Nottinghamshire County Council

Health and Wellbeing Board

Wednesday, 02 April 2014 at 14:00

County Hall, **County Hall, West Bridgford, Nottingham NG2 7QP**

AGENDA

NOTES:-

(1) The formal meeting of the Board will be followed by a workshop about adult mental health.

(2) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(3) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Members or Officers requiring clarification on whether to make a declaration of interest are invited to contact Paul Davies (Tel. 0115 977 3299) or a colleague in Democratic Services prior to the meeting.

(4) Members are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

Notes

(1) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(2) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

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Nottinghamshire County Council

minutes

Meeting	HEALTH AND WELLBEING BOARD
Date	Wednesday, 5 March 2014 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNTY COUNCILLORS

Joyce Bosnjak (Chair)
Kay Cutts MBE
John Peck
Muriel Wiesz
Jacky Williams

DISTRICT COUNCILLORS

Jim Aspinall – Ashfield District Council
Simon Greaves – Bassetlaw District Council
Jenny Hollingsworth – Gedling Borough Council
Pat Lally – Broxtowe Borough Council
Debbie Mason – Rushcliffe Borough Council
Tony Roberts MBE – Newark and Sherwood District Council
Phil Shields – Mansfield District Council

OFFICERS

A	David Pearson	-	Corporate Director, Adult Social Care, Health and Public Protection
	Anthony May	-	Corporate Director, Children, Families and Cultural Services
	Dr Chris Kenny	-	Director of Public Health

CLINICAL COMMISSIONING GROUPS

	Dr Steve Kell	-	Bassetlaw Clinical Commissioning Group (Vice-Chairman)
	Dr Judy Jones	-	Mansfield and Ashfield Clinical Commissioning Group
	Dr Mark Jefford	-	Newark & Sherwood Clinical Commissioning Group
A	Dr Guy Mansford	-	Nottingham West Clinical Commissioning Group
	Dr Paul Oliver	-	Nottingham North & East Clinical Commissioning Group
	Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group

LOCAL HEALTHWATCH

A	Joe Pidgeon	-	Healthwatch Nottinghamshire

NHS ENGLAND

A	Helen Pledger	-	Nottinghamshire/Derbyshire Area Team, NHS England

NOTTINGHAMSHIRE POLICE AND CRIME COMMISSIONER

Vacancy

SUBSTITUTE MEMBERS IN ATTENDANCE

Tracy Gaskell	-	NHS England
Claire Grainger	-	Healthwatch

OFFICERS IN ATTENDANCE

Kate Allen	-	Children, Families and Cultural Services
Paul Davies	-	Democratic Services
Geoff Hamilton	-	Children, Families and Cultural Services
Cathy Quinn	-	Public Health

ALSO IN ATTENDANCE

Lucy Dadge	-	Director of Transformation, Mansfield and Ashfield CCG
Linda Syson-Nibbs	-	NHS England
Sam Walters	-	Nottingham North & East Clinical Commissioning Group

MINUTES

The minutes of the last meeting held on 5 February 2014 having been previously circulated were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Joe Pidgeon and Helen Pledger.

Councillor Kay Cutts had been appointed in place of Councillor Martin Suthers, for this meeting only.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

APPROVAL OF THE HEALTH AND WELLBEING STRATEGY

Cathy Quinn introduced the draft Health and Wellbeing Strategy, which had been prepared after three months of consultation, and discussion in the Health and Wellbeing Workshop on 4 December 2013. Appended to the report, as well as the draft Strategy itself, were a summary of consultation responses and the draft Delivery Plan, which gave more detail of how the strategy would be delivered. She drew attention to an additional recommendation to authorise the Health and Wellbeing Implementation Group to agree and monitor the Delivery Plan on behalf of the Board.

Comments by the Board included:

- Some of the documents were early drafts, with typing errors. Some of the wording was weak or confusing. Consecutive page numbering would be helpful.

- There should be mention of support to victims of domestic violence, and to residential care for people with dementia.

- Long term conditions were combined. Defining anyone over 65 as elderly did not reflect the trend for people to develop age-related conditions later in life.

- The Nottinghamshire Strategy was unusual in its breadth. It was therefore important to prioritise, and for the Board to be consulted on some commissioning plans.

- There was insufficient recognition of the district council contribution to health and wellbeing.

In response, it was explained that was an over-arching strategy, focussing on priorities. Most of the comments by the Board related to the detailed Delivery Plan, of which the Board had an early draft. The Delivery Plan would cross-reference to other strategies, and cover integration issues in some detail. In order to make the Strategy itself readable, its language had been kept simple. The Board was reminded that commissioning organisations themselves were responsible for commissioning decisions. It was agreed the bring the Delivery Plan, as revised by the Implementation Group, back to the Board in July.

RESOLVED: 2014/012

1. That the final Nottinghamshire Health and Wellbeing Strategy for 2014-17 be approved.

2. That the Health and Wellbeing Implementation Group develop the Delivery Plan for approval by the Board in July 2014.

CLINICAL COMMISSIONING GROUPS' FIVE YEAR PLANS 2014-19

Dr Paul Oliver introduced a presentation on the preparation of the CCGs' five year strategies. Early drafts of the strategies were included in the presentation. The CCGs had formed three units of planning, covering south and mid Nottinghamshire

and Bassetlaw. The Board's comments were invited, as part of the engagement process about the plans. It was intended to bring the strategies back to the Board after the consultation period. Comments included:

- A lack of detail in the plans, and little time for Board members to consider them as they had not been circulated before the meeting. - Detail would be developed over the next few months. The role of the Board at this stage was to assess whether the direction of travel complied with the Health and Wellbeing Strategy.

- Lack of reference to district councils. – District councils would be involved in the next stages of work, and in delivery of the plans.

- The shared values in the Bassetlaw plan were seen as pivotal.

- How did CCGs share good practice? - The ten CCGs reporting to the Derbyshire/Nottinghamshire Area Team were sharing good practice and rolled out projects which had proved to be of value. This was a suggested as a possible theme for a stakeholder network event.

RESOLVED: 2014/013

That support be given to the direction of travel demonstrated in the draft CCG five year plans.

INTEGRATED COMMISSIONING ARRANGEMENTS FOR CHILDREN'S HEALTH SERVICES: PROGRESS AND PROPOSED PRIORITIES 2014-16

Anthony May and Kate Allen introduced the report which updated the Board on the work of the Children's Integrated Commissioning Hub and sought approval for the Hub's priorities for 2014-16. They invited comments on the report, which included:

- Support for the review of Child and Adolescent Mental Health Services (CAMHS). – It was indicated that early attention was being given to CAMHS, following comments made at the workshop about CAMHS on 5 February.

- Would there be links to the CCGs' commissioning plans? – Appropriate links would be made.

- The active engagement of children and young people was welcomed, but should be coordinated with the engagement activities of other organisations such as Healthwatch.

- The plans for the Commissioning Hub could be more ambitious. – The intention was to prove the value of the Hub first.

RESOLVED: 2014/014

1. That the progress of the integrated commissioning arrangements for children's health services in Nottinghamshire be noted.

2. That approval be given to the proposed work priorities for the Children's Integrated Commissioning Hub for the two years, April 2014 - March 2016.

CHILDREN AND YOUNG PEOPLE'S HEALTH AND WELLBEING: LOCAL IMPLICATIONS OF THE CHIEF MEDICAL OFFICER'S ANNUAL REPORT

Anthony May and Geoff Hamilton introduced a report on the Chief Medical Officer's (CMO) annual report, which this year had focussed on services for children and young people. The report considered local implications and local responses to the CMO's findings, and identified the next steps to be taken. Board members commented on aspects of the report, including the emphasis on sport and fitness, child sexual exploitation, alcohol misuse and poor services for children who were wheelchair users. It was suggested that there be a report to the Board on the latter.

RESOLVED: 2014/015

1. That the findings and implications of the Chief Medical Officer's annual report in relation to local efforts to improve health and wellbeing outcomes for children, young people and families be noted.

2. That a local adolescent public health strategy be prepared for consideration by the Board, as suggested on page 7 of the report.

3. That a report be presented to a future meeting of the Board on services for children and young people who use wheelchairs.

ARRANGEMENTS FOR NATIONAL IMMUNISATION PROGRAMMES AND UPDATE ON MEASLES, MUMPS AND RUBELLA CATCH-UP PROGRAMME

Linda Syson-Nibbs introduced the report on immunisation programmes in Nottinghamshire. She emphasised the importance of reaching the targets for immunisations, in order that the populations would have "herd immunity". In response to questions, she stated that NHS England was satisfied with progress locally; that figures for Bassetlaw were reported to the South Yorkshire Area Team; that there was no requirement to report the immunisation of carers or care workers; and that take-up by Health Service workers could be better. It was pointed out that surgeries were not allowed to give vaccinations to their own employees.

RESOLVED: 2014/016

1. That the arrangements for commissioning national immunisation programmes for Nottinghamshire County were noted.

2. That the uptake rates for MMR vaccination in Nottinghamshire County be noted.

LEARNING DISABILITY SELF ASSESSMENT FRAMEWORK

The report showed performance in Nottinghamshire in a range of services for people with learning disabilities, giving particular attention to areas of good performance or where there was scope for improvement.

RESOLVED: 2014/017

1. That the report be noted.

2. That agreement in principle be given to a joint action plan to ensure improvement in areas currently scoring red or amber in the self-assessment, with the priority in 2014/15 being on the red areas; actions to be monitored with the help of the Better Health Group.

IMPROVING HEALTH AND PATIENT CARE THROUGH COMMUNITY PHARMACY – A CALL TO ACTION

The report invited comments on NHS England's Call to Action for Community Pharmacy.

RESOLVED: 2014/018

That Board members submit any comments on the Call to Action to Cathy Quinn by 17 March 2014, with a view to preparing a response for the Chair to send on behalf of the Board.

WORK PROGRAMME

RESOLVED: 2014/019

That the work programme be noted, subject to the inclusion of reports on

- CCG five year commission plans – final versions
- services for children and young people who use wheelchairs
- development of a local adolescent public health strategy
- period report on activities of the Health and Wellbeing Implementation Group

The meeting closed at 4.25 pm.

