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

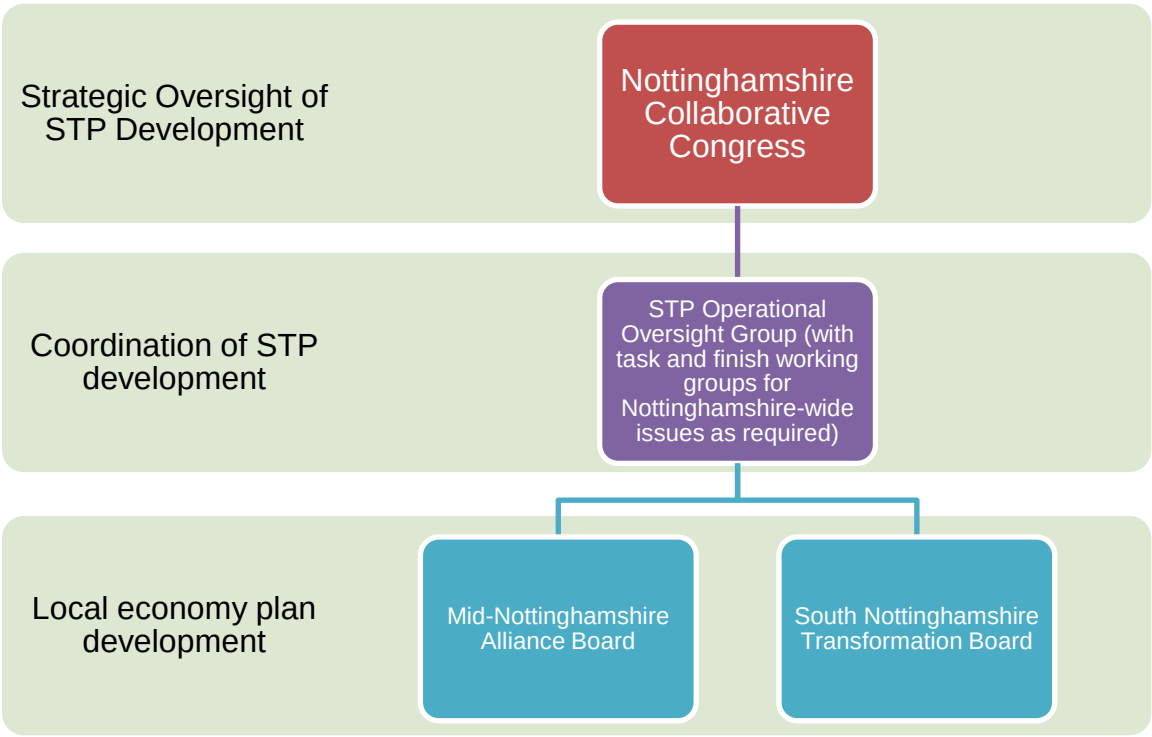
The Partners have also confirmed the need for a new philosophy based on:

- **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

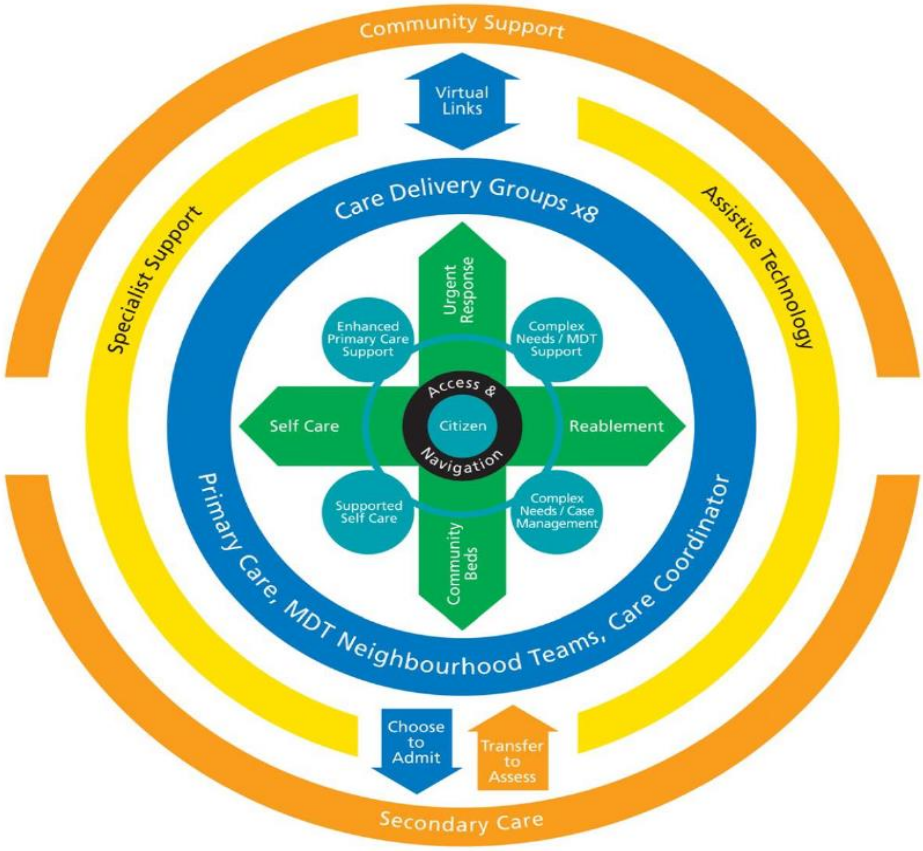
2.2 Better Care Fund (BCF)

