketoacidosis and lower limb amputation

Weight Management

The CCG will commission a Tier 3 weight management programme. This programme will be integrated into the community with the aim of providing primary care with a holistic weight management service for patients with a BMI of 40+ to either facilitate sustainable weight loss in order to improve health and wellbeing or fully prepare the patient for bariatric surgery to ensure long term success of the surgery.

The CCG will explore the responsibility of commissioning Tier 4 weight management. Tier 4 includes surgical intervention in which surgery for morbid obesity is considered for patients with a BMI of less than 50kg/m2. The GP must be satisfied, and provide evidence, that all avenues of non-surgical management have been pursued (tier 3) and that the patient has not been able to lose weight using conventional weight loss programmes or referral to Dietetic or Psychotherapy services as appropriate.

Bariatric Surgery is carried out by the NHS only at centres commissioned to provide Specialised Weight Management Services. Referral to one of these services does not mean that the patient is being referred for surgery, however surgery is a potential outcome following assessment and further non-surgical treatment if required.

Respiratory

The CCG will work with patients and support groups to review its community Integrated Respiratory Services with the aim of focusing on prevention, reduction in admissions, while developing self-management pathways. In order to deliver this we will:-

- Review the entire respiratory system to look at current usage, interfaces and gaps.
- Work with stakeholders to identify appropriate assistive technology and self -management pathways highlighted as best practice.
- Work to ensure that 57.1% of the COPD population is diagnosed and receiving care for their condition.
- Increase the percentage of patients having their FEV recorded using the MRC dyspnoea score

- Increase the number of patients being offered smoking cessation treatment to 84.3%.
- Reduce the number of COPD/Respiratory emergency related admissions by 2%.

Cardiac Rehabilitation

Our objective is to prevent people from dying premature from heart related conditions. While we recognise that prevention is critical, we also understand that illness occurs. We will ensure that the Cardiac Rehabilitation service which comprises of a multi-disciplinary team of: nurses, physiotherapists, exercise professionals, health care assistants and clerical staff is mainstreamed within primary care. The aim being to ensure easier access to community teams for those patients who have suffered a heart-related illness enabling them to be supported back towards a healthier lifestyle quicker and more effectively in a setting that is more comfortable. Managing this will:-

- Helps people to make changes to their lifestyle.
- Helps patients to regain their confidence.
- Helps patients to recover psychologically.
- Helps patients to deal with social issues.
- Helps people to live longer

This will be delivered by:-

- Reviewing existing "system wide" provision
- Identifying best practice and areas for improvement, utilising NICE guidance for cardiac rehabilitation
- Mainstream the primary care cardiac rehabilitation service into care delivery group settings
- Ensuring a community programme for follow ups is in place, accessible and monitored.
- Ensure prevention and healthy lifestyles prevention is aligned as a key outcome to longer healthier lives.

Stroke

We aim to review and improve stroke services for our patients. This will involve identifying how integrated teams are able to support improved outcomes and monitor performance based on key outcomes. This will be delivered by:-

- Reviewing current services available in the community, monitoring this via the contract.
- Ensuring 85% of the stroke population is diagnosed and receiving care for their condition.
- Take a more targeted approach in diagnosing people with Atrial Fibrillation (known risk factor for stroke).
- Increase the number of patients on anticoagulation treatment in order to reduce the number of people having strokes.
- Identify outcomes that improve better outcomes for those suffering from stroke.
- Work with practice pharmacists and ensure primary care is supported in diagnosing Atrial Fibrillation and ensure that the number of patients on anticoagulant therapy is maximised.
-

3.5. Maternity, Children & Young Adults

The CCG will continue to review and agree actions to improve care pathways for children and young adults from birth to 24 years, and for their families. We will also focus on delivering more flexible services for children and young people, including children and young people with complex needs ensuring we take better account of their needs and preferences in terms of accessing care and support when they need it. We will work with partner organisations to deliver our priorities, which will align with the Nottingham Children and Young People's Plan.

Maternity

The Five Year Forward View published by NHS England in 2014 identified that having a baby is the most common reason for hospital admission in England. Births to mothers in cohorts deemed higher risk are increasing, including first-time mothers aged over 35 years, mothers with medical or complex social factors and the number of pregnant women who are obese.
What happens during the early years, starting in the womb, has lifelong effects on a range of health and wellbeing outcomes including obesity, heart disease, mental health, educational attainment and economic status. Healthy mothers are more likely to have healthy babies and a mother who receives high quality maternity care throughout pregnancy is well placed to provide the best possible start for her baby.

The CCG is involved in and leading a number of multi-agency work streams, including the child development review and the Maternity Pathway Improvement Plan to optimise how maternity services are commissioned and provided in Nottingham. All actions will be reviewed when the National Maternity Review report is published.

Maternity – Neonatal mortality and stillbirths

Data to be confirmed

Data for 2013 published in December 2015 shows that Nottingham had a neonatal mortality rate of 7.7 per 1,000 live births compared to the England average of 7.3% per 1,000 live births. Actions that will continue to be undertaken with the objective of reducing neonatal mortality and still births will include:

Antenatal education
- The Parent Education Department at NUH provides antenatal classes or workshops for women and their birth partner.
- Nottingham CityCare Partnership health visiting service have reviewed and amended their antenatal education course (based on DH Preparation for Birth and Beyond) to ensure quality and consistent provision across the City. It is expected that the numbers of parents-to-be who access the programme will increase.
- The above programmes include information and advice around maternal health during pregnancy.

Breastfeeding
- Baby Friendly full accreditation has been achieved in maternity and health visiting services and embedded in service specifications.
- Breastfeeding peer support service is provided which consists of a targeted, intensive element for mothers aged under 25 provided by paid peer supporters and group peer support for all other mums provided by volunteer peer supporters. Evaluation shows very positive outcomes in increasing breastfeeding rates and reducing age-related inequalities.
- Nottinghamshire and Nottingham City Breastfeeding framework for Action 2016-2020 (strategy) has been refreshed and is driven by a joint breastfeeding strategic action plan group.

Maternal obesity
- A new maternal obesity programme has recently been launched at NUH.

Increasing Access
- Continued promotion about direct access to midwifery
- Specialist midwives (domestic abuse, alcohol, substance misuse, teenage pregnancy, homeless)
- Language barriers are assessed at booking and interpretation initiated as appropriate via face to face or telephone interpreting services. NUH have developed guidance regarding how to prioritise face-to-face interpretation which includes the booking appointment, 16 weeks, 28 weeks and 36 weeks.
- Antenatal and postnatal care is offered in a number of settings. This takes place in Nottingham City, with the options of GP practices, Health Centres and Children's Centres.
- Clinical and social needs will be assessed on an ongoing basis through the pregnancy with appropriate referral to specialist medical and social care support services when required.

- Development of 'Pocket Midwife' app which provides basic information about pregnancy and labour with useful links

Antenatal screening
All women are offered the following screening programmes:

- NHS Infectious Diseases in Pregnancy Screening (IDPS)
- NHS Down's syndrome screening programme
- NHS Fetal Anomaly Screening Programme (NHS FASP)
- NHS Sickle Cell and Thalassaemia Screening Programme offers antenatal sickle cell and thalassaemia screening to all women (and couples)

Sudden Infant Death

- A Safe Sleeping strategy is being developed across Nottingham and Nottinghamshire to ensure standardised information and training is available to multiple agencies involved with parents/carers utilising the Lullaby Trust evidence based work.
- Poverty is a key risk factor for SUDI –the requirement for health visitors/FNP to assess financial vulnerability and refer to appropriate services including debt advice will be included in the 0-5 integrated specification that is being developed

Smoking – Maternal smoking at delivery

Data to be confirmed

There is a high prevalence of smoking households in Nottingham City and the latest date for quarter 2 2015/16 shows that Nottingham City is in the higher quartile for the number of women smoking at delivery.

The smoking in pregnancy and Early Years steering group has recently completed the CLeaR smoking in pregnancy self-assessment with support from PHE. This involved maternity, health visiting, FNP and public health to look at our current position and where we need to improve using a whole systems approach. The findings from this are informing the development of a smoking in pregnancy and early years strategic action plan due to be completed by end March 2016.