CHAIR

Nottinghamshire County Council

Report to the Health and Wellbeing Board

2 April 2014

Agenda Item: 4

REPORT OF THE CORPORATE DIRECTOR FOR ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION AND CLINICAL LEAD, NHS NOTTINGHAM NORTH AND EAST CCG

BETTER CARE FUND – FINAL PLANS

Purpose of the Report

1. To seek approval for the final version of the two year operational plans for the Better Care Fund (BCF) for 2014/15 and 2015/16 to be submitted to NHS England.

Information and Advice

2. At its meeting on 5 February 2014, the Board considered the draft Better Care Fund plans before their submission to the NHS England Area Team.

3. Subsequent discussions determined that there was scope to strengthen to the narrative section of the submission. This was carried out with the agreement of the local planning groups, and the updated draft plans were submitted following consultation with the Chair and Vice Chair of the Board.

4. The draft plans were strengthened by:-

- Describing the approach being taken to build a strong evidence base for BCF schemes contributing to the proposed outcomes and metrics, to provide confidence that the performance improvements required are achievable from the investments proposed.
- Providing details of the range of schemes under development but not included in the BCF plan, particularly in the South, that should further contribute to meeting the proposed outcomes and metrics
- Updating the plan to reflect the completed consultation phase of the Health and Wellbeing Strategy, and how this supports the overall vision for integrated care
- Stating that a county-wide communications and engagement approach will be developed if necessary to support implementation of the plan Clarifying detailing related to Mid-Notts Intermediate Care Team investments to explain that while the costs will be in 2015/16, the bulk of financial benefits are not expected to materialise until 2016/17
- Confirming in principle that the BCF plans address the implications of Care Bill implementation (estimated at £2m for Nottinghamshire)

5. Since submission on 14 February, the draft plans have undergone an assurance process conducted by the Area Team and the Local Government Association (led by John Sinnott, Chief Executive of Leicestershire County Council).

6. The BCF Working Group (whose members include representatives from the County and District Councils, CCGs, NHS England and NHS provider trusts) has continued to meet. Comments made during the assurance process have been incorporated in the plans, which are presented for approval by the Board today.

7. In summary, the recent changes are:

   - Detailed assessment of the impacts of the BCF plan on individual providers, including reference to methods of continuing engagement and the empirical approach being applied to assess financial and activity shifts
   - A detailed and coordinated plan for 7 day services to augment the commentary on approach
   - A review of performance metrics, supporting data quality and the level of ambition, as well as adding local definitions of the patient/service user experience metric
   - Further detail in relation to the proposed governance arrangements for the pooled budget and contingency funds
   - A stronger link to the financial commitment to protecting social care services in the narrative
   - Further clarification on the role of the Accountable Professional
   - A clearer implementation plan for adoption of the NHS number
   - Details of other schemes in place or under development that will be additionally supporting achievement of BCF outcomes and metrics

Changes regarding penalties for failing targets

8. The Government has recently indicated a change in its approach to areas which fail to meet their BCF targets. As originally announced, BCF funding in 2015/16 would be dependent on performance in 2014/15.

9. The Care Minister, Norman Lamb MP has announced that there will be no longer be penalties in 2015/16. Instead, the Department of Health, NHS England and Local Government Association will offer support to improve performance. This change has not been confirmed formally at the time of writing this report.

Reason/s for Recommendation/s

10. To meet the Department of Health requirement for the Health and Wellbeing Board to approve the plans before submission.

Statutory and Policy Implications

11. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are

described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Implications for Service Users

12. It is expected that integrated systems will improve the service user journey and experience. Work will need to be done to assess the impact on existing service provision to ensure any redirection of resources is not detrimental.

Financial Implications

13. Alongside the completion of the plan and its priorities, detailed work has been undertaken to consider the impact of the proposed pool upon existing services, and the sharing of risk. While many of the revenue funding streams are currently committed to core services and assist with pressures in base budgets, the capital allocations are currently the subject of grant conditions and dedicated to one purpose, so the consequences of any dis-investment proposals will need to be considered carefully. For example Disabled Facilities Grants (DFG) are dedicated for use to fund major adaptations in privately owned property and any reduction would have an impact on the availability of grants for this purpose.

Equalities Implications

14. Equality issues will be taken into account as part of the planning process undertaken in the working group. Better integration of services should mean that people receive a more consistent service across the county.

RECOMMENDATION

That the Board

1. approves the final Better Care Fund plans for 2014/15 and 2015/16 for submission to the NHS England Area Team.

DAVID PEARSON
Corporate Director for Adult Social Care, Health and Public Protection
DR PAUL OLIVER
Clinical Lead, NHS Nottingham North and East CCG

For any enquiries about this report please contact:

Lucy Dadge, Director of Transformation
lucy.dadge@mansfieldandashfieldccg.nhs.uk / 01623 673330.

Constitutional Comments (SG 24/03/14)

15. The Board is the appropriate body to consider the matters set out within this report.

Financial Comments (KAS 26/03/14)

16. The financial implications are contained within paragraph 13 of the report.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

None

Electoral Division(s) and Member(s) Affected

All.

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Nottinghamshire County Council**
Clinical Commissioning Groups	**Bassetlaw**
	Mansfield and Ashfield
	Newark and Sherwood
	Nottingham North and East
	Nottingham West
	Rushcliffe
Boundary Differences	**There is a 2.7% population difference between the Local Authority and CCG boundaries. This small figure is not expected to impact significantly on delivery of this Better Care Fund (BCF) plan.**
Date agreed at Health and Well-Being Board:	**02/04/2014**
Date submitted:	**04/04/2014**
Minimum required value of ITF pooled budget: 2014/15	**£16,100,000**
2015/16	**£54,905,000**
Total agreed value of pooled budget: 2014/15	**£33,971,484**
2015/16	**£59,464,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Bassetlaw
By	Phil Mettam
Position	Chief Officer
Date	21/03/2014

Signed on behalf of the Clinical Commissioning Group	Mansfield and Ashfield
By	Amanda Sullivan
Position	Chief Officer
Date	21/03/2014

Signed on behalf of the Clinical Commissioning Group	Newark and Sherwood
By	Amanda Sullivan
Position	Chief Officer
Date	21/03/2014

Signed on behalf of the Clinical Commissioning Group	Nottingham North and East
By	Sam Walters
Position	Chief Operating Officer
Date	21/03/2014

Signed on behalf of the Clinical Commissioning Group	Nottingham West
By	Oliver Newbould
Position	Chief Operating Officer
Date	21/03/2014

Signed on behalf of the Clinical Commissioning Group	Rushcliffe
By	Vicky Bailey
Position	Chief Officer
Date	21/03/2014

Signed on behalf of the Council	Nottinghamshire County Council
By	David Pearson
Position	Corporate Director, Adult Social Care, Health and Public Protection
Date	21/03/2014

Signed on behalf of the Health and Wellbeing Board	Nottinghamshire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Joyce Bosnjak
Date	02/04/2014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Engaging with a range of stakeholders across the health and social care economy is critical to the success of delivering integrated care in Nottinghamshire. Plans have been developed in partnership across the county, with commissioners and providers working jointly.

An Operational Planning Event for the BCF plan was held in early December 2013, with providers attending, where it was agreed that provider representatives would join the BCF Local Planning Groups in developing a plan for integrated care as part of our resolute commitment to co-developing our plans for integrated care alongside providers.

Our comprehensive engagement process has so far included borough and district councils, acute providers, community services, the independent sector (including care homes), mental health, voluntary organisations, and the East Midlands Ambulance Service (EMAS).

A county-wide consultation between health and social care has also been concluded, including providers and all key stakeholders, regarding budget cuts required by the County Council and the potential impact upon them of any reduction in funding arrangements. The results were presented to elected members, and plans agreed by the Council in late February. The development of our BCF plan has been fully cognisant of these plans.

The Nottinghamshire Health & Wellbeing Strategy underwent consultation between June to September, and was agreed by the Health and Wellbeing Board in March, and the final delivery plan will be agreed by the Health and Wellbeing Board in July 2014. A stakeholder event was also held in December 2013 to ensure the emerging strategic objectives took account of local plans and pressures.

There have also been significant and on-going provider engagement programmes at locality level, all ensuring providers are not just kept abreast of plans, but are actively involved in designing the local integrated care programmes. These include:

- The North Nottinghamshire Urgent Care Working Group and Integrated Care Board, engaging clinical and non-clinical members at a senior level
- The HWB Stakeholder Network and Living at Home Programme to engage with providers and patient representatives in North Nottinghamshire, with further events planned as the Strategic Priorities develop
- The Mid-Nottinghamshire 'Better Together' Transformation Programme care design group process, which engaged local clinicians, care professionals, and patients to design a blueprint for future service delivery in a challenging health economy
- A communications forum where communications leads from each organisation involved in the Mid-Nottinghamshire 'Better Together' programme meet on a monthly basis to review the ongoing communications required
- The Greater Nottingham's Vision for Integrated Care (covering South Nottinghamshire), working together with providers to improve quality, outcomes and drive cost efficiencies
- The Strategy and Implementation Group for Nottinghamshire South (SIGNS) with a focus on Frail Elderly – a group of commissioners and providers to set the

strategy for frail older people across Greater Nottinghamshire boundaries and oversee its implementation

- The South Nottinghamshire Transformation Board oversees and is accountable for the delivery of the South Nottinghamshire Transformation Programme, with the aim of improving the way care is delivered to citizens, patients, and carers through service redesign and integration
- The Bassetlaw Integrated Care Board has been mobilised as part of BCF implementation in North Nottinghamshire
- South Nottinghamshire's local planning group for the BCF includes a representative of Circle (Independent Sector Provider) as well as the main acute provider NUH

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our vision of integrated care is important, but it is how outcomes are met and experienced by the citizen that really matters. Nottinghamshire's plan for integrated care has therefore been designed with the needs of the citizen at its core. In this vein, we have deliberately implemented all engagement activity at locality level, based on prior experiences on how to best achieve deep and impactful engagement. A further county-wide communications and engagement approach will be developed if necessary as the BCF schemes are implemented.