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

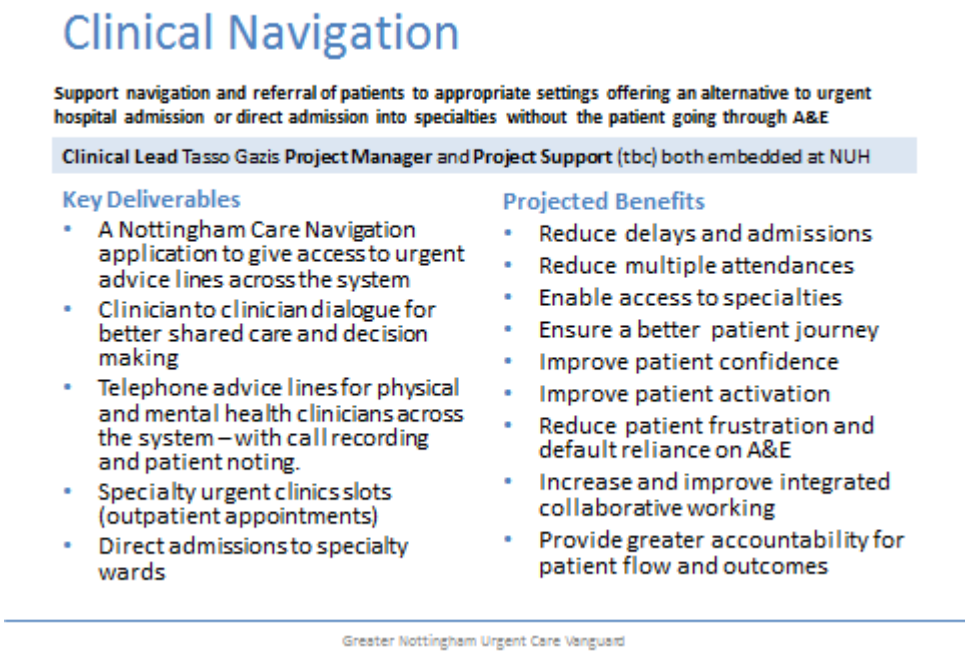
We have ambitious plans that will impact the whole of the system. Our experience and proven successes in partnership working will enable us to do this working across organisational structures, commissioners and providers together.

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.