Prior to the development of the strategic action plan, the following actions will continue to be monitored:

- Community midwifery are currently meeting NICE guidance regarding smoking in pregnancy including CO monitoring at booking and two additional points in pregnancy.
- Women identified as smokers, or those with a CO reading of 4 or above are referred to New Leaf on an opt-out basis through a well-established referral pathway.
- The New Leaf stop smoking service has two specialist pregnancy advisers who have a midwifery background. The specialist advisers contact all pregnant smokers within two working days of receiving a referral unless they have specifically asked not to be contacted. Women are followed up pro-actively and receive intensive support throughout their pregnancy from the specialist team. Consultations through an interpreter are offered if needed. Clients are also contacted post-natally (a time when relapse may occur); support to remain smoke free or to re-access the service is available.
- Training is planned for staff in Children's Centres

Maternal mental Health

There will continue to be a focus on joined up care and focus on the emotional wellbeing of new parents to identify women with mental problems post birth, we will do this by:

- Strengthening the maternal mental health pathway to support women with emerging mental health needs and increase the support provided to women with anxiety or depression in pregnancy and increase referrals to primary care psychological therapies (PCPT).

Children and Young Adults

The CCG is a member of the Nottingham Children's Partnership Board, which oversees delivery of the Nottingham Children and Young People's Plan (2015-16), which is a multi -agency plan which has the following overarching vision for children and young people in Nottingham:

"A city where every child and young person can enjoy their childhood in a warm and supporting environment, free from poverty and safe from harm; a city where every child grows up to achieve their full potential"

There are a number of priorities, underpinned by the JSNA that will be taken forward in 2016/17 to improve the health and wellbeing of children and young adults:

1. Reducing Emergency Admissions

The CCG will continue to focus on actions to reduce emergency admissions for under 19 year olds, to date these have included implementing specialist training to support and inform primary care decision makers, focusing on practices with high admission rates and implementing a home safety equipment pilot scheme. The actions have resulted in a 7% reduction in June 2015 against the 2012/13 baseline figures.

2. Improving Mental health and Wellbeing

Nottingham has developed a five year plan reflecting the recommendations of 'Future in Mind', actions that will be taken in 216/17 to deliver year 1 of the plan include:

- Promote resilience, prevention and early intervention
- Improving access to effective support
- Care for the most vulnerable
- Developing the workforce

  and:
- Evaluate the effectiveness of the Nottingham Childrens Provider Network in developing the workforce and reducing barriers to accessing services.

3. Reducing Child Obesity

Nottingham City has above average rates of excess weight in 4-5 and 10-11 year olds, 37.8% compared to 32.2% in region and 33.5% nationally.

The CCG will continue to work with local authority colleagues to refresh the Nottingham Healthy Weight Strategy and will specifically work with commissioned services including Community Paediatricians and the provider of Integrated Community Children and Young People's Health (ICCYPH) services to implement recommendations.

4. Looked After Children

Looked after children show significantly higher rates of mental health issues, emotional disorders such as anxiety and depression, hyperactivity and autistic spectrum disorder conditions (Royal College of Paediatrics and Child Health, 2015)

The majority of children are in care (CiC) due to abuse or neglect, and this is also true within Nottingham, with 64% of Nottingham's CiC population entering care as a result of abuse or neglect.

For some children and young people, entering care becomes the only option to ensure they are safe. There is much evidence to suggest that the life changes of children in care are less promising than those of children who do not live in the care system. In spite of numerous government initiatives the gap between these children and their peers still remains in relation to education, offending, health and substance misuse.

In 2016/17 the CCG will be undertaking the following:

- Working with local authority colleagues to review a number of complex cases to analyse information and agree joint commissioning priorities to ensure services are implemented early that are easily accessible – e.g. access to online counselling
- Working with Nottinghamshire County CCGs review the Looked After Children Health team and processes to ensure pathways are improved.

5. Implementing the Children and Families Act, specifically in relation to Special Educations Needs

Local authorities and clinical commissioning groups (CCGs) must make joint commissioning arrangements for education, health and care provision for children and young people with disabilities and SEN (Section 26 of the Act). They should aim to provide personalised, integrated support that delivers positive outcomes for children and young people, and bring together support that improves planning for transition points such as between early years and school, college and between children's and adult social care services, and between paediatric and adult health services.

The CCG is engaged with Nottingham City Council on implementing this through the SEND Reform programme, Joint Commissioning and the Whole Life Disability Strategic Commissioning Review. These will shape the future of services and pathways to support for children with lifelong disability. A series of reviews to determine the compliance with SEND Reforms will be inspected by the CQC from 2016 and the CCG is a key strategic stakeholder in the inspection preparation group for Nottingham City.

In 2016/17 the CCG will:

- Continue to build on the joint work that has been undertaken with Nottingham City Council to implement joint arrangements for commissioning and implementing Education, Health and Care Plans
- Oversee the implementation of an integrated community health service for children and young people with complex needs and disabilities, reducing fragmentation and barriers between services
- Implementing the outcomes from the joint review that has been undertaken with the city council and specifically focus on short breaks.

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HEALTH AND WELLBEING BOARD - 30 March 2016

Title of paper:	**2016/17 Better Care Fund Plan**	
Director(s)/ Corporate Director(s):	Colin Monkton - Director Strategy and Commissioning, Nottingham City Council Maria Principe - Director of Contracting and Transformation, NHS Nottingham City CCG	**Wards affected:** All
Report author(s) and contact details:	Joanne Williams – Assistant Director Health and Social Care Integration, Nottingham City CCG and Nottingham City Council Joanne.Williams@nottinghamcity.nhs.uk	
Other colleagues who have provided input:	Clare.Gilbert@nottinghamcity.gov.uk	
Date of consultation with Portfolio Holder(s) (if relevant)		

Relevant Council Plan Key Theme:	
Strategic Regeneration and Development	☐
Schools	☐
Planning and Housing	☐
Community Services	☐
Energy, Sustainability and Customer	☐
Jobs, Growth and Transport	☐
Adults, Health and Community Sector	**x**
Children, Early Intervention and Early Years	☐
Leisure and Culture	☐
Resources and Neighbourhood Regeneration	☐
Relevant Health and Wellbeing Strategy Priority:	
Healthy Nottingham - Preventing alcohol misuse	☐
Integrated care - Supporting older people	x
Early Intervention - Improving mental health	☐
Changing culture and systems - Priority Families	☐

Summary of issues (including benefits to citizens/service users and contribution to improving health & wellbeing and reducing inequalities):
This report presents the draft 16/17 Better Care Fund (BCF) Plan submitted to NHS England on 21 March 2016. The plan will be amended following feedback with final submission due on the 25 April 2016.

Recommendation(s):

1	HWB reviews the draft submission for the 2016/17 BCF planning return and agrees amendments for inclusion in the final version for submission on 25 April 2016.

How will these recommendations champion mental health and wellbeing in line with the Health and Wellbeing Board aspiration to give equal value to mental health and physical health ('parity of esteem'):

Integration of mental health services is planned for 2016/17

1. REASONS FOR RECOMMENDATIONS

1.1 In developing BCF plans for 2016-17 local partners are required to develop, and agree, through the Health and Wellbeing Board (HWB):

i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions;

ii. Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;

iii. A scheme level spending plan demonstrating how the fund will be spent;

iv. Quarterly plan figures for the national metrics.

2. BACKGROUND (INCLUDING OUTCOMES OF CONSULTATION)

2.1 The Better Care Fund requires Clinical Commissioning Groups and local authorities to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation to support the integration of health and social care. The legal framework for the Better Care Fund derives from the amended NHS Act 2006, which requires that in each area the Fund is transferred into one or more pooled budgets, established under section 75, and that plans are approved by NHS England in consultation with DH and DCLG.

2.2 The below table sets out where the information to fulfil the above planning requirements will be collected and how it will be assured:

Narrative Plan	Submitted to NHS England regional / local Directors of Commissioning Operations (DCO) teams in an agreed format	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Confirmation of funding contributions	Submitted through CCG Finance Template and through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Conditions	Detail submitted to NHS England regional / DCO teams through narrative plans (as above), with further confirmations submitted through a nationally developed high level BCF planning return (spreadsheet)	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Scheme level spending plan	Submitted to NHS England regional / DCO teams through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National metrics	Submitted through UNIFY and through a nationally	Collated and analysed nationally, with feedback

	developed high level BCF template return (spreadsheet)	provided to DCO teams for regional moderation and assurance process

2.3 **Narrative Plan**

The Narrative Plan is a high level plan designed to show the changes that have been made to last year's plan to reflect the progress seen over the first year. The guidance sets out five areas that the Narrative Plan must demonstrate have been agreed by the partners:

i. The local vision for health and social care services – showing how services will be transformed to implement the vision of the Five Year Forward View and moving towards integrated health and social care services by 2020, and the role the BCF plan in 2016-17 plays in that context;
ii. An evidence base supporting the case for change;
iii. A coordinated and integrated plan of action for delivering that change;
iv. A clear articulation of how they plan to meet each national condition; and
v. An agreed approach to financial risk sharing and contingency.

Narrative plans are also expected to show the partners arrangements in relation to data sharing and in particular digital or information technology including reference to local digital roadmaps.