The following is a flavour of the range of communication and engagement activity being used locally to facilitate on-going and meaningful dialogue with patients, service users, carers, and the public to ensure that the patient and public voice is fully embedded within the development of the integrated care programmes across the county:

South Nottinghamshire

From September 2013 onwards, the three South Nottinghamshire CCGs and Nottingham City CCG have carried out a large-scale Call to Action engagement exercise to involve patients, the public and partners in how the NHS should respond to meet the challenges of the future. There have been more than 40 events and this significant engagement with a wide range of individuals with different experiences of health and social care has helped inform the debate as to how health and social care services can make bold change. At the end of January, one such exercise engaged over 130 patients.

Mid-Nottinghamshire

In Mid-Nottinghamshire, service users and the public contributed to the Better Together blueprint, and service users were also involved in the clinical design groups. The case for change and the outcomes from the workstreams are now being tested with a wider service user and public audience. A brand has been created for the Better Together programme, accompanied by a public website, as well as social media accounts, and four outreach events have already been held.

North Nottinghamshire

As part of the development of its five year strategy, Bassetlaw CCG has been undertaking a review of all the patient and public feedback it has received during the last year. This includes feedback that has been received through partner organisations such as providers, local authorities and voluntary organisations. It includes informal feedback and comments as well as the output of more formal engagement activities and events. The feedback has been mapped against priority areas to establish what is already known about people's views. This exercise enabled us to share learning across the planning area, especially where feedback on one particular service or experience is more widely relevant. The next stage in this process is for commissioning leads to review the existing information and identify key areas where they would like more detailed feedback to develop an engagement framework. This framework will link directly to the plans for the BCF and will be used to inform proposals throughout the BCF period.

Patient representatives across the county have also been engaged in the development of the plan through the HWB Stakeholder Network. Healthwatch are also represented on our Health and Wellbeing Board, as well as the South Nottinghamshire Transformation Board. This Transformation Board is co-chaired by a lay member (who is also a patient), and is supported by a Citizen Panel made up of patient representatives from all 12

organisations involved. In a similar vein, a member of the Citizen Board advises the Mid-Nottinghamshire Transformation Board.

There are more engagement plans beyond this submission as our BCF work develops. The county-wide imperative is to ensure that the outcomes from all of the above communications and engagement sessions inform Nottinghamshire's integrated care plans, and are adequately reflected therein.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
01: Planned Schemes	A table of planned schemes to be implemented under each of our overarching BCF themes
02: 7 Day Services Mapping and Aspirations	Details of Nottinghamshire's 7 day service status and aspirations
03: Bassetlaw – A community of Care and Support	An overview of Bassetlaw's plans for integrated care
04: Mid-Nottinghamshire NHS Integrated Care Transformation Programme – Presentation to the Nottinghamshire County Council Health and Wellbeing Board	Outlines a blueprint for a safe and sustainable health and social care economy for Mid-Nottinghamshire
05: South Nottinghamshire Integrated Care – Benchmarking and Better Care Scheme Analysis	A high-level view of the benefits that may be associated with South Nottinghamshire's BCF schemes
06: Greater Nottingham's vision of integrated care for older people	Includes details of the South CCGs' work on integrated care for older people

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The overall vision is that people living in Nottinghamshire will be enabled to take control of their health and independence through convenient access to timely and joined up services that maximise wellbeing. This is a shared vision, and steps have been taken across Nottinghamshire to transition towards this patient-centric model of health and social care. What matters most to commissioners and providers are the improvements we make together for the benefit of patients and service users by optimising choice, where possible.

The Nottinghamshire Health and Wellbeing Strategy has now been completed, and a final strategy approved by the Health & Wellbeing Board in March 2014, and a delivery plan is now being concluded. The consultation undertaken between June and September 2013 outlined and fully supported three key principles, reflecting our overall vision:

- Prevention and Early Intervention – to reinvest earlier in pathways to help prevent future problems
- Supporting Independence – assisting people to retain their independence, improve their own health and wellbeing, and reduce the need for traditional services
- Promoting Integration across partners – to provide strong leadership across partners to join up services and deliver consistent messages on key issues

This vision for integrated care combines county-wide transformation with locally tailored services where appropriate. There are a number of interventions that will act across the county to provide large scale transformation for our citizens. However, we also understand the importance of local ownership and so our strategic approach is tailored to the specific needs and challenges of each region. All of these schemes are underpinned by a focus on improving independence and control through personalisation of care.

We have well-aligned 5-year integration plans across the county to this effect (outlined below), all underpinned by the principle of health and social care services being jointly funded, jointly commissioned, and jointly provided, wherever possible. There is a great deal of commonality around these integration plans centred around an unwavering commitment to, accountability for, and delivery of truly seamless and joined up care within the joint resources available:

- Services will be preventative, proactive and focus on anticipatory care
- Patients will have equitable access to the care that they need regardless of where they live
- Patients will be at the centre of their care, with health and social care professionals working closely together, with patients, and with carers to meet jointly identified and agreed needs and goals
- Care will be proactive and focus on those patients at highest risk to prevent crisis and reduce the need for unnecessary admission to hospital and long-term care
- Wherever possible, care will be delivered in the patient's own home, with care in a

hospital or care home only when absolutely necessary
- Mental health services will meet our citizens' needs and expectations, and be delivered through an integrated approach

By focusing on supporting patients' post-acute illness (reablement, maintenance, and independence), mental health services, care home and specialist accommodation for older people, care for the elderly in the community, and the urgent care system, we aim to redesign intermediate care offered in the patient's own home to be more flexible, and consequently reduce the number of acute and mental health patient beds.

Our services will all look radically different to patients and service users as outcomes will place them at the centre of seamlessly delivered, well co-ordinated Health and Social care services. These outcomes will include a strong drive towards improving alternative forms of support to self care and an integrated direct payment and health care budget to allow people to experience outcomes which are truly person centred and flexible improve their aspirations to maintain control, choice and independence. This can only be achieved through a resolute focus on patients, services, and resources.

In short, integrated care in Nottinghamshire will bring the experience of our citizens to the forefront of everything we do. Through these interventions, we will tackle the growing pressures of ageing populations and increasing numbers of people with complex, long term conditions by radically challenging how health and social care currently work. We will build resilience by enabling people to be real partners in their own physical and mental health, moving from a dependency model to one of co-production, treating citizens as people – not cases.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our aim is to create a new and sustainable model of care that will deliver a greater proportion of health and social care services outside acute hospital settings, with care professionals working seamlessly across organisational and professional boundaries. This will create a community of care and support across Nottinghamshire to provide person centred co-ordinated care for older and younger adults by radically changing the way health and social care work together.

We are committed to improving outcomes for service users and patients, and improving user experience of health and social care from the Local Authorities and the CCGs working together to shape sustainable health, social care and housing requirements to deliver the national vision of fully integrated health and social care by 2018.

Our joint objectives are:

- Reduce avoidable admissions (to both hospital and long-term care) and facilitate discharges to reduce all delays as well as DTOCs (Choose to Admit and Transfer to Assess)
- Care provided wherever possible in the person's own home (Choose to Admit and Transfer to Assess)
- Improved outcomes for people (Support to Thrive)
- Maximised use of health and social care resources (Support to Thrive, Choose to Admit and Transfer to Assess)
- An integrated strategic commissioning approach to community provision (including appropriate housing solutions)
- Helping people to be enabled in living independently with risk, through education and awareness
- An integration programme that responds to the wider strategic landscape of the BCF, Integrated Health and Social Care: Our Shared Commitment, the Care Bill, the Local Authority's and County CCGs' wider strategic priorities (especially reducing avoidable admissions and facilitating discharges and reliance on acute care), and the NHS "A Call to Action".

We will measure these through robust jointly agreed KPIs, which reflect the needs, aspirations, and values of those for whom the services are designed. Our measures of health gain will be devised through a process of integrated partnership to engage with the desired outcome measures of stakeholders. They will specifically relate to:

1. Satisfied Patients
   - Qualitative and quantitative analysis of patient experience

2. Motivated and positive staff
   - Staff questionnaires, training, and development
   - Proportion of WTE working in services

3. Outcomes
   - Mortality and morbidity rates
   - Case management of long term conditions
   - Proportion of people entering long term care
   - Patients managed in community bed services
   - EOL plans in place/Preferred place of death
   - Suitable housing options

4. Financial Management
   - A reduction in acute bed capacity through the increase in community bed/at home places
   - Information and advice to self-funders
   - Unplanned admissions
   - Delayed transfers of care
   - Readmission rates

1. Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The schemes developed across the county to support delivery of the BCF aims offer the opportunity to address immediate pressures on services and lay foundations for a much more integrated system of health and social care delivered at scale and pace. The schemes have been developed in line with the Nottinghamshire Joint Strategic Needs Assessments, the Health and Wellbeing Strategy, as well as being prioritised through CCG/Local Authority commissioning plans.

All localities have sought to build a strong evidence base for both the clinical changes being proposed and the impact that these changes were forecast to have on the health economy.

In North Nottinghamshire, review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group (e.g. Integrated Care Board / Urgent Care Strategy Group) for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies and the use of specialist analytical software where appropriate. Consultation activity on the five year plan will also inform progress.

The Mid-Nottinghamshire process has been split into a number of phases. The first of these developed a 'case for change' (or Blueprint) for the health economy, outlining strategic options for improvement. Following this a 'detailed design' was undertaken for each of the options set out in this Blueprint. This approach involved:

- Care design groups, involving both primary and secondary clinicians from across the health and social care economy, were used to detail how the future service would differ from the one currently in place. These also identified the patient groups that would be impacted by the changes proposed.
- Desk-based research was carried out considering where similar schemes had been implemented or proposed elsewhere. The impacts of these schemes were then compared against those proposed by clinicians in Mid-Nottinghamshire.
- Detailed analysis was then carried out, combining the evidence from the care design groups and desk-based research, to quantify the impacts both in terms of activity and financial costs/benefits. The methodology and results of this analysis were fed back to clinicians throughout the process to ensure that it correctly modelled the schemes proposed.

The outputs of the 'detailed design' phase of work were a number of proposal documents, which are now publically available, detailing the evidence base described above.