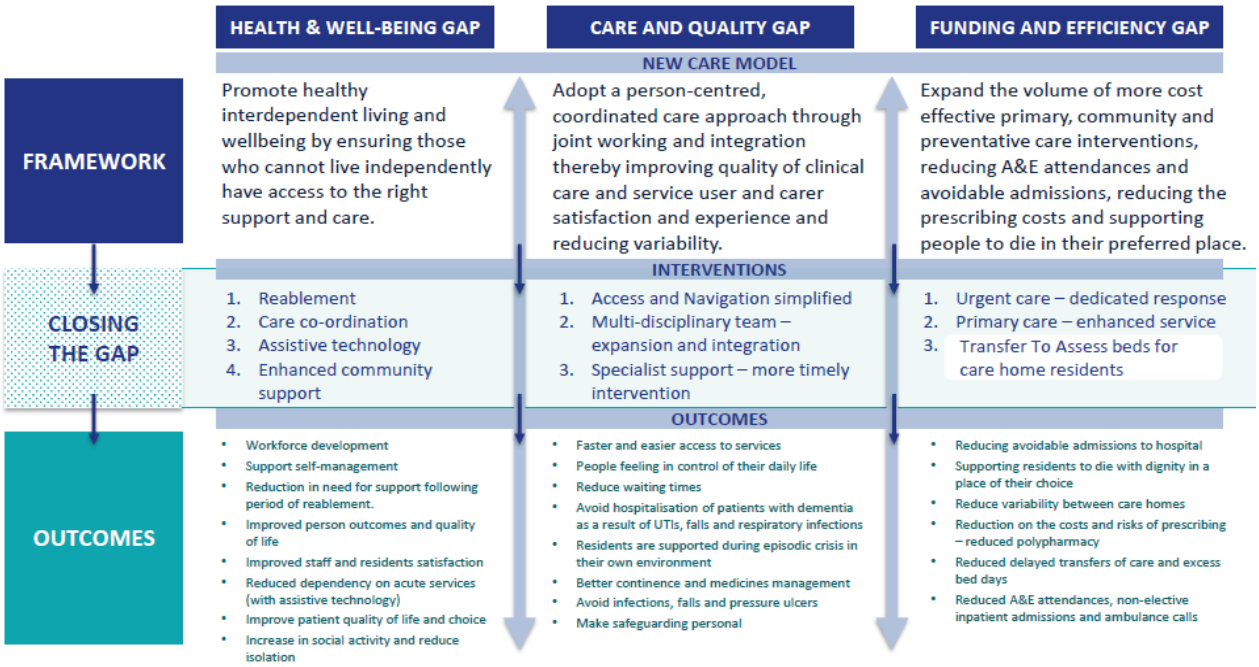
Care home residents have complex medical needs. The average resident has six diagnoses and takes eight medications. Currently, care homes residents are 0.5% of the city's population but account for 5% of all admissions to hospital. Many older people are cared for in hospital but best practice evidence 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.

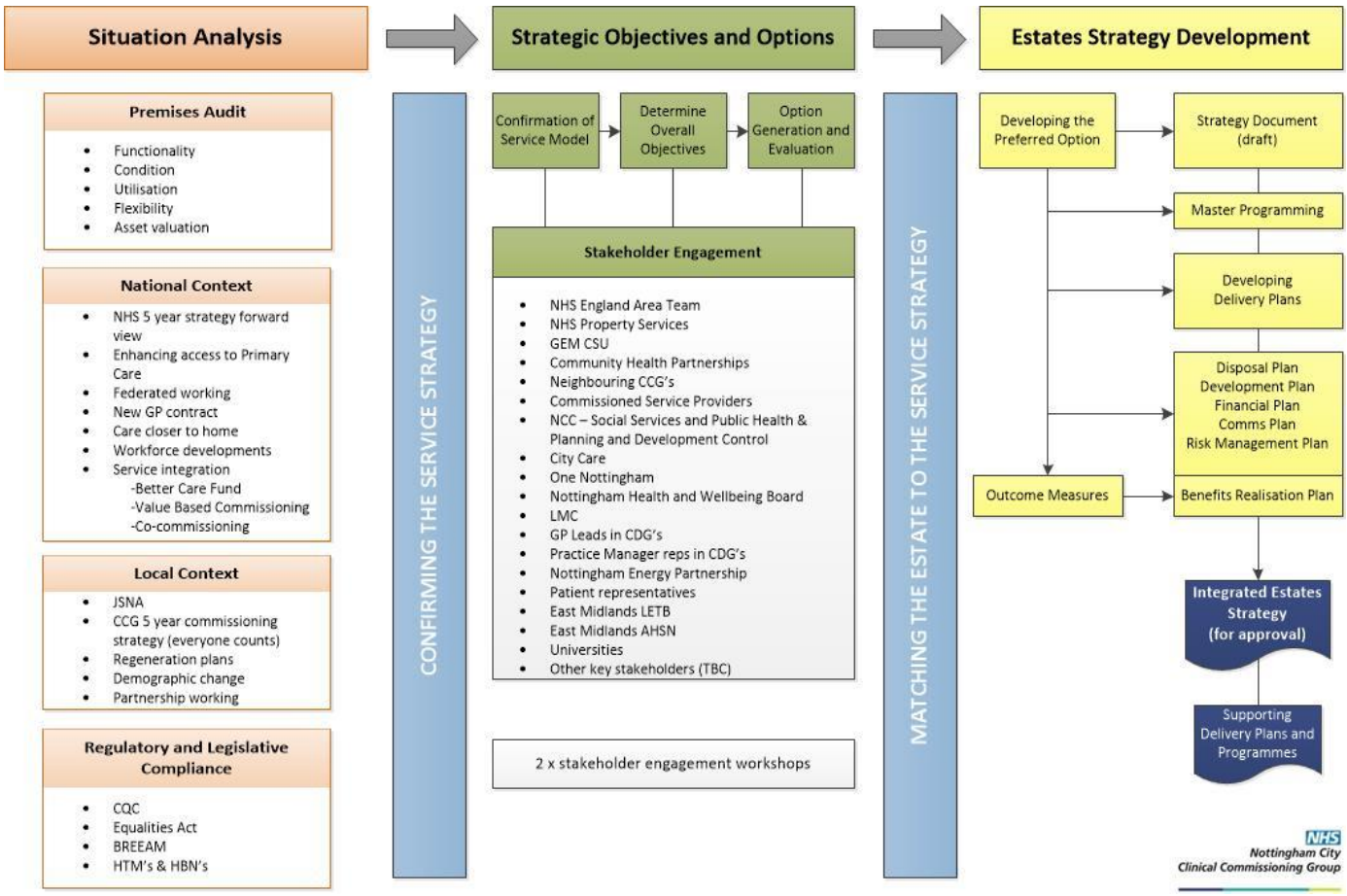
A key element of the Primary Care Vison is the CCG's member practices being aligned into 8 Care Delivery Groups (CDGs). The CDG model facilitates the establishment of productive