2.4 **Confirmation of funding contributions**

Nottingham City Better Care Fund contributions are as follows :-

	Gross Contribution
Total Local Authority Contribution	£2,604,709
Total Minimum CCG Contribution	£21,504,692
Total Additional CCG Contribution	£1,748,000
Total BCF pooled budget for 2016-17	**£25,857,401**

2.5 **National Conditions**

NHS England requires that Better Care Fund plans demonstrate how areas will meet the following national conditions:

i. Plans to be jointly agreed;
ii. Maintain provision of social care services;
iii. Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
iv. Better data sharing between health and social care, based on the NHS number;
v. Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
vii. Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
viii. Agreement on local action plan to reduce delayed transfers of care.

Conditions i - vi were included in the 2015-16 BCF framework. They have been updated to reflect further policy developments and the 2015 Spending Review.
New condition vii replaces the national payment-for-performance element of the Fund, linked to delivering a reduction in non-elective activity that was a condition in 2015-16. Guidance states that areas can agree on the use of this funding in 2016/17 based on achievement of the target in 2015/16. The Nottingham City plan therefore does not include a risk share arrangement following achievement of a reduction in non-elective activity in 2015/16.

Condition viii is also a new national condition for 2016-17. A system wide resilience plan has been developed which includes our approach to improving DTOCs. Providers in our system have produced a self-assessment of their progress to implement the high impact change model for reducing DTOCs. Work is also underway to develop a framework for measuring 'transfer of care' activity and performance, DTOCs will be a key feature of this. To support this work further we plan to:

- Conduct a local deep dive analysis into reasons for the recent increase in DTOCs across all providers, NUH, CityCare, Nottinghamshire Healthcare Trust and Community Health Partnerships recognising that the issues for individual providers may vary.
- Produce a local situation analysis which will include a review of interventions against national best practice.
- Co-produce with providers a local DTOC action plan for 2016/17 which supports the system wide action plan.

2.6 **Scheme level spending plan**
Schemes remain unchanged from the 2015/16 BCF plan, scheme descriptions have been updated. Service level amendments have been included in the narrative plan.

2.7 **National Metrics**
The four national metrics and the two locally determined metrics are described below with a rationale for the target in the 2016/17 plan based on national guidance.

Metric	Target and rationale
Non-Elective Admissions (General and Acute)	0.5% reduction in line with CCG operating plan (1% overall reduction)
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	8.6% reduction Level of ambition remains the same as 2015/16, although this target was not achieved mitigating actions have been agreed.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Additional 4% increase Stretch target following consistent improvement in 2015/16
Delayed transfers of care from hospital per 100,000 population	0.5 reduction Target based on consistent poor performance in 2015/16. Local action plan to be developed as described above
Proportion of the population supported by	Additional 1800 citizens supported by AT

assistive technology	
Proportion of citizens who have long term conditions (including the frail elderly) reporting improved experience of health and social care services.	Maintain or improve from current position (84% of citizens reporting improved experience of health and social care services)

3. OTHER OPTIONS CONSIDERED IN MAKING RECOMMENDATIONS

3.1 A wholesale review of BCF schemes: This option has been rejected as, in general, good progress is being made in delivery BCF objectives and the delivery of the Integrated Adult Care programme. Evolution of current schemes is viewed as the more appropriate and proportionate option.

4. FINANCE COMMENTS (INCLUDING IMPLICATIONS AND VALUE FOR MONEY/VAT)

4.1 N/A

5. LEGAL AND PROCUREMENT COMMENTS (INCLUDING RISK MANAGEMENT ISSUES, AND LEGAL CRIME AND DISORDER ACT AND PROCUREMENT IMPLICATIONS)

5.1 N/A

6. EQUALITY IMPACT ASSESSMENT

6.1 Has the equality impact of the proposals in this report been assessed?

No x☐

An EIA is not required because:

- The schemes identified do not significantly differ from those identified in 2015/16.
- The new schemes that are identified have been previously funded from other sources
- The extended services will provide continuation of provision

7. LIST OF BACKGROUND PAPERS OTHER THAN PUBLISHED WORKS OR THOSE DISCLOSING CONFIDENTIAL OR EXEMPT INFORMATION

7.1 N/A

8. PUBLISHED DOCUMENTS REFERRED TO IN COMPILING THIS REPORT

8.1 BCF Technical Guidance
Draft 2016/17 Better Care Fund Plan HWBCSC 20th January 2016

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Updated March 2016

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Part 2 is in Excel and contains metrics and finance.

Contents

1 Plan Details

A Summary of Plan

Local Authority	**Nottingham City Council**
Clinical Commissioning Groups	**NHS Nottingham City CCG**
Boundary Differences	**Boundary is coterminous with the City Council.**
Date agreed at by CCG & LA:	**21st March 2016**
Date submitted:	**21st March 2016**
Minimum required value of BCF pooled budget: 2016/17	**£ £21,504,692** (ccg minimum)
Total agreed value of pooled budget: 2016/17	**£ £25,857,401**

B Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	[April submission version to be signed]
By	Dawn Smith
Position	Chief Officer, NHS Nottingham City CCG
Date	[April submission version to be signed]

Signed on behalf of Nottingham City Council	[April submission version to be signed]
By	Alison Michalska
Position	Corporate Director of Children and Adult Services, Nottingham City Council
Date	[April submission version to be signed]

Signed on behalf of the Health and Wellbeing Board	[April submission version to be signed]
By	Councillor Alex Norris
Position	Chair - Nottingham City Health & Wellbeing Board
Date	[April submission version to be signed]

C Related documentation

Document or information title
01 Nottingham City Health and Wellbeing Strategy 2013-16
02 Nottingham City BCF Narrative plan 2015-16
03 Updated case for change 2016-17
04 CDG Health Profiles
05 Connecting Care Newsletter Issue 19 – February 2016
06 Annex 1 detailed scheme description forms 2016-17
07 Nottingham BCF Audit Report 2014/15
08 Nottingham BCF & Integrated Care Risk Log
09 Summary from joint HWB workshop on workforce issues
10 Nottingham City Joint Carers Strategy 2012-17
11 Wellness in Mind – Nottingham City Mental Health and Wellbeing Strategy 2014-17
12 Sharing the future model for citizen engagement
13 Impact change model (Self-assessment against DTOC actions)

2 The Local Vision for health and social care services

Nottingham City CCG and Nottingham City Council share a vision to enable our citizens to live longer, be healthier and have a better quality of life, especially in communities with the poorest health. We have achieved much together in recent years, particularly in implementing our integrated care programme and progressing the Better Care Fund. There is though recognition that only so much can be achieved without further breaking down organisational boundaries, eradicating the corporate silos and forging a new approach to commissioning and provision.

Our approach to integrated care for adults with long-term conditions and the frail elderly will be extended to cover the entire adult population. Importantly, we need citizens to continue to receive more care in their home or community, reducing unnecessary hospital admissions and shortening hospital stays. Our commissioning needs to be joined up and strategic, focusing on the value achieved or outcomes gained rather than on activity. Wherever services are provided, they must be high quality, accessible, sustainable and based on population need.

We need health and social care organisations to be working together in a 'place-based system of care' that will best improve the health and wellbeing of local people. This will see organisations acting collectively for the best interests of communities, managing the common resources available to them. The alternative to this might be for each organisation to adopt a 'fortress mentality', acting to secure its own future regardless of the impact on others.

In line with the five year forward view and building on the implementation of our model of integrated care our vision for Nottingham City is:

"To achieve the best possible health and wellbeing in our communities, breaking down current organisational barriers, so that citizens are encouraged to look after themselves wherever possible, with excellent integrated health, social care and other public services supporting them when they need them"