Significant work is also underway across South Nottinghamshire, utilising an integrated health and social care commissioning approach to plan over the next 5 years how the commissioning investments can be best configured to produce a more effective integrated commission model. The CCGs' commissioning plans will include monitoring and evaluation of access to 7 day GP services and the implementation of personalised care plans co-ordinated by GPs. This will be developed from national evidence and local evaluation using the Collaboration for Leadership in Applied Health Research and Care (CLAHRC) to support this process. Other commissioning intentions for community based health services have been developed following reviews of current service provision and associated investments. This work will be supported via the Transformation Programme.

The schemes selected for inclusion in our BCF plan for Nottinghamshire are therefore those that we believe will contribute to the proposed outcomes and metrics, and help us to meet the National Conditions. These schemes are broadly defined across six themes:

7 Day Service Provision and Access
These schemes work to avoid admissions to A&E services and facilitate timely discharges, through developing an increase in flexibility across GPs, community providers, and assessment health and social care functions 7 days per week. These services will ensure appropriate community services are available to reduce the requirements on the acute sector.

The success factors are:

- Reduction in avoidable admissions
- Reduction in delayed transfers of care
- Reduction in admissions to long term care
- Decrease in use of residential settings for intermediate care and rehabilitation
- Care at the right time and place
- Reduction in the number of people attending A and E/Walk in Centre services

Supporting Integration
Making integrated care happen is challenging. Well-developed integrated services for older people deliver seamless services improving quality of outcomes for people, improved efficiencies of health and social care resources, decrease avoidable admissions, and facilitate discharges. These schemes will support shared leadership, as well as development and understanding of innovative new partnership ways of working between providers and commissioners. In turn, this will enable us to identify service users and groups where integrated care benefits are greatest, use integrated care resources flexibly, share information, and develop innovative approaches to skill-mix and staff substitution of across health and social care. The schemes will deliver a range of programmes designed to embed an integrated approach to managing the transformation necessary in the delivery of health and social care services, against an increasing demographic and a diminishing level of resources requiring a fundamental shift in commissioning of health and social care services to deliver the required efficiencies.

The success factors are:

- Increase in integrated community support services between health and social care
- Reduction in avoidable admissions
- Reduction in delayed transfers of care
- Increase in service user satisfaction levels

- Reduction in admissions to long term care
- Decrease in use of residential settings for intermediate care and rehabilitation
- More effective use of resources through integration of staff roles
- Increase in development of alternative residential rehabilitation models in the independent sector
- Clear leadership and vision
- Increased care closer to home

Transforming Patient Satisfaction
These schemes focus on the range of services available to patients and service users, either utilising these services directly or to focus on the needs of carers. By developing a range of support either directly to people, or through a range of assistive technologies, training programmes to provider services or carers. These projects will enhance and develop the 3rd sector and a range of options for promoting self-care or alternative and innovative solutions to decrease dependency upon direct access to the acute sector or primary health and social care services.

The success factors are:

- Decrease in avoidable admissions from care homes to hospital
- Decrease in safeguarding referrals from care homes
- Reduction in emergency call outs
- Decrease in use of carer support services and emergency respite care
- Increase in use of Assistive technology units
- Increase in patients reporting satisfaction of care

Protecting Social Services
Through aligning the commissioning intentions of each organisation highlighted in the Joint Strategic Needs Assessment, and closely aligning the key outcomes deliverable between health and social care, we will ensure that the range of schemes provided enable social care to deliver the key services requiring protection and develop the integration agenda which will transform the way that services are delivered. We will collectively be able to plan and reshape services to deliver the required efficiencies being imposed upon social care nationally, and at the same time deliver improved outcomes that truly put people at the centre of services.

The success factors are:

- Increase in use of direct payments to promote service user choice and facilitate discharges
- Decreased admissions to long term care
- Reduction in safeguarding referrals
- Reduction in delayed transfers of care
- Reduction in avoidable admissions
- Reduction in emergency admissions to dementia services
- Reduction in use of services in a crisis

Accelerating Discharge
Services will be redesigned to support ‘transfer to assess’ ensuring timely discharge from acute services to appropriate community or home based services. Health and social care will work together to provide good discharge planning and post-discharge support. This includes work around structured discharge planning and early supported discharge to

enable people to return home earlier, remain at home in the long-term, and regain their independence.

The success factors are:

- Integrated IT systems
- Reduced delayed transfers of care
- Reduced admissions and readmissions to Acute services
- Improved processes within and out of hospital

Infrastructure, Enablers and Other Developments
Effective leadership is key to the implementation of complex change programmes. The projects in this theme focus on processes to ensure integrated systems will enable the delivery of project outcomes. There will be specific focus on leadership, Information Technology developments, organisational development and support for delivery of projects. Our Clinicians, leaders and patients will be involved and rigorous programme management will underpin our approach.

The success factors are:

- Integrated IT systems – Shared platform for information sharing developed via 'Connecting Nottinghamshire'
- Information sharing agreements
- Programme Management Systems that deliver plans
- Shared processes across health and social care where appropriate
- Improvements in operational processes

Details of the specific schemes being implemented under each theme, along with timescales for delivery, can be found in the attached document 01.

Other Schemes Additionally Supporting BCF outcomes and Metrics
In addition to these, CCGs across Nottinghamshire are also working up further schemes to support the BCF outcomes and metrics that are not currently included in the pooled BCF arrangements. There will be a range of investments that will further contribute towards our vision of an integrated of health and social care system centred around the patient.

In some planning units (e.g. Mid-Nottinghamshire), where detailed planning is well advanced, these form key planks of BCF planning. In other areas, where further work is required to firmly establish the evidence base to link investment to benefits, the schemes will continue, albeit not directly linked to the BCF plans. The range of schemes in the South Nottinghamshire CCGs is detailed at the end of the attached document 01. In future years, as the evidence base grows, more of these schemes will be delivered through the BCF plan pooled arrangements.

As an example, integrated health and social care is a key strategic priority for the South Nottinghamshire County CCGs, which has resulted in the appointment of an Integrated Health and Social Programme Manager to lead this area of work, alongside the Local Authority.

Areas of work being targeted include, for example, intermediate care. This workstream is looking at the assessment process, deployment of staff, and resource allocation invested

into the numerous services which interface to deliver rehabilitation services. This work has led to a review of current services and opportunities are being explored to deliver care closer to home through alternatives to residential provision.

The integration programme also now includes a short term project to scope and review the NUH delayed discharge pressures. This work is focusing on four workstreams:

- Data Analysis
- The Care Co-ordination Team
- The assessment process
- The discharge process.

In the short term, this work will deliver an effective process for accurate data recording and discharge management. In the longer term, this project will ensure a robust and financially viable process to effectively manage the discharge of patients from the acute setting in a timely manner. This work has a strong strategic interface with the wider developments outlined within the BCF plan to be delivered over the next 5 years.

2. Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Nottinghamshire has the following main acute provider hospitals:

- Doncaster and Bassetlaw Hospitals NHS Foundation Trust – DBH; operating from two sites within Bassetlaw
- Sherwood Forest Hospitals NHS Foundation Trust - SFH; operating from two sites in Mid-Nottinghamshire
- Nottingham University Hospitals NHS Trust – NUH; operating from two sites in Nottingham
- Nottingham NHS Treatment Centre (Circle); operating from one site in Nottingham

All acute providers are active partners in the development of short, medium and longer term plans and engaged the leadership of the strategic priorities for integration (avoiding health deterioration giving rise to a need for hospital care and supporting people after acute illness). An equal focus is being applied to avoiding crisis ("support to thrive"), providing alternatives to ED attendance ("choose to admit") and streamlining discharge ("discharge to assess"), taking full account of the personalised needs of each citizen.

Analytical work continues to iterate the impacts of the BCF plan on provider Trusts. The plan will mitigate the risks of additional activity in the acute setting and will also seek to redefine acute care provision and allow for more services to be delivered in the community, in care homes and peoples' homes. A range of services will be provided in the community; including therapy and assessment, 24 hour intensive nursing/therapy assessment, complex sub-acute nursing and therapy managed in the home or low level reablement services.

The plan will also reduce reliance on hospital acute care by targeting prevention activities and managing long term conditions in a more integrated and holistic way, including the physical, social, psychological and environmental (focusing on carers and families, as well patients/service users), thereby supporting improved empirical performance in the following areas:

- Reduction in A&E attendances
- Reduced pressures on ambulance services
- Reduction in emergency admissions
- Reduction in acute hospital bed days (from reduced admissions and reduced length of stay)

The consequence of the planned changes described will be less reliance on secondary care. The current baseline indicates that there are opportunities to change the profile of care across Mid-Nottinghamshire: recent Utilisation Reviews of un-scheduled medical in-patient, in-patient admissions to community settings and the intermediate care utilisation review of bed based and home based services will be used to set achievable targets. A reduction in acute sector beds is anticipated, together with optimisation of intermediate care beds for step/step down and a greater utilisation of home based intermediate care. Early analysis suggests that the quantum of reduction in acute beds could be in excess of 250 across the county. Further detailed analysis is underway at local planning unit

level to further validate the potential.

Clinicians and care professionals have been fully engaged in the design of the new care system and are committed to making the changes effective. In the unlikely event that the impact of the change is not as great as anticipated, the community services will be further enhanced to bring about the required shift of care from secondary care. A number of pilot schemes are underway that provide an evidence base for future success, and confidence in delivery is enhanced by these results. Further mitigation, should the positive impacts upon acute activity take longer than envisaged, will include a major focus on organisational development and acceleration of the required workforce change. In recognition of the importance of developing the appropriate workforce in a timely manner to deliver citizen-centred integrated services, a system-wide post has been created (covering the East Midlands region). This is a senior role, within Health Education England, funded by commissioners and demonstrates a commitment to reshape the workforce at pace. There are also strong plans within local risk registers to ensure that workforce transformation does not become a material limiting issue to successful integration.

The Health and Wellbeing Board have also committed to supporting the health and social care system in re-aligning public expectations to support the shift away from the acute system as default towards home/community based care wherever feasible, focusing on proactive care, and self-management as the preferred option.