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.

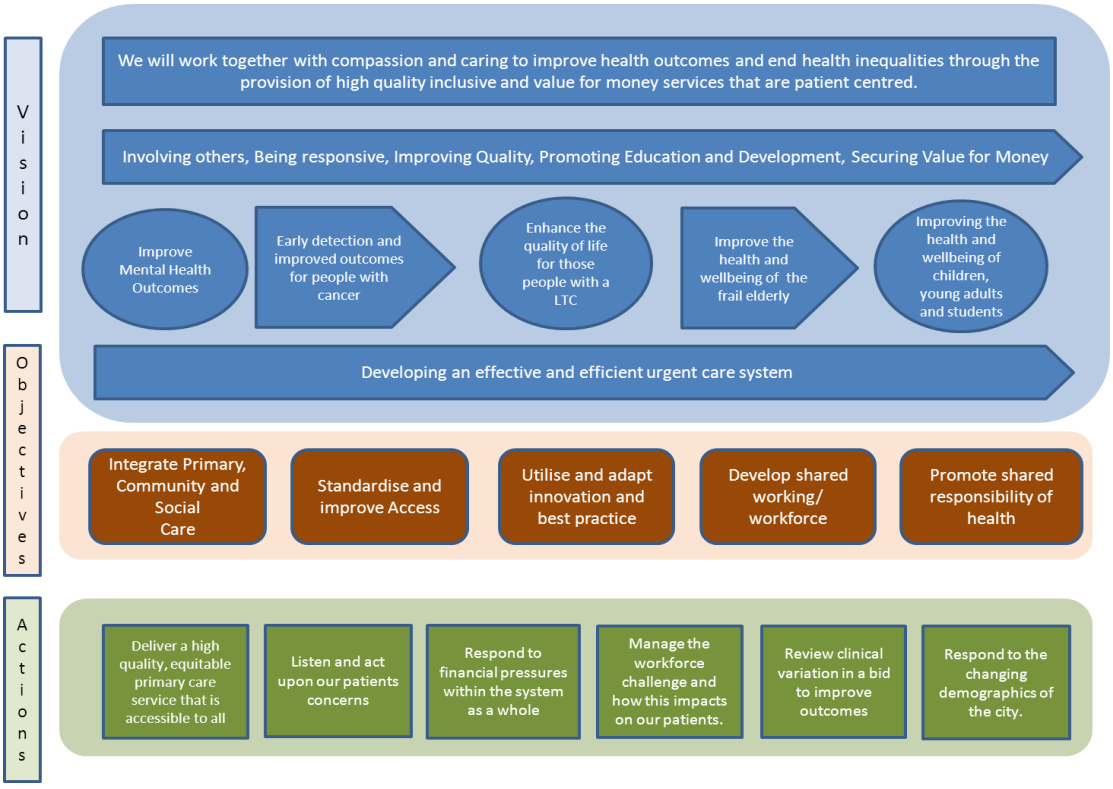
Workforce challenges are one of the top issues, in the East Midlands the workforce crisis for Primary Care is evident with 38% of training posts for the Vocational Training Scheme not being filled in 2015. Nottingham City has the highest percentage of GPs over 55years, the highest number of single handed 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.