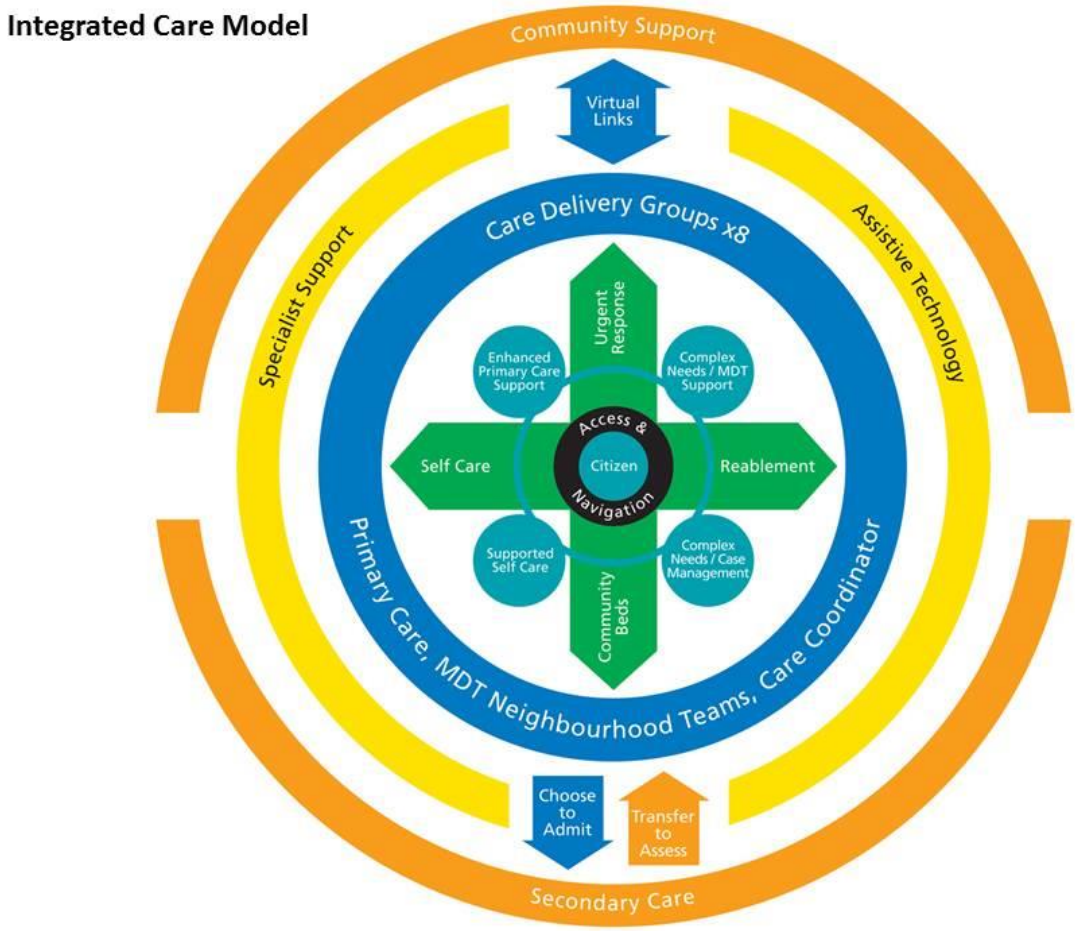
Key features of our vision and strategy will be to:

- Create a more cost efficient and clinically effective approach to care
- Ensure care is delivered in the right place – by the right people – with the appropriate skill mix
- Ensure care is delivered at home or in the community wherever possible
- Ensure provision of high quality, clinically safe and accessible services
- Focus on prevention and the ways in which individuals and resilient communities can best support themselves
- Move away from a 'paternalistic' top-down approach to one in which individuals are better informed, empowered and managing their own conditions
- Ensure that decisions are made in the best interests of citizens – not organisations
- Build medium and long term sustainability in response to rising demand and constrained resource
- Continue to work towards reducing and ending health inequalities in our communities

Our BCF plan for 16/17 will continue to support the implementation of the Nottingham City Health and Wellbeing Strategy **(document 01)** and is set within the context of longer term plans for the integration of health and care. Work is underway to support the development of System Transformation Plans (STPs) building on the success of our integrated care programme and work of the HWB.

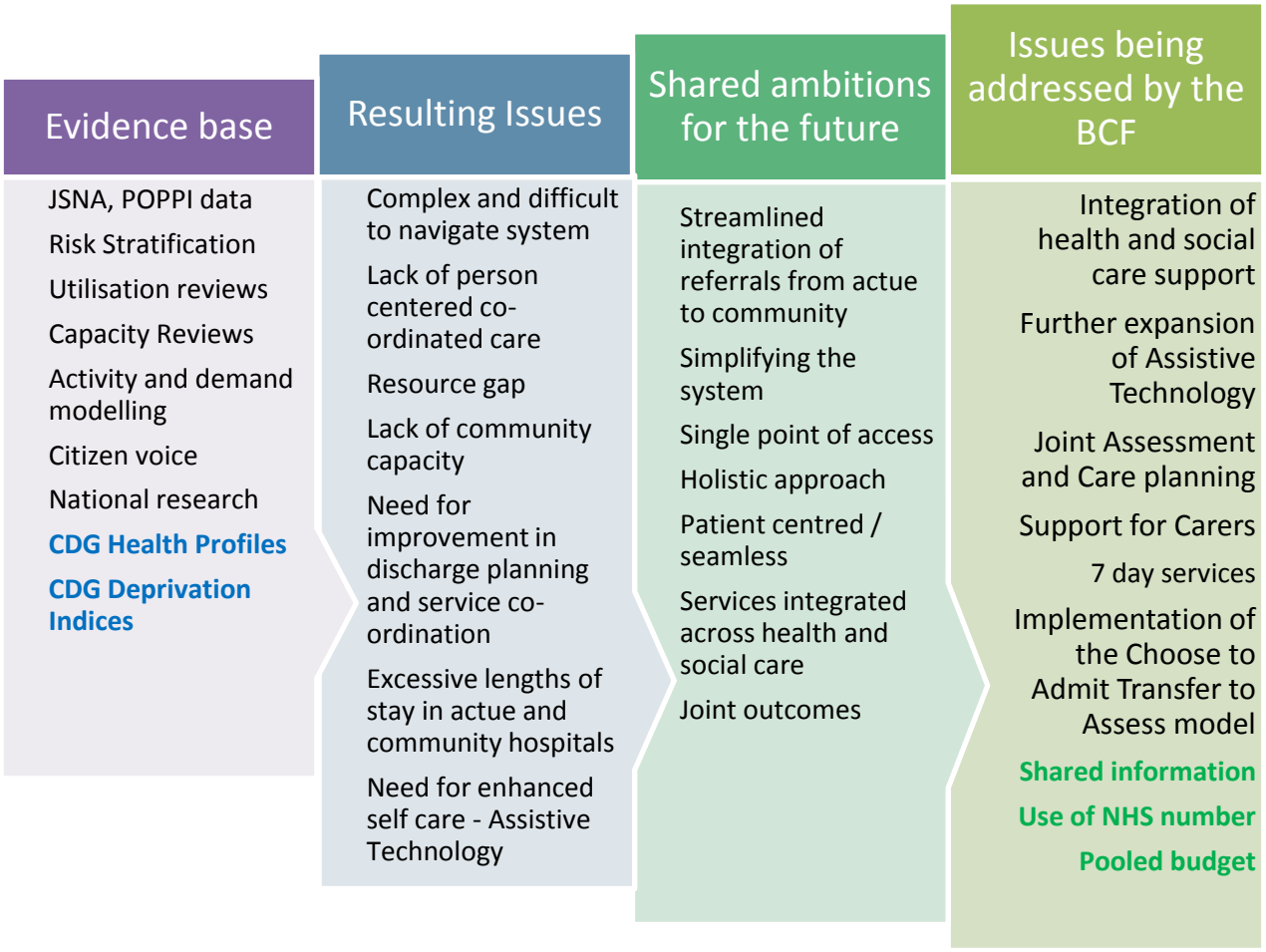
Furthermore it has provided a formal mechanism bringing together health and social care to explore system wide issues and has ensured implementation of the model. We will build on our achievements to date to take integration to the next phase which will include joint prioritisation of resources, avoiding duplication of commissioned services, flexibility across organisational boundaries for spending decisions and targeting of investment to meet shared priorities by taking a whole economy perspective.

We will continue to develop the aspects of the integrated care model already in place, for example the Care Delivery Groups. The BCF will support the next steps of the model's implementation such as self-care and mental health integration.



3 An evidence base supporting the case for change

We have reviewed the case for change described in our 15/16 plan, this remains consistent and we have added in additional information specific to Nottingham which we are using to inform the development of integrated care plans across the system. This is summarised in the diagram below which describes the link between the evidence base, resulting issues, our ambitions for change in Nottingham and how we will meet unmet need through the BCF. Please refer back to the 15/16 BCF narrative plan, **document 02**.



Key: **Green = Progress from 15/16 Blue = New for 16/17**

Additional information is available in **document 03** which has been produced to support the wider plans for transforming care and integration locally; this provides updated figures on long term condition prevalence, life expectancy, cancer survivorship, mental health prevalence and levels of deprivation across each Care Delivery Group in Nottingham.