We have undertaken differential impact analysis on providers in the acute sector and beyond across Nottinghamshire, a summary of which is below.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Bassetlaw CCG has strong relationships with its providers across all sectors. The acute trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT), has worked closely with Bassetlaw CCG, community providers and Nottinghamshire County Council over the past 3 years through the local strategy group to develop health and social care plans to address avoidable hospital admissions and reduce delayed transfers of care. The strategy group was instrumental in developing plans for the reablement monies in 2010/11, which have formed the starting point for further planning for the BCF and Bassetlaw's five year integration plans. The Strategy group feeds into the Bassetlaw Integrated Care Board (ICB), on which DBHFT has 4 members: 3 executive directors and a clinical director.

The Integrated Care Board has focused on working across the health and social care economy on 5 key strategic priorities detailed elsewhere in our BCF plan and attached in document 03. The pathway includes the whole health and social care economy and has been influenced by engagement with providers, patient and service user feedback, and an independent report from the Emergency Care Intensive Support Team. As a key partner, DBHFT are leading on the Post Acute Care strategic priority within the plan.

A number of key principles were agreed with all partners on the behaviours expected when developing the work plans for each element, including:

- Working with partners to develop a shared vision and case for change
- Develop an impact assessment, analysing the impacts of change in acute and out of hospital services and the providers of those services
- Shift care into closer-to-home / better value care settings where appropriate

- Optimise the use of fixed costs such as estates with locally required activity – including acute, community, private and non-healthcare
- Provide single points of access for patient, and integrated provision of services (which may require single management control)
- Using all of this to enable the system to cope with growing demand within expected resource constraints
- To design interventions that once implemented will make a significant contribution towards the NHS and Adult Social Care Outcomes Frameworks

The ICB members have held a confirm and challenge session on all 5 work group plans to ensure they are robust and will meet the challenges presented by the BCF. A joint approach by health providers and the CCG using a range of agreed assumptions is modelling the impact of service change interventions on acute activity using a range of currencies, including length of stay, numbers of admissions, and bed days/numbers. Through the joint ICB arrangements plans, very clear sight will be maintained of actual activity shifts and consequent financial implications to commissioners and providers. This information will be visible to all parties.

The ICB will be overseeing progress of the BCF plan locally, and will continue to monitor performance against key metrics and refresh the system-wide modelling of the impact that the BCF to ensure that we are on target. The priorities within the plan have been used to shape in-year contract discussions and commissioner QIPP/provider CIP plans.

Because of the geographical nature of the Trust, DBHFT works with 2 CCGs and 2 local authorities, consequently spanning two Health and Wellbeing Board areas. The process for agreeing plans for the BCF has been mirrored by both CCGs and the Trust has been an active member of both Boards. The Trust has good integrated models of care currently and has made great advances in working together with local authorities to benefit patients.

The DBHFT annual plan for the next 2 years has also been shared widely with both CCGs (Doncaster and Bassetlaw) in order to triangulate Trust assumptions on possible reductions in emergency activity with the CCGs. The DBHFT bed plan makes agreed assumptions on potential reductions in length of stay due to 7 day services and improved information sharing and discharge processes, including transfer to assess.

Sherwood Forest NHS Foundation Trust
In 2013, the 5 organisations involved in the delivery of health and social care in Mid-Nottinghamshire (Newark and Sherwood Commissioning Group, Mansfield and Ashfield Clinical Commissioning Group, Nottinghamshire Healthcare NHS Trust, Sherwood Forest NHS Foundation Trust and Nottinghamshire County Council) agreed to work together to design a blueprint for the future delivery of services that would meet the needs of the population both now and in the future, and do so whilst operating under the financial constraints that exist.

The programme of work which resulted involves three phases of work, and has been extended to involve East Midlands Ambulance Service and Nottingham University Hospitals NHS Trust:

- “Blueprint” design
- Detailed planning
- Implementation

In order to ensure appropriate buy-in at the Blueprint design phase work focused on 4 main areas:

- Establishing a vision and objectives, mobilising the resources
- The current model of care: agreeing a baseline for how the health and social care economy currently operates
- The future model of care: engaging clinicians, health and social care professionals and patients in four Care Design Groups to design options for redesign, followed by modelling to understand the financial and activity impact of the proposed changes
- The creation of a roadmap to deliver the changes put forward

The Current Model of Care

Through engagement with key stakeholders, data analysis, and document review, a baseline for the current health and social care economy was established. This highlighted a significant overall financial challenge.

In January 2013, the total cost of the physical health and social care economy was £398m. For FY12/13, it was forecast that the financial deficit of the health and social care economy will be £19m. If services were to continue as they currently are and taking into account funding levels, population growth, and inflation, this financial gap could increase to at least £70m and possibly be more than £100m by 2018.

At the outset, it was key that the organisations involved identified a series of overarching objectives of design phase of the programme. These included working with partners to develop a shared vision and case for change, and developing an impact assessment to analyse the impacts of change in acute and out of hospital services and the providers of those services.

Design Principles

Prior to undertaking any design work, it was key that a set of overarching design principles were put in place that would guide the development of any design options and ultimately the blueprint. The design principles were put together by the system leadership Board (comprised of primary and secondary care clinicians and senior executives and social care leaders), and then validated by the care design groups. The principles are identified below:

- Prevent illness or crises where possible – and transfer resources (people, physical assets and finance) from reactive services to support this
- Shift care into closer-to-home/better value care settings where appropriate
- Only provide services where there is the critical mass/volumes for the services to be delivering high outcomes and be economical; but also repatriate activity from out of area/private provision where this delivers better outcomes
- Optimise the use of fixed costs such as estates with locally required activity – including acute, community, private and non-healthcare
- Provide single points of access for patient, and integrated provision of services (which may require single management control)
- Using all of this to enable the system to cope with growing demand within expected resource constraints
- To design interventions that once implemented will make a significant contribution towards the NHS Outcomes Framework

Working in conjunction with the Blueprint workstream, a significant data analytics workstream was tasked with the gathering and modelling of quantitative data to produce analytics on current services in Mid-Notts. This workstream also took responsibility for modelling the impact of the proposed design options coming out of the care design groups.

The approach taken was to provide an indication of the expected impact of our interventions on the financial challenges facing the health and social care economy by constructing a series of tactical models and calculations based on the best available data from a range of publicly available sources and information provided to us by the participating parties.

While findings will need to be revisited and tested in detail throughout implementation, the results provide a clear and robust indication of the benefits and costs associated with the blueprint proposals.

Using a range of agreed assumptions, the impacts of service change interventions on acute activity have been modelled using a range of currencies, including length of stay, numbers of admissions, and bed days/numbers. The detail arising from this modelling has been fed in to the CCGs' 5 year strategy, but also used to shape in-year contract discussions and commissioner QIPP/provider CIP plans.

As the programme now moves from design in to implementation, local governance arrangements are being reconstructed so as to sure absolute triangulation of BCF investment proposals, local commissioning QIPP schemes, joint transformational initiatives, and provider CIP plans. It is expected that joint programme management office (PMO) arrangements will be established across the health economy and that providers and commissioners will use common information and analytical models to create a single evidence base to monitor the impact of changes.

As the Blueprint design outcomes and supporting analytics form the CCGs' 2 to 5 year strategy, they also shape BCF schemes and QIPP/CIP plans, meaning that there is no scope for duplication/double counting.

The overall programme has been predicated upon a "total activity and cost of provision model", and an analysis of impact on each provider produced based on current PbR arrangements and income and expenditure plans. Through the joint PMO arrangements planned, very clear sight will be maintained of actual activity shifts and consequent financial implications to commissioners and providers. This information will be visible to all parties.

It is however acknowledged by all parties in the Transformation Partnership that to be effective in the context of a "shift left" model, with activity and consequent funding moving from the acute sector to more appropriate home and community settings, successful interventions in primary care, community care, and self care will be paramount to manage demand and improve the management of patients with complex and multiple long conditions. The way in which the analytical models underpinning plans have been designed means that there is a visible causal link between investment in services and improved outcomes. It will be critical to ensure that these are continuously reviewed and plans iterated accordingly should the proposed beneficial impacts not materialise.

It is also worth noting that a particular condition exists in Mid-Nottinghamshire that

requires more sophisticated approaches to be considered in separating the burden of fixed overheads from service provision i.e. the acute PFI hospital incurs a significant fixed charge for a further 30 years, that will not diminish if demand for traditional (and often inappropriate) acute care patterns is reduced. Sherwood Forest Hospitals NHS FT and the commissioners recognise that this will need very careful management and impact assessment as estates cannot be decommissioned in a way that directly correlates with reduction in acute activity, and to do so may well penalise provider financial viability and disincentivise providers to exhibit system behaviours. Commissioners and providers will therefore continue to work together to best match the more integrated models of care essential to ensure system sustainability and meet population health need, but also best deploy fixed assets.

Nottinghamshire University Hospitals NHS Trust
There is recognition and support of the importance of developing integrated service models that better meet community needs, and which therefore mitigate demand for acute care. Joint provider/commissioner work is developing a service improvement plan, which will outline actions for implementation during 2014/15 to implement the clinical standards set out in the NHS Services, Seven Days a Week Forum.

Whole system transformation work to date has seen NUH as a significant contributor to shaping discussions and delivery, for example as a partner in the Greater Nottingham Frail Older People Programme and the Urgent Care Working Group and its subgroups. This included participation in the system-wide analysis of the reasons for delays to transfer of care out of NUH and the approach to assessing the amount and type of alternative community services that are needed to reduce pressure on the acute beds. NUH will be part of ongoing discussions about future capacity needs through the Local System Resilience subgroup of the Urgent Care Working Group.

To deliver the BCF plan, the Trust will continue to actively engage with other health and social care providers. NUH is a key member of the new South Nottinghamshire Transformation Board, which is a NHS Commissioner, NHS provider and Local Authority Board established to oversee the development of the five year strategy and Transformational Plan for South Nottinghamshire, and straddles two Health and Wellbeing Board areas. This Board will support the implementation of BCF interventions across the three South CCGs as well as Nottingham City CCG, which is part of the South Nottinghamshire Unit of Planning but falls in a separate HWB area.

Recognising the need for ambition, service change at real scale, and pace of delivery, senior clinical staff time has been committed to this process through their participation in recent local health economy planning events to develop system-wide clinical models for the next five years.