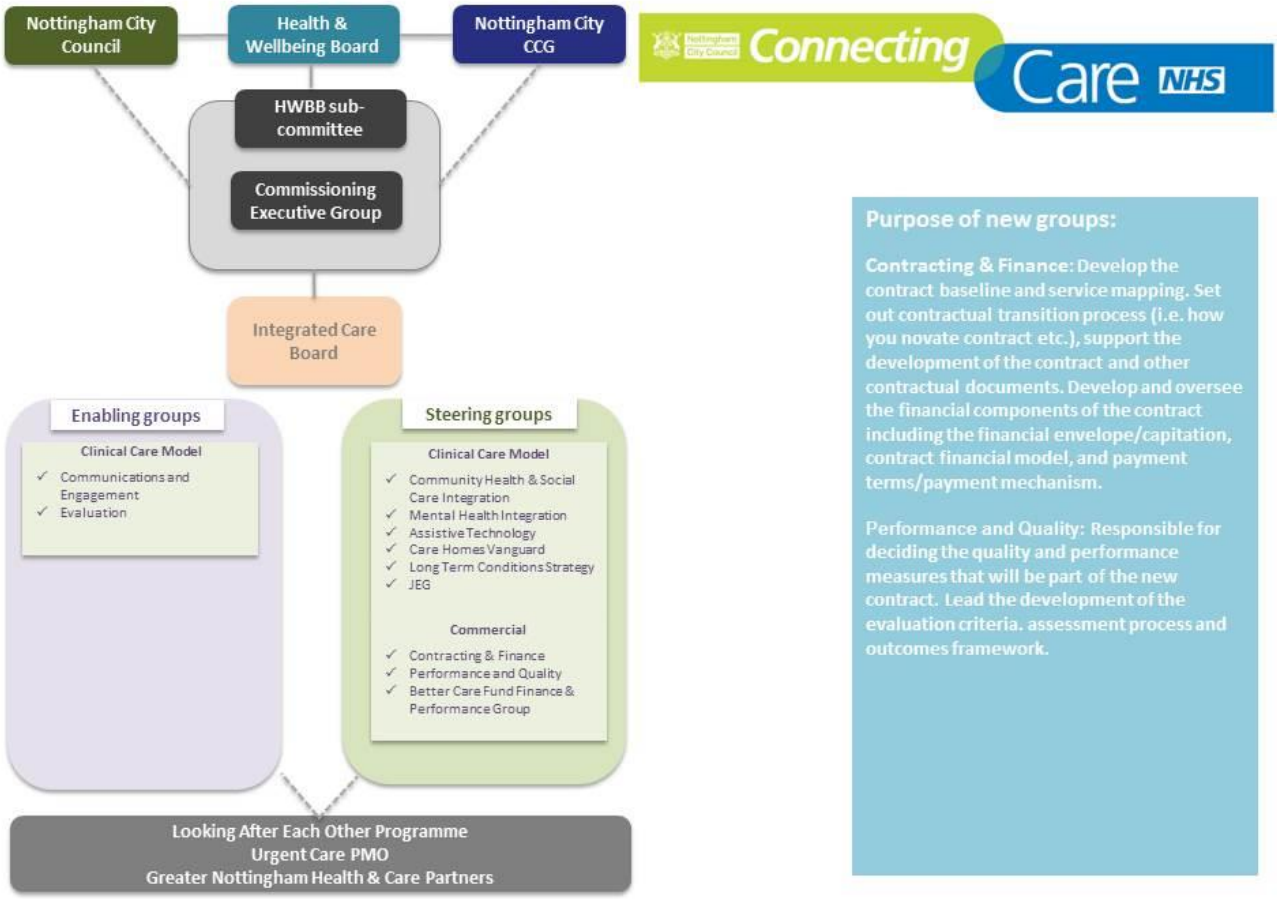
Finally to support the planning and delivery of co-ordinated care on a locality basis Public Health have produced health profiles for each Care Delivery Group, these are available in **document 04**.

Each of the "schemes" within our BCF plan will continue to address the local issues which we have identified and will continue to be implemented through our Integrated Care Model. Full descriptions for each scheme are available in **document 05**.

4 A coordinated and integrated plan of action for delivering change

Governance and accountability arrangements remain in place as outlined in our BCF 2015/16 plan with the HWB being ultimately responsible for maintaining oversight of the health and social care system. The Health and Wellbeing Board Sub-committee was established in April 2015 and has delegated authority to make decisions in relation to the BCF, papers for this committee can be accessed via the following link: http://bit.ly/253L5X8

The BCF and Integrated Care Programme Board continue to oversee development and delivery of the plan, with monitoring undertaken by the BCF Finance and Performance Group. The BCF governance arrangements are outlined in the chart below. As an example of the communications materials produced about the programme for key stakeholders and staff we have included Issue 19 of our Connecting Care newsletter – **document 06**.



Having reviewed schemes as part of the evaluation process, there will be minimal changes to schemes / services within the BCF plan.

BCF scheme	Amendments to 2015/16 plan	Rationale
Access and navigation	Additional funding for integrated health and care point	Supports our aim to simplify access to and navigation through services for citizens
	Information and advice directory	Under section 4 of the Care Act 2014 Nottingham City Council and partners need to ensure that there is robust, accessible information for citizens to help them to understand services available to them.
Assistive Technology	Additional funding for new delivery model	Supports early intervention
Carers	Addition of primary care carers service	Supports the planned redesign of carers services
Coordinated Care	Addition of CPN step down pilot	Support integration of mental health services and increased support for neighbourhood teams
	Addition of CDG social care assessor posts	Supports a change in the model of social care delivery to move to CDGs
	Addition of social care 7 day working	Supports plans for expansion of 7 day support for citizens
	Funding for 7 day working in the Care Homes Nursing Team	Supports plans for expansion of 7 day support for citizens
	Funding for 7 day working for the Care Co-ordinators service	Supports plans for expansion of 7 day support for citizens
Independence pathway	Addition of older people home safety and improvement service	Supports prevention and early intervention
	Additional posts in enablement gateway	Supports early intervention across each Care Delivery Group in the City
Programme costs	Additional 3 posts	Supports delivery of the planned transformation

Health and social care providers and housing colleagues have been involved in the development and agreement of the BCF 2016/17 plan, either through representation on the BCF / Integrated Care Programme Board or through contract negotiations.

Since 2014 we have undertaken two audits of the BCF programme, the first audit review is available in **document 07**.

In December 2014 an audit review was completed in respect of the preparations for the implementation of the Better Care Fund, focusing on the governance arrangements surrounding the management and delivery of the Better Care Fund. The report aimed to ensure that:

- ✓ There is a structured framework in place to coordinate, communicate, manage and control the activities that support implementation of the Better Care Fund.

- ✓ There is clear CCG senior management ownership, leadership and clinical involvement in the Better Care Fund.

- ✓ Regular management information is reported through the governance structure of the CCG which provides appropriate assurances to the Governing Body in relation to the management of the Better Care Fund.

- ✓ Risks in relation to the Better Care Fund are being identified and appropriately managed within the CCG's risk management framework.

The report gave **significant** assurance that the CCG working in partnership with Nottingham City Council was putting in place appropriate governance arrangements in relation to the BCF.

A second audit review is currently underway with the following focus:
Risk Management

- How risks relating to the BCF are identified and recorded
- The process for assessing risk, assigning responsibility and managing mitigation
- Reporting of risk and how BCF risks are integrated with other CCG risk management processes.

Developing Governance Structure

- Review of the effectiveness of the governance structures in the light of BCF operation.

The report is due to be published in April 2016.

A risk register is regularly reviewed at Programme Board, this is available in **document 08**. Risks and issues associated with the work to implement better data sharing between health and social care are recorded and managed through Connected Nottinghamshire programme.

5 BCF National Conditions

NATIONAL CONDITIONS

A Plans to be jointly agreed

Health and social care providers, housing and third sector colleagues have been involved in the development and agreement of the BCF 2016/17 plan, either through representation on the BCF / Integrated Care Programme Board or through contract negotiations. Further details are provided in section F.

We recently held a Chief Officers event to review progress and plan for the next phase of integration. Our strategic priorities were identified as follows and our approach to developing a work plan agreed.

1. Culture and leadership
2. Prevention and early intervention
3. Governance
4. Vehicle for delivery
5. New models of care and guidelines and pathways
6. Finance
7. Communications
8. Citizen engagement
9. Workforce and competencies
10. Information sharing

A joint workshop was hosted by Nottinghamshire and Nottingham City HWBs to explore possible local solutions to known workforce issues. The workshop was designed to give participants the opportunity to share experiences and discuss local strategies to address workforce issues, such as 7 day working, use of agency staff, integrating workforce, skills and retention, new models of care, and implications of the living wage. **Document 09** contains a summary of the findings and outlines the next steps locally.

B Maintain provision of social care services

There has been no change in the eligibility threshold provided. Prior to the Care Act, the threshold set by the City Council was High Moderate and is continuing to provide support at this level which goes beyond the requirements of the Care Act.