As part of the analysis supporting the development of the South Nottinghamshire Transformation five year strategy, a process is underway to triangulate Commissioner QIPP and NUH CIP plans against BCF schemes so that benefits align and provides assurance that are not double-counted. There will be an impact on NUH from both the Nottinghamshire County BCF, Nottingham City BCF, and Derbyshire County BCF plans and this analysis will apply a consistent approach across both BCF areas. Baseline activity levels have already been agreed between the CCG Consortium and NUH following a number of planning sessions. Two subsequent Confirm & Challenge sessions were held between NUH Directorates and CCGs to confirm the underlying demand projections and the deliverability of this demand within the available capacity.

The identification of QIPP schemes has been based the use of benchmarking information, national available in other health communities and an inherent knowledge of existing pathways as well as an understanding of the health needs of the local populations. The current QIPP schemes address the need to reduce avoidable hospital emergency admissions, prevent inappropriate attendances to A&E, reduce unnecessary elective referrals and improve the outcome and experience for patients through the reduction in lengths of stay etc. A number of these QIPP schemes will contribute towards the successful achievement of the BCF ambitions. This process has enabled commissioners to mitigate the risk of any double counting between QIPP and BCF schemes.

The NUH Contract is in the final stages of negotiation and the impact of the Emergency Rate Threshold has been a key item of discussion. Modelling undertaken to identify the impact of QIPP schemes has included the associated financial impact of the Emergency Rate Threshold.

Monitoring will be focused around demonstrating the impact and effectiveness of schemes. The analysis will be tailored to each scheme to quantify the impact against agreed milestones. Around emergency admissions, the use of forecasting techniques, statistical significance and segmentation by diagnosis will be essential to demonstrate achievement of the metric. Delayed Transfers of Care analysis will focus on nationally available data, local benchmarking and trend analysis. Schemes that impact on other activity types will be monitored using a range of nationally and locally available data.

Workforce will also play their part alongside partners in delivering the required change, building upon the various pathways where they already support the delivery of community based care. Work is already underway with local partners to ensure effective commissioning and development of the wider health and social care workforce. There is also recognition that the timely supply of this workforce is a key risk for all providers.

The scale of the transformational and financial challenge that the BCF process presents to the Trust is accepted along with the part it must play in delivering changes to its own services and ways of working, including reducing the size of the acute footprint.

Nottinghamshire Healthcare Trust
To deliver the BCF plan, Nottinghamshire Healthcare Trust (NHT) will continue to develop alliances and partnership working with other providers to reduce fragmentation, better manage the interface between providers and facilitate the provision of shared care that is wrapped around the person.

The BCF plan offers significant opportunities for growth and development in community services to build capacity, capability and new service offers. This will come with significant challenges requiring a high level of change management, organisational, system, and workforce development as NHT radically change ways of working, redesign and reconfigure existing services, develop new service offers, and create a workforce that looks and behaves very differently in an environment of blurred boundaries. This will require capacity and skill in managing change, project management, and service redesign.

For the Trust's mental health services, the focus will continue to be on ensuring that they meet the needs of people who present in crisis and build capacity and capability to care for people safely in their own homes and reduce the need for people to attend either ED

or be admitted to an inpatient facility. The Trust will work with all acute providers in continuing to develop the Rapid Response Liaison Service to ensure that people who do present in ED are appropriately assessed and treated in a timely manner and also to support and facilitate discharge as appropriate.

Workforce changes probably forms the most significant challenge to the successful delivery of this plan. For example:

- Recruitment, i.e. availability of suitably skilled staff
- Building new integrated teams and multi-agency working (primary, community, mental health teams)
- Changes to terms and conditions of employment to facilitate 7 day services
- Developing new roles, e.g. primary care facing mental health practitioner
- Developing increased clinical skills to practice level
- Changing a task focused culture to promote choice, personalisation, self-care, recovery, reablement, and wellbeing

Circle (Independent Sector Treatment Centre Provider)
Circle acknowledge the huge opportunity the BCF plan provides in improving service integration across the health and social care community, and are committed to work with all organisations to transform the existing models of care and deliver more efficient patient pathways. As a purely elective provider, Circle has a different part to play in delivering this plan, and have considered the potential implications of whole system transformational change.

Success will only be possible by fundamentally changing the way services are delivered, where they are delivered, and by whom. This will require significant change to the workforce including the need for new roles, the development of different skills within the existing workforce, changes to terms and conditions (particularly based on the aspirations for 7 day services), and the development of a culture which supports staff better work across organisational boundaries. Delivering a transformation programme of this size will also require project management expertise, communication expertise, and robust stakeholder management, particularly regarding consultation.

Adult Social Care (Nottinghamshire County Council)
The County Council commissions a range of community based care and support services from independent sector providers to support people to live independently in their own homes. The Council has contracts with over 400 care and support providers for a range of services including domiciliary care, supported living for people with learning disabilities, physical disabilities and/or mental health needs, and community equipment services including minor adaptations. Many of these services are commissioned jointly with the CCGs.

One of the primary objectives is to ensure that people have access to services which prevent avoidable admissions to hospital and divert people away from, or delay the need for, long term care in residential or nursing homes. There is a strong emphasis on reablement and rehabilitation so that people are supported to regain and retain their independence and maintain self-care wherever possible.

From a provider perspective, implications of the BCF plan include:

- Ensuring there is sufficient capacity amongst providers now and in the future to meet increasing demand for community based services
- Ensuring the social care workforce has access to and is supported to undertake the relevant training and have the right skills which help people to regain and retain their independence and to manage self-care
- Ensuring the workforce has the experience and expertise in caring for people in their own homes when they may have a range of complex health care needs and/or are at end of life
- Ensuring care staff are able to deliver personalised care to meet people's outcomes – this will be a greater challenge with the roll out of personal health care budgets
- A focus on 'commissioning for outcomes', which will mean cultural changes across providers

Providers will need to be given the opportunity, and the responsibility, to develop and agree the individual support plan together with the patient/service user and their family members so that they can find flexible, innovative and cost effective ways of delivering the required care and support services.

Primary Care

To deliver the BCF plan, GPs as providers will need to be aware of the change in service provision of all other providers. The BCF plans will depend considerably on GPs' in hours and CCG commissioned Out of Hours providers knowing the changing landscape and making most appropriate use of it.

General Practice is reflecting and restructuring as a provider system to a more integrated possibly federated provider model. This will put primary care in a better position to support a 7 day service. Different delivery models will be explored through development of a Primary Care Strategy. The strategy is due to be completed by June 2014.

There are serious workforce issues in General Practice across the county, with a high percentage of the skilled workforce ready to retire in the next 5 years. There will need to be a strategic approach both at a local and national level to encourage recruitment. An increasing number of GPs have portfolio careers which can both reduce availability and reduce flexibility but sometimes provide valuable skills to support the service transitions required.

The value and relevance of 'Skill Mix' deployment in primary care will assume greater importance. Skilled support from community staff including nursing and therapists, from pharmacy as well as dentists and optometrists will all facilitate delivery of the BCF plan and 7 day services. The Community Services provider is working collaboratively to address the required transition and transformation required to help facilitate the delivery of 7 day services in primary care, and as such a final action plan will be agreed and varied into their contract by the end of April 2014.

The possible alteration of 'Acute Demand Management' in General Practice will create a workforce change and potentially free GPs to proactively manage vulnerable people and those with long-term conditions to a higher level of specification and thus hopefully reduce acute care requirements and the hospital footprint. This is essential to the BCF.

Changes to the General Medical Services (GMS) contract from April 2014 will also support more proactive integrated and personalised care through:

- Ensuring that all people aged 75 and over have a named, accountable GP who is responsible for overseeing their care
- Introducing more systematic arrangements for risk profiling and proactive care management, under the supervision of a named GP, for patients with the most complex health and care needs
- Giving GP practices more specific responsibilities for helping monitor the quality of out-of-hours services for their patients and supporting more integrated working with out-of-hours services

The Out of Hours providers have a strong history of local service provision and awareness of local systems. This will enable an IT co-ordinated platform to support and facilitate 7 day services, multi-location access to key patient records will lead to improved care and safety. Innovative new ways of working will also deliver extended primary care access for both booked urgent and planned care – 8am-8pm Monday to Friday, and 8am-6pm Saturday and Sunday. Primary care services will be:

- Designed in sufficient capacity to meet local need
- Delivered by local clinicians – not locums
- Supported by clinical protocols created to define new ways of working and how practices will work together
- Backed by solid joint working and the coming together of a new team to deliver the project against very challenging time frames

The BCF plan aims to ensure systematic implementation of primary and secondary prevention and chronic disease management in primary care through benchmarking and targeted incentive schemes. A key focus will be integrating physical, social, and mental health in a wraparound citizen-oriented model.

Care Homes and Homecare

The intended impact of our plans is that more people are supported to live independently and safely in the community for as long as possible. This may negatively impact on the number and duration of care home beds commissioned for long-term care across the nursing and residential sector. We envisage that there will be an increased demand for care homes that can support service users with higher levels of need, such as nursing and dementia needs, and for short-term services focussed on enabling service users to return home. Conversely, we expect that there will be an increase in demand and in the complexity of cases for domiciliary care providers.

As such, we have already been engaging with providers and wider stakeholders to discuss the strategic commissioning intentions through engagement events and contract negotiations. These discussions have also involved their role in avoiding unnecessary admissions to hospital, facilitating timely discharge and the sharing of pertinent information with health and social care professionals. The Local Authority is working with providers and colleagues from CCGs and the CQC to drive quality standards in care homes and for homecare providers.

For example, a strategic review was completed for care homes to guide commissioning intentions, and a Dementia Quality Mark has been developed for care homes to provide a high standard of care to people with dementia, which has been awarded to 32 providers

across the county. The Local Authority is also sponsoring and financially supporting a number of workforce development initiatives across the independent care home and domiciliary care sectors. This will develop capacity to enable appropriate support for people to remain at home wherever possible.

3. Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

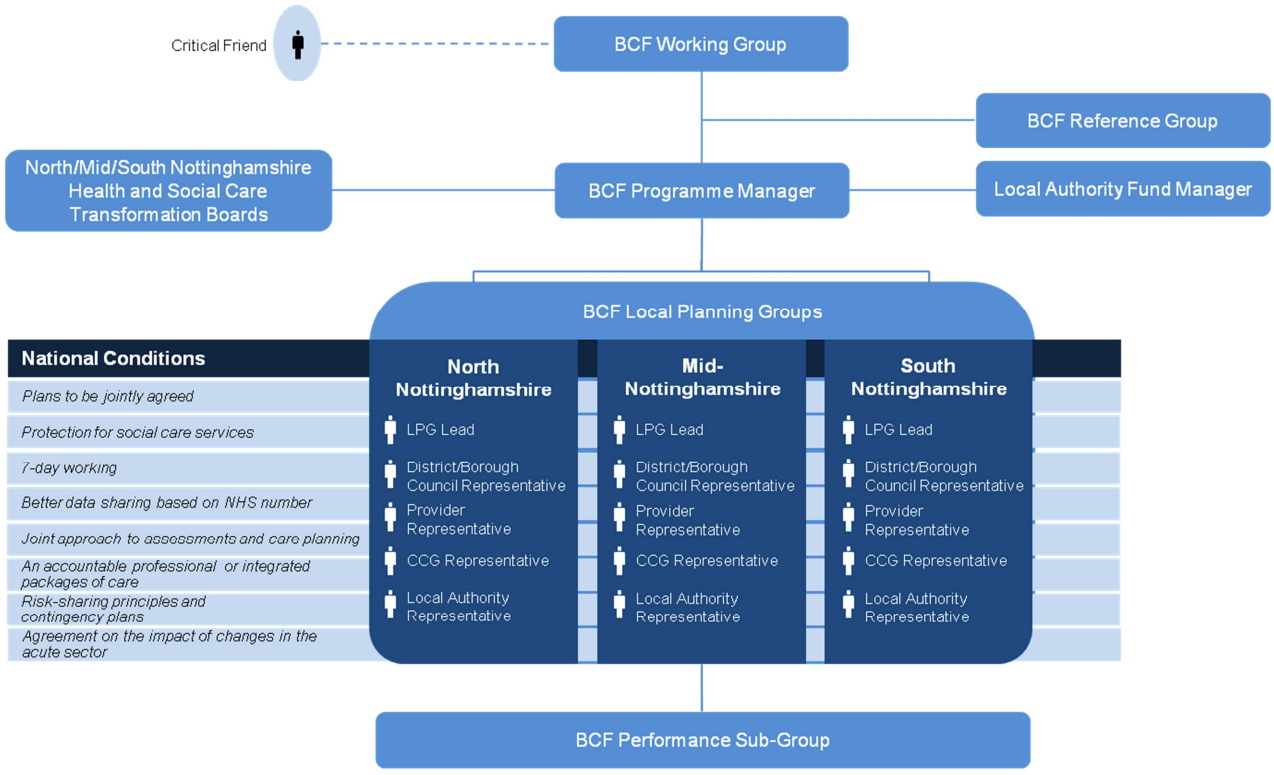
A county-wide BCF Working Group has been mobilised to oversee the development and delivery of a county-wide Nottinghamshire plan for pooled budget(s) under the terms of the BCF. The Working Group is co-chaired by the Chief Executive of Nottinghamshire County Council and a CCG Clinical Chair, and includes members from each District Council and CCG, along with social care representation.

The Working Group coordinates to identify and commission required resources to deliver the plan and agree necessary milestones and timescales. As well as ensuring that the plan conforms to the national conditions and is consistent in meeting required performance targets, the steering group will maintain oversight on the delivery of the plan, including financial governance and flexibility to instigate a review to ensure that the intended benefits are realised.

The BCF Working Group will report directly to the Health and Wellbeing Board. Reports will be shared between the Working Group and the Health & Wellbeing Implementation Group to ensure communication and coordination of work to promote integration across health and social care.

This is supported at locality level by the Integrated Care Board in the North, the Transformation Board in Mid-Nottinghamshire, and the BCF Planning Group in South Nottinghamshire, who all oversee local implementation of integrated care plans.

Our county-wide BCF governance structure is shown below:



As an overarching principle, accountability for performance, mitigation of risks and any remedial action will be managed wherever possible at unit of planning level and will be monitored and overseen through the BCF governance process outlined. A partnership agreement will be drawn up to formalise the BCF management arrangements.

- **Hosting arrangements:** The County Council will be the host. Prior to the financial year funds will transfer into the pool.

- **Commissioning and contracting:** Responsibility for commissioning a service will remain with the accountable body. Providers will be paid from the pool and must invoice the pool for the related services. Monies within the fund are set out in the approved submission. These must be spent on the schemes documented. If resources are diverted elsewhere, this must be agreed by all parties in the unit of planning.

- **Overspends:** Where an area of spend is over budget, this must be identified early and remedial action should be agreed between the provider and commissioner, and then reported to the Monitoring Group. Responsibility for the overspend is the commissioner's. If the commissioner feels that another party should carry some of the financial burden, then this must be discussed. However, no responsibility will be carried across the unit of planning boundaries.

- **Underspends:** Funds may be unspent in one year. In these circumstances, the unspent balance will be ring fenced to fund a related service (for example to support backfilling another service before the new integrated teams are fully operational) or carried forward into the following year. If funds are diverted to a service outside the descriptor then this must be agreed by all parties within the unit of planning.

- **Contingency funds:** The contingency fund will be held with the risk pool / contingency funds of each body. The contingency fund will operate on a unit of planning basis and monies will be ring fenced accordingly. Any draw on additional monies due to lower performance will be from the unit of planning contingency fund nominally allocated. The use of any contingency will be at the discretion of the planning unit. However, if the remedial action plan is failing to deliver, through the BCF governance process, the planning unit may have to consider further mitigations which will have an impact on contingency funds.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

In Nottinghamshire, eligibility is set at Critical and Substantial.

The Care Bill, which is currently in Parliament, includes national eligibility criteria. The criteria are yet to be finalised but the intention is to set the criteria at a level which will be consistent with Critical and Substantial.

Therefore, the criteria are not the substantive issue; rather the challenge is to deliver services which meet the needs of existing and future service users, given the known increases in the number of older and younger adults with increasingly complex needs arising from disability and long term conditions.

Please explain how local social care services will be protected within your plans.

In the context of the BCF, our priorities for protecting social care services are:

- Ensuring the ability to respond to demography/increasing social care needs of younger adults with disabilities and older people
- Funding the costs of Care Bill implementation
- Maintaining essential social care services
- Funding innovation in social care in line with transformation plans to improve social care outcomes and realise savings and efficiencies in both health and social care budgets

One of the main themes across our BCF plan is the principle of reducing dependence on health and social care services.

As detailed in the list of schemes contained in Part 2 of this plan, each of the three planning units has explicitly allocated the mandatory funds for the specific purpose of protecting social care services (summarised in the below table). This commitment is made in addition to other BCF schemes that will also be supporting social care less directly.

Locality	**Protecting Social Care Services**	
	2014/15	**2015/16**
North Nottinghamshire	£2,227,000	£2,227,000
Mid-Nottinghamshire	£6,245,000	£6,245,000
South Nottinghamshire	£7,645,000	£7,645,000
Countywide Total	**£16,117,000**	**£16,117,000**

Supporting the allocation of the funds is a detailed breakdown of the schemes, identification of health gain, and the approximate number of people that each allocation will support. The £16.1 million for protecting social care does not eliminate the need for further savings to be identified from the Council's adult social care budget over and above those already approved in 2015/16. The Council has not decided on a precise target or amount that has to be saved from adult social care or other service areas, but this will be considered taking into account the Council's commitments in this plan and the performance targets that are to be set. The implications of any proposals will be thoroughly explored with partners. It will also take account of the requirements of the

Care Bill as the legislation is finalised and regulations and statutory guidance are issued.

We will be allocating appropriate funding to cover new duties that come in from April 2015 as a result of the Care Bill, in line with requirements in the BCF guidance to do so. Based on published allocations, this amounts to £1,946,000, with an additional £735,000 capital investment funding (including IT systems) – this gives a grand total for Nottinghamshire of £2,681,000.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Nottinghamshire is committed to providing 7 day services within its local planning groups, and within the Joint Health and Wellbeing Strategy. The principles were consulted on as part of the refresh of the strategy aligned with all National Conditions.

7 day services to support hospital discharge and avoid admissions to both hospital and care homes are particularly key to supporting the strategic principles. One related initiative to support our vision for 7 day services has been the involvement of primary care in discharge planning following an emergency admission.

Nottinghamshire currently has a number of 7 day services already in place, such as Rapid Response Teams and Intermediate Care Teams, and a number of new services outlined in the BCF plan, such as a 24/7 acute care liaison service, where gaps in provision have been identified by local planning groups. The continuation, and/or expansion of existing services are crucial to delivering the change required. To ensure a consistent approach across Nottinghamshire, a working group was established led by a senior Local Authority officer with CCG and Public Health Consultant input. This working group took a multifaceted approach to:

- Comprehensively baseline the availability of key health and social care services across acute, community and primary care identified from the Keogh report, the Academy of Medical Royal Colleges 2013 report Seven Day Consultant Present Care and expert knowledge of the system
- Follow Cochrane Review processes to systematically search the published literature in order to provide evidence based advice from published research and locally commissioned research and evaluations to develop evidence based recommendations on the impact that particular services can have on our BCF goals
- Use these evidence based statements to develop a countywide position with timescales for delivery for the duration of the BCF period and beyond
- Work with the three planning groups, which include commissioners and providers, to identify how 7 day services will be implemented in their unique planning areas

A copy of this is included with this plan in the attached document 03. A process for agreeing Action Plans with providers to deliver the clinical standards for 7 day services is in place. Contract negotiations have already taken place with providers, with final action plans to be agreed and varied into contracts by the end of April 2014. For example, in the South to ensure consistency and that plans are aligned and support each other, it has been agreed by the Chair of the Provider Sub-Group of the Urgent Care Board that further discussion will take place through that group. The outcome of discussions at the Provider Sub-Group will feed into the Service Development and Improvement Plans within provider contracts.