The principle mechanism by which this is delivered is through the Enablement Gateway. The Enablement Gateway team provides a combination of low level social work and Occupational Therapy interventions. They make use of low cost/no cost services which already exist and can help to re-engage citizens with their community. The team is funded via the Better Care Fund to provide early intervention and reduce the need for long term care services. Gateway team members provide a holistic assessment which may lead to information around connections to local community organisations, advice and low level/low cost aids and equipment to help people retain their independence at home and signposting citizens to other services in the community which may be able to support them with their independence and care needs.

The focus on protection for social care services in Nottingham City is mitigating demand pressures and maintaining eligibility at the national standard as a minimum. This will not

only ensure continued access to quality social care provision including homecare, day-care and day opportunities but enable maintenance of a preventative focus through further expansion of early intervention approaches including assistive technology and promotion of self-care.

The independence pathway strand of the Integrated Adult Care programme and BCF Plan enshrines a preventative approach through the development of a self-care pathway accessed through a joint Health and Care Point and removal of financial eligibility considerations for enablement and reablement provision. The aim of this approach is to encourage and support citizens to manage their condition within a community setting as effectively as possible maximising the community resources available, thus reducing demand on more intensive health and care provision.

The independence pathway services will run concurrently with Health Improvement initiatives to reduce health inequality and raise living standards that the City has committed to within the Nottingham Plan to 2020 and the Vulnerable Adults Plan. Such an approach is essential given identified demographic pressures, for further details in relation to demographic change see **document 03**.

In addition to maintaining the current eligibility criteria the local definition of protection for social care services includes the following:

- Ensuring that we can respond to demographic pressures/increasing levels of need in particular; dementia, long-term conditions and younger adults with complex care needs
- Promoting innovation in social care and integration with Health in line with transformation plans to improve social care outcomes and realise savings and efficiencies in both health and social care budgets
- Future proofing – capacity for Care Bill implementation
- Maintaining (not compromising) existing social care model – essential core services, enhancing personalisation, focus on support for carers, promoting enablement and reablement, building community capacity to deliver preventative services.

The adult social care schemes within the BCF have been largely maintained. There has been some additional strengthening of provision in relation to hospital discharge and to supporting the roll out of 7 day working. Additional funding has also been used to strengthen more effective access through the Health and Social Care Point and to develop a stronger presence for social care in the local Care Delivery Groups.

Additional specific social care services that will be protected through Better Care funding include:

- Community Alarm provision.
- Additional Hospital Discharge assessment posts
- Additional Specific Reablement Assessment Posts
- Additional Specific in-reach discharge posts
- Older person Home Safety and Improvement Service
- Seven Day Services in Rapid Response and Hospital Discharge
- Care Delivery Group Assessor posts
- Access and Navigation Pilot

There has been an increase in the protection of social care services which is integral to the delivery of an effective integrated care model in Nottingham. Within the 15/16 BCF plan the amount protected for social care was £6.807 million; we can confirm that within the 16/17 plan we will protect £7.403 million.

Implementation of the Care Act through the BCF

The 2013 Care Act was introduced by the City Council on 1st April 2014. We recognise that it was designed to:

- Embed the wellbeing principle into discussions between assessment colleagues and citizens
- Shift the focus of service provision towards being preventative and maximising the skills and independence of citizens through taking a skills based approach with person centred planning

This has been achieved in Nottingham by the following changes:

- Advocacy – The contract with the current provider of advocacy was amended to ensure compliance with the Act.
- Providing information and advice – A new service has been commissioned to provider information and advice as per the content of the Act.
- Adult safeguarding – Internal systems and culture change programme was undertaken. Adult Safeguarding Board set up as a statutory Board.
- Provider failure planning – Established local market oversight process and procedures and a robust provider failure action plan
- Eligibility for services, following a national framework – Internal systems, paperwork and training change programme was undertaken.
- Supporting carers and giving them new rights to support services - The contract with the current provider of services for carers was amended to ensure compliance with the Act. Staff training was undertaken to ensure assessment colleagues' compliance. Carers now receive a great deal more direct support.
- Working in partnership with other agencies – Nottingham City has a programme of Health and Social Care Integration which includes BCF monies.
- Citizens moving between local authority areas – New arrangements are embedded around ordinary residency and transfer between local authority areas.
- Social care in prisons – The Council is meeting its requirement to assess the social care needs of prisoners.

Implementation of the Care Act duties aligns with BCF principles and activity to deliver integrated care. All social care services funded via the Better Care Fund could be deemed to be working towards further implementation of the spirit of the Care Act, as detailed above. Examples of this could include, among others:

- The preventative and enabling nature of services such as: Telecare, Care Coordinators, drop in service for citizens with learning disability, Community Navigator Pilot
- More comprehensive support for carers through the Carers' Counselling Service or Carers Respite Service
- Maintaining eligibility criteria, applying the Council's interpretation of the Care Act

Carer specific support

For further details about carer specific support please the Carer Scheme descriptor which describes how we will address key priorities within the Nottingham City Joint Carers Strategy – **document 10**.

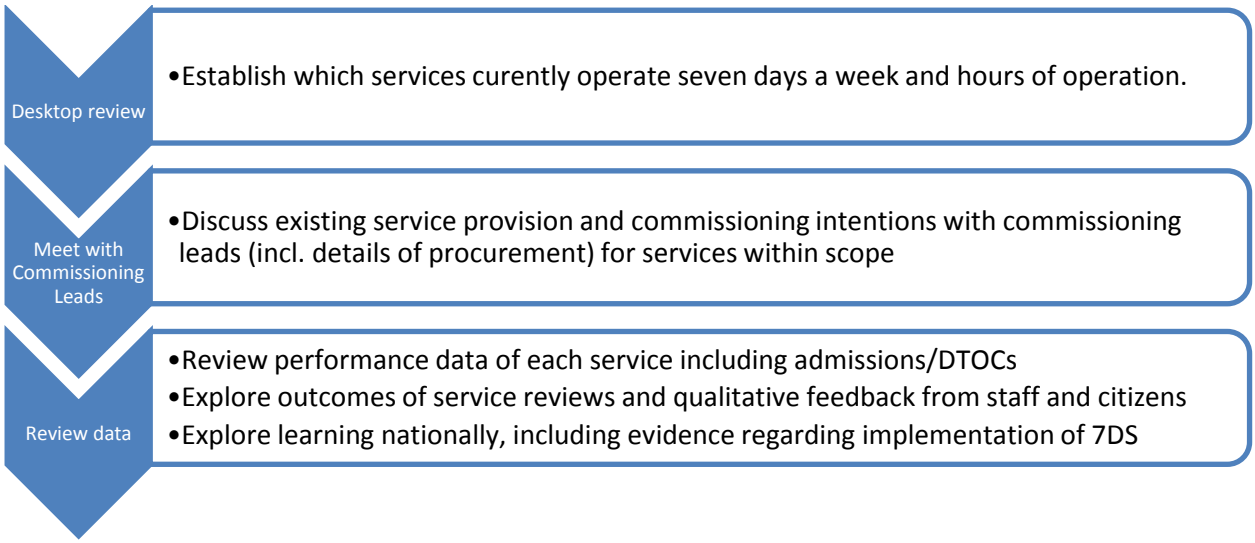
C Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

Within Nottingham there are a number of seven day services already in place across primary care, community care, social care, mental health and secondary care. These include:-Reablement services, urgent care (crisis response), community nursing, integrated respiratory service, integrated diabetes service and some end of life services also cover 7 days to support people in their home wherever possible.

Phase 1

During 2015/16 we established a seven day services project and task and finish group to identify where further service development was required. The vision of this project is to ensure availability of appropriate health and social care services in the community as well as ensuring co-ordination to prevent hospital admission and facilitate timely discharge. The main objective is to support patients being discharged and to prevent unnecessary admissions at weekends as well improving citizen experience and outcomes.

The first phase of the project focused on reviewing demand for seven day community services, using the process outlined below.



Through this task and finish group the following services have been extended to work seven days: Community Matrons, Care Homes Nursing team (enhanced capacity); Care Co-ordinators; Integrated Community Equipment Loans Services (ICELS).

In 16/17 the social care Hospital Discharge Team and Access & Rapid Response Service will be extended to seven day services. It is expected that seven day working will commence from Q3 16/17. Development of this service expansion will be overseen through the Community Health & Social Care Integration Steering Group.

Phase 2

A Mental Health Integration Steering Group has been established, this group reports into the BCF & Integrated Care Programme Board. The main purpose of the group is to scope the current delivery of mental health services across the city and identify priorities for integration (and seven day service development). This steering group meets bi-monthly and includes representatives from the CCG, our community mental health provider, the local authority public health and Nottingham Community Voluntary Services.