Evaluation findings of local 7 day initiatives will be shared amongst Nottinghamshire's planning groups. Local planning groups will be responsible for reviewing the findings, and refining plans for their areas as appropriate over the duration of the BCF period.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS Number is currently in use in all NHS organisations and used as the primary unique and unambiguous identifier, supporting communication with other providers of healthcare services. With modern systems in place, the timeliness of NHS number matching is primarily at the point of contact via PDS linked PMI trace. During 2014/15, formal agreement and arrangements for the expansion of the NHS number matching across social care systems will be put in place via direct entry or batch tracing of NHS number via PDS. This will be supported by the use of portal technologies.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The Nottinghamshire health and social care community has established a collaborative programme called Connected Nottinghamshire that will facilitate developments in IM&T and record sharing. The programme has established a shared identifier, and at the recent IT summit event the NHS number was identified as the way to do this. Health systems are already using the NHS number and matching in a timely way. Social care systems are using the NHS number by direct entry and have plans for batch tracing via PDS which are progressing. Governance and technical issues are being worked through and the plan states that completion of this work will be by October 2014. Where systems are limited in their use of NHS number, the use of portal technologies to supplement functionality will be used. The Connected Nottinghamshire Board has oversight of this project, and represents the health and social care providers and Commissioners in Nottinghamshire.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Systems with open APIs or utilising ITK standards will be introduced, facilitated by the Nottinghamshire-wide Connected Nottinghamshire programme.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Nottinghamshire is working together as a health and social care community to develop and implement system-wide best-practice information policies to support the sharing of patient / client confidential information. The newly formed Nottinghamshire Record Sharing Group, which is GP and Caldicott Guardian led, is implementing the actions from the Caldicott 2 review and subsequent response the Department of Health. This group is bringing together the professional standards and best practice guidance to ensure the appropriate level of information is available to support the delivery of the best possible care.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

There is county-wide agreement to mobilise multi-disciplinary teams incorporating health and social care, mental health and rehabilitation professionals, led by a suitably skilled Community Practitioner and with access to specialist services as required. These provide access to specialist disease knowledge such as respiratory, diabetes or heart failure. This model has already been implemented as part of Mid-Nottinghamshire's Integrated Proactive Care programme.

Based on stratifying the risk profile of the population using a Combined Predictive Model tool, these multi-disciplinary integrated care teams systematically conduct regular MDT case review / ward rounds with input from the patient's GP to facilitate joint discharge planning, monitoring and decision making.

Accountability is assured within this MDT process, and the model puts the patient at the centre of care decisions and requires GP practices to play an active part in the MDT.

All patients are allocated a named care coordinator at MDT meetings who is accountable for ensuring that the care plan and agreed interventions are delivered by the various team members. This person could be any of the MDT members depending on the patient's primary needs.

While the GP remains medically accountable for all patients identified in a primary or community care setting, the GP is currently rarely the named care coordinator, as it is not always practicable to oversee multiple and complex interventions from a wide range of people. With the 2014/15 General Medical Services contract changes, this is due to change to meet the requirement that all patients within a certain risk level are assigned a named accountable GP, who ensures they are receiving coordinated care.

It is likely that lead accountability for oversight and ownership of the patient's care plan will nearly always sit with the GP, but could be another care professional according to the patient's particular health and social care needs. Medical accountability will remain with the GP, but care coordination and delivery responsibility will be allocated to the individual professional who can most effectively manage the integration of required interventions through the MDT.

4) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

The Local Planning Leads across Nottinghamshire have agreed this risk register based on the specific schemes being implemented in each locality. As well as the specific mitigations identified for each risk, the implementation of integrated care boards (or equivalent) across the county provides an additional layer of risk mitigation.

Risk	Risk rating	Mitigating Actions
NORTH NOTTINGHAMSHIRE		
Agreement for whole scale change from all partners, including changes to ways of working	HIGH impact MEDIUM likelihood	On-going leadership from the Urgent Care Working Group and Integrated Care Board Early engagement of partners with work programmes agreed in partnership at a senior level Planned change management approach for all organisations involved to communicate these changes to the front line
Information Governance: local arrangements contingent upon National agreement	HIGH impact HIGH likelihood	Informal local systems in place for MDTs and community staff Develop and maintain links to Connected Nottinghamshire Programme
Performance related funding reliant on outcomes that may not be evidenced in the short to medium term	HIGH impact MEDIUM likelihood	On-going monitoring of outcomes at a senior level through the Urgent Care Working Group and Integrated Care Board and early identification of slippage On-going monitoring and evaluation of the five programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers
Quality of care and financial stability of providers across all sectors due to the changes proposed	HIGH impact MEDIUM likelihood	On-going leadership from the Urgent Care Working Group and Integrated Care Board Early engagement of partners with work programmes agreed in partnership at a senior level
National changes to Urgent and Emergency Care (primary care, A&E and OOH) and	HIGH impact MEDIUM likelihood	NHS England Area Team representation on the Urgent Care Working Group and Integrated Care Board

changes to the primary care contract		
Recruitment of qualified and skilled preventive staff	HIGH impact MEDIUM likelihood	Workforce development plan, including a succession plan Review recruitment and retention plans
MID-NOTTINGHAMSHIRE		
Assumed change in residential and nursing home placements does not materialise	HIGH impact MEDIUM likelihood	Activity modelling informed by evidence and local clinical opinion; model to include impact of best, base, and worst case scenarios.
Public resistance to proposed changes	MEDIUM impact HIGH likelihood	Engagement plan in place; citizens' champions being recruited.
Insufficient non-recurrent monies available for the enabling/implementation costs	HIGH impact LOW likelihood	Requirements included in CCGs' annual planning assumptions.
IT suppliers do not have capacity to respond to requirements of Mid-Nottinghamshire within required timescales	HIGH impact MEDIUM likelihood	Requirements are similar to those of other Nottinghamshire CCGs, giving greater leverage with suppliers.
Insufficient qualified staff can be recruited in time to meet required increase in community service staffing levels and new services	HIGH impact MEDIUM likelihood	Reduce scale of services and/or phase delivery to accommodate extended recruitment timescales. Use of agency staff to bridge gaps. Early discussions with regional workforce development teams to facilitate long term recruitment and development planning.
There is a risk that staff moving from existing services within Mid-Nottinghamshire or from neighbouring HCEs will destabilise existing services, leading to overall loss of performance	HIGH impact MEDIUM likelihood	Reduce scale of services and/or phase delivery to accommodate extended recruitment timescales. Use of agency staff to bridge gaps. Early discussions with regional workforce development teams to facilitate long term recruitment and development planning.
SOUTH NOTTINGHAMSHIRE		
There is a risk that the sign up and cultural changes required to enable whole scale change from all partner organisations, including changes to ways of working is not achieved	HIGH impact MEDIUM likelihood	On-going leadership from the BCF Working Group/South Planning Group Early engagement of partners with work programmes agreed in partnership at a senior level Planned change management approach for all organisations involved to communicate these changes to the front line
There is a risk that recruitment difficulties, engaging and changing	HIGH Impact MEDIUM Likelihood	On-going leadership from the BCF Working Group/South Planning Group Early engagement of partners with work

ways of working for front line provider staff do not enable whole scale change to be achieved		programmes agreed in partnership at a senior level Planned change management approach for all organisations involved to engage and communicate these changes to the front line
There is a risk that if the existing contractual arrangements with providers remain unchanged this will have a negative impact on delivery of the plan	HIGH impact HIGH likelihood	On-going leadership from the BCF Working Group/South Planning Group Early engagement of partners with work programmes agreed in partnership at a senior level
There is a risk that quality of care may be affected as a result of implementing the proposed changes	HIGH impact MEDIUM likelihood	On-going leadership from the BCF Working Group/South Planning Group Early engagement of partners with work programmes agreed in partnership at a senior level
There is a risk that as performance related funding is reliant on outcomes these may not be evidenced in the short to medium term	MEDIUM impact MEDIUM likelihood	On-going monitoring of outcomes at a senior level through the BCF Working Group/South Planning Group with a robust approach to performance management On-going monitoring and evaluation of programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers
There is a risk that implementation of the changes will impact on the financial stability of providers	HIGH impact HIGH likelihood	On-going leadership from the BCF Working Group/South Planning Group Early engagement of partners with work programmes agreed in partnership at a senior level Ensure individual projects and overall programme subject to robust analysis and modelling to ensure any financial impact on providers is clear
There is a risk that social care funding challenges result in a reduction of available care packages to support long term care resulting in a shift in cost of long term care to health	HIGH impact MEDIUM likelihood	Ensure individual projects and overall programme are subject to robust analysis and modelling to ensure that the impact of funding cuts is identified and included
There is a risk that	HIGH impact	On-going leadership from the BCF

implementation of the changes will result in an increase in admissions to care homes	MEDIUM likelihood	Working Group/South Planning Group Bed availably in care home sector to be monitored Intermediate Care / Assessment Beds to be used flexibly when necessary to support patients out of hospital
There is a risk that the assumed change in residential and nursing home placements does not materialise	HIGH impact MEDIUM likelihood	Activity modelling informed by evidence and local clinical opinion; model to include impact of best, base and worst case scenarios
There is a risk that there is public resistance to the proposed changes and that population behaviour change will not materialise	HIGH impact MEDIUM likelihood	Plan to be supported by the on-going development and implementation of a communication and engagement strategy

This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

The three tabs containing tables have been protected so that the structure can not be modified in a way that will impede the collation of all HWB plans. However, for the finance tables whole rows can still be inserted by right clicking on the row number to the left of the sheet and clicking 'insert'.

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1 . Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Local Authority Social Services				
Nottinghamshire County Council	Y	£ 2,939,000	£ 1,964,000	£ 1,964,000
Disabled Facilities Grant	N	£ 3,444,692	£ 3,204,000	£ 3,204,000
CCG				
Bassetlaw CCG	N	£ 6,904,000	£ 7,526,000	£ 7,859,000
Newark and Sherwood CCG	N	£ 3,735,422	£ 7,718,000	£ 9,210,545
Mansfield and Ashfield CCG	N	£ 6,009,578	£ 12,418,000	£ 14,819,455
Nottingham North and East CCG	N	£ 4,367,016	£ 9,115,000	£ 9,115,000
Nottingham West CCG	N	£ 3,101,243	£ 6,180,000	£ 6,180,000
Rushcliffe CCG	N	£ 3,138,533	£ 6