The first phase of work is focussing on mapping and scoping the delivery of mental health services across primary care, secondary care, social care and the third sector. The mapping work will be aligned to ten priorities for mental health integration identified within the recent Kings Fund report "Bringing together physical and mental health: a new frontier for Integrated Care", March 2016.

D Better data sharing between health and social care, based on the NHS number

A countywide programme "Connected Nottinghamshire" is leading on information systems integration. This includes work on integrated datasets, Information Governance, underpinning infrastructure and standards; implementation of APIs and development of the Digital roadmap for Nottinghamshire. The work is progressing well with engagement across all partners and supporting the integration of services by enabling the sharing of key information. By progressing work across the city and county economies of scale can be achieved in relation to the procurement of new software solutions.

Digital road maps

As part of the overall planning for BCF and STP, Connected Nottinghamshire is facilitating the development of the Nottinghamshire Digital Roadmap which will set out the plan for 2015-2020. Planning for the Nottinghamshire Digital Roadmap commenced at a Nottinghamshire Health and Care IT summit held in November 2015, which involved members from all Connected Nottinghamshire partners including citizens and patients.

Connected Nottinghamshire members have submitted the Digital Footprint and are progressing the development of the Roadmap for submission later this year. The Nottinghamshire Digital Roadmap will be aligned to BCF and STP plans with HWB approval. This document will outline the programme vision, governance arrangements and accountabilities. It will be made available from March 2016 and will supersede the existing Connected Nottinghamshire Blueprint. The content will include:

- Access to information systems
- Integrated Digital Care Records
- Plans for exchange of data
- Plans for workflow (tasks/referral/S2&5)
- Integration tools such as MIG and the "Care Portal"
- Citizen access to records
- Mobile workforce
- Information Governance arrangements
- Benefits and evaluation/exploitation

All project boards have citizen representation, and through existing engagement forums we ensure that citizens and patients play an active part in the design of solutions. To engage the wider population we have developed a set of leaflets and posters, which are utilised across partners, and explain how information is being used. Alongside this, website privacy notices have been updated to incorporate these messages. A communications plan will be developed to support the implementation of the Digital Roadmap.

Use of the NHS number and approach to APIs

Connected Nottinghamshire is concluding Tranche 1 of implementation. Tranche 1 has laid the foundations for future integration requirements (technical enablement and information governance principles development).

Excellent progress has been made in populating systems with the NHS number. Agreement of the use of the NHS number has been in place for some time. With modern systems in place, the timeliness of NHS Number matching is primarily at the point of contact via PDS linked PMI trace.

Recent research puts tracing/use of NHS number at 98% in the main providers, with the Ambulance Service matching approx. 60% of electronic records within 24 hours.

Matching and recording of NHS Number across social care systems is in place and on-going via direct entry or batch tracing of NHS number via PDS. Key systems have been modified to support the storage and use of the key identifier. Using the MACS Service, social care system data has been submitted from the local authorities and matched to NHS Numbers, which are then data quality checked and uploaded. Progress to date is 85% of current caseload records matched.

All procurements now have a set of requirements addressing the requirements for Open APIs. Recent procurements have addressed this specifically and now basing development of these APIs on the NHS England API standards document. Our position at Quarter 3 2015/16 is as follows:

Progress towards installation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	Installed (not live)	Installed (not live)	Installed (not live)	Un-available	In develop-ment	In development
Projected 'go-live' date (dd/mm/yy)	01/10/17	01/10/17				

Approach to Information Governance

Connected Nottinghamshire has oversight of the Nottinghamshire Health and Social Care Records Information Group. This GP, Caldicott Guardian led group is leading the way in relation to IG requirements and ensuring Nottinghamshire has good information sharing for direct care and risk stratification. In addition to this and in line with Caldicott 2 recommendations and best practice, pseudonymised or anonymised information is used

sharing for reporting. A Nottinghamshire Data Sharing Protocol is already in place across all partners and due for review in summer 2016.

Sharing to date has been using existing messaging capability and shared access to multiple systems. This has been supplemented with the use of the Medical Interoperability Gateway (MIG) and is now moving into the key phases of MIG2 and implementation of the Care Portal.

Once the National Data Guardian review has been published the key recommendations will be considered and implemented as appropriate through the Connected Notts work stream.

As part of the overall delivery and assurance framework, benefits of the Connected Nottinghamshire programme are reported into Connected Nottinghamshire. The Programme Director provides regular updates to the Better Care fund Implementation Board and the HWB.

The table below sets out the forthcoming key milestones, along with expected and required dates. The overall plan is reported by the Connected Nottinghamshire Programme Director and monitored by the Connected Nottinghamshire Board. The milestones are inter-organisational some require cross-organisational delivery.

Milestone	**Date**
MIG2 sharing of additional datasets across Health and Care live	October 2016
Electronic workflow (S2,3 & 5) phase one live	October 2016
Nottinghamshire Care Portal 1. Phase one (estimated February 2016-November 2016) a. NUH, SFHFT, NHCFT connectivity (through trust integration engine connected between Highway, Rhapsody and Ensemble respectively). b. Commercial arrangements in place for phase one providers c. IG arrangements in place d. MIG connectivity into CareCentric e. CareCentric viewer available for Care Co-ordinators and Call for Care f. GP direct connect phase one - pilot (12 practices?) g. Structured messaging in place for ITK transit (e-discharge and letters) h. EPaCCS transition i. Governance arrangements in place j. Benefits framework in place 2. Phase two (estimated January 2016-October 2017) a. Nottinghamshire County Council connectivity (via TotalMobile connect interface?) b. Nottingham City Council (connection via Liquid Logic)	January 2016 – October 2017

E Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

The Joint Assessment and Care Planning Task and Finish group is currently working on the following outputs:

- A Transfer of Care (ToC) document to follow the patient from hospital discharge into community health and social care services. The document is being finalised for a paper based pilot on two hospital wards in Q1 & Q2 2016/17.
- Alongside the piloting of the paper based ToC document a dataset is being defined to enable the CareCentric Portal to provide this electronically when it goes live in Q3 2016. This dataset will be ready for the Connected Notts Programme to include in their roll-out plan.
- A review of the care plans and folders kept in citizen's homes has been undertaken and was completed in February 2016. The standardised contents list and associated Information Governance requirements will be signed off at the next task and finish group in April 2016 and taken to the Community Health and Social Care Integration Steering Group for approval to be implemented in Q1 and Q2 of 2016/17.

Additionally in Q1 2016/17 the scope and workplan of the project will be revised to include the minimum and further KLOE conditions. Initial work will include mapping the citizen/patient pathway through services identifying where joint assessments and care planning occur and what action needs to be taken to meet the KLOE conditions. Learning from the current outputs (detailed above) will be applied across the pathway and will utilise the CareCentric portal as it rolls out. The revised workplan will be presented to the CH&SC Integration Steering Group for approval in early Q2.

The Mental Health Integration Steering Group is due to agree the workplan priorities in Q1 2016/17; and dementia services have already been agreed as priority in line with the key priorities outlined within the Nottingham City Mental Health and Wellbeing Strategy – Wellness in Mind – **document 11**. It will also be decided if work on joint assessment and care planning in relation to dementia services will be a task and finish group reporting to the Mental Health Integration Steering group, or if it will be implemented through the workplan for the Joint Assessment and Care Planning Task and Finish group.

F Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

As outlined in Section 4, our BCF/Integrated Care Programme Board and work streams continue to include representation from providers including our acute, community and mental health trusts as well as third sector and social care providers. A number of these providers also sit on the Nottingham City Health and Wellbeing Board and the BCF/Integrated Care Programme Board.

An independent evaluation of the Integrated Care programme highlighted the robust governance arrangements in place to support decision making and management of risks. The Health and Wellbeing Board receive regular updates on integrated care as a key priority within the health and wellbeing strategy.

Providers and wider stakeholders continue to be engaged to discuss strategic commissioning intentions through engagement events and contract negotiations. Discussions focus on system impact and ensuring sustainability for both health and

social care services. For example we are currently developing a plan to integrate appropriate mental health services into Care Delivery Groups; this will ensure holistic care for citizens as well as safeguarding essential interventions.

Risks are managed through the Integrated Care / BCF Programme Board; impact of changing one part of the system on the rest of the system can be managed proactively by the multi-agency Board. For example, in agreeing the reduction in non- elective activity we have been able to give assurance that community capacity and operational processes are robust enough to manage the change in activity. Through the reporting of outputs from relevant work streams gaps and concerns could be addressed in a timely manner.

An overarching objective of the Integrated Adult Care Programme is to transform citizen experience of Health and Social Care provision in the City. Early engagement work within the programme informed the design of the key programme work streams and aims of the integrated care model. We will continue to engage throughout the implementation of the integrated care model using the sharing the vision model developed by colleagues in Nottingham City Council. In essence sharing the future is an approach which shares leadership, decision making, ideas and information, views and experiences with citizens. Further details are available in **document 12.** Additionally Healthwatch are represented at our HWB and BCF/Integrated Care Programme Board.

G Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

The investment in NHS commissioned out of hospital services, including social care is clearly set out in the summary and expenditure plan tabs of the BCF planning return template.

Our BCF Programme Board has considered a risk sharing arrangement for out of hospital services and concluded that it is not required at this time due to our strong working relationships and performance against the BCF non-elective activity metric in 2015/16.

The focus of our BCF plan has, and will continue to be on out of hospital services in the community to support the shift in activity, prevent avoidable admissions, facilitate system flow and improve person-centred co-ordinated care. The key work steams within our integrated care model are all focused on out of hospital services including social care and primary care. Our level of investment by scheme is summarised in the table below.

Scheme	Investment in NHS commissioned out of hospital services	
	2015/16 investment (£000)	2016/17 allocation (£000)
Access & Navigation	787	1,199
Assistive Technology	400	475
Carers	667	714
Capital (DFG)	N/A	N/A
Co-ordinated Care	1,349	1,144
Independence Pathway	7,672	7,341
Programme Management	166	305
City Total	11,041	11,178

H Agreement on local action plan to reduce delayed transfers of care (DTOC)

Across Nottingham Delayed Transfers of Care (DTOCs) are managed through the System Resilience Group (SRG) and monitored by the BCF Programme Board.

Work to reduce DTOCs across the system is led by the work stream two of the Urgent Care Programme Office which reports to the System Resilience Group. Links are established between SRIG and the BCF / Integrated care programme Board.

A system wide resilience plan has been developed which includes our approach to improving DTOCs. Providers in our system have produced a self-assessment of their impact change model for deducing DTOCs; this is included as **document 13.** The self-assessment was produced using a tool provided by the national Emergency Care Improvement Programme and identifies for each provider the “high impact” change they are implementing, progress to date, remaining tasks, timescales and identifies how we will know it has been successful.

We have used the information provided within the self-assessment to highlight the key findings about the progress to implement each high impact intervention for each provider; NUH; CityCare; Nottingham City Council Social Care :-

- Two of the three providers have identified that plans are in place to implement discharge planning with a commitment to fully implement these approaches by August 2016. The community services provider will be approached to confirm its plans for early discharge planning during Q1 16/17.
- Systems to monitor patient flow across each provider have been implemented with subtleties in the level of sophistication of these systems. A number of key tasks have been identified to improve these systems in early 2016/17 this includes a system wide consensus on the appropriateness of Medically Safe for Transfer (MST) decision and to ‘sign off’ the 120 delays.
- The acute provider has a multi-disciplinary multi-agency team in place to facilitate discharge; within the community multi-disciplinary locality based teams operate across the city with social care input.
- A system wide pilot has been implemented for six months to prove the concept of transfer to assess, there is full engagement across each provider and the CCG has oversight over the monitoring and develop of this pilot (along with the consequential impact on system flow and DTOCs). An external evaluation of this pilot has been commissioned; this will be used to inform the decision about extension of this approach.
- The acute provider have agreed to review 7 day working for the Supported Transfer of Care (STOC) team by the end of Q2 16/17. The urgent care and reablement services within the community already operate 7 days and through the community health & social care integration group (with BCF funding) the social care hospital discharge team will move to seven day working by Q3 16/17.
- Trusted Assessors is considered to be a mature approach in the acute provider; during 16/17 the community provider will continue to roll out its holistic worker competency framework and this will be trialled across adult social care.
- The leaving hospital policy is understood, but there is agreement that this needs to be implemented in a systematic and consistent way. This will be re-launched during Q1-Q2 16/17.

- Work to enhance health in care homes through the Care Homes Vanguard programme will be supported by each provider.

Work is also underway to develop a framework for measuring 'transfer of care' activity and performance, DTOCs will be a key feature of this. To support this we plan to:

- Conduct a local deep dive analysis into reasons for the recent increase in DTOCs across all providers, NUH, CityCare, Nottinghamshire Healthcare Trust and Community Health Partnerships recognising that the issues for individual providers may vary.
- Produce a local situation analysis which will include a review of interventions against national best practice.
- Co-produce with providers a local DTOC action plan for 2016/17 which supports the system wide action plan.

Our BCF Programme Board has considered a risk sharing arrangement for DTOCs and concluded that it is not required at this time due to our strong working relationships and need for local management at a System Resilience Group level.

6 Financial risk sharing and contingency

The 2015/16 BCF plan established a financial risk sharing mechanism that has operated successfully in the first year of the pooled fund. Our programme board has considered the need for a risk share agreement in 2016/17 in relation to NEA activity and DTOC activity and concluded that it is not required at this time due to strong working relationships and progress made during 2015/16.

We will continue to monitor performance against the NEA and DTOC targets on a monthly basis through the BCF Finance & Performance Group, reporting to the BCF & Integrated Care Programme Board and Commissioning Sub-committee of the Health & Wellbeing Board. This is in addition the CCG continuing to manage activity variances through contractual processes. CCGs hold both contingency and specific risk reserves based on calculated risk at plan stage, so these resources will be utilised should investment be needed for any mitigation or corrective action.

Mechanisms also exist and are built into provider contracts to manage and minimise the impact of any variation to the system. In addition, it is important to note that the schemes currently being implemented that focus on admissions avoidance have been developed across the health and social care community through the Integrated Care Programme. This has involved full engagement with community and local authority colleagues. Each scheme has its own set of risks which have been identified within the risk log alongside mitigating actions.

As part of our broader plans for integration and the move to full integration of health & social care by 2020 as outlined in the five year forward view we are exploring risk share arrangements for an adult pooled budget in future years.

Chief Officer Update

1. Sustainable Transformation Plans

NHS England has announced the footprints for Sustainability and Transformation Plans (STPs) along with the STP leaders. There are 44 STP areas across the country and NHS England has described the leaders as creating "broadly equal representation" from clinical commissioning groups and from hospitals and other providers of care, as well as some key figures from local authorities.

As indicated in the update to Health and Wellbeing Board members in January 2016, Nottingham City is part of the STP footprint which extends across Nottinghamshire (except for Bassetlaw) and covers a population of just over 1.1m. The leader of the Nottinghamshire footprint was announced as being David Pearson who is Corporate Director of Adult Social Care, Health & Public Protection for Nottinghamshire County Council.

Simon Stevens, chief executive of NHS England, has set out that STPs' success

"….will largely depend on the extent to which local leaders and communities now come together to tackle deep-seated and long-standing challenges that require shared cross-organisational action."

Stakeholders from across the health and social care community in Nottinghamshire and Nottingham City met at a workshop on March 19th to begin to identify key priorities. The priorities, along with a proposed governance structure, have to be submitted by 15th April in advance of final submission of the plan by the end of June.

2. St Mary's Medical Centre

A recent inspection by the Care Quality Commission (CQC) found that the St Mary's Medical Centre in Top Valley failed to meet expected standards. The practice has temporarily closed until further notice whilst necessary improvements are made. Patients registered with the practice are being advised to contact two other local surgeries if they need an appointment with a GP or practice nurse as the surgery cannot provide any appointments or prescriptions during the closure.

All patients registered with the practice have been sent a letter advising them of the temporary closure and signposting them to alternative practices. A recorded telephone message also provides this information should patients phone the practice, and there are notices displayed at the practice. Patients with queries or concerns can contact the Patient Experience Team at Nottingham City CCG by email (patientexperienceteam@nottinghamcity.nhs.uk) or by phone (0115 883 9570).

3. Nottingham University Hospitals NHS Trust Care Quality Commission Rating

Nottingham University Hospitals NHS Trust has been rated 'Good' overall by Care Quality Commission. The Trust was rated as outstanding in the well-led domain, and good in the caring, effective and responsive domains.

The Care Quality Commission's Chief Inspector of Hospitals, Professor Sir Mike Richards, said:

"Overall, Nottingham University Hospitals NHS Trust provides good care to the population it serves. The Trust can be proud of the services that it manages and we were impressed by most areas we visited. We found staff to be dedicated, kind, caring and patient focused. Overwhelmingly staff were positive about working at the Trust and they talked about being proud of their workplace, the facilities they had and about the care they delivered."

The Care Quality Commission found a strong safety culture across the Trust, including a good reporting culture for safety incidents and near misses. However, there were some concerns about some relatively localised staffing and specialist training issues which the Trust were aware of ahead of the inspection and will accelerate their action plans.

Dawn Smith
Chief Officer
Nottingham City CCG
March 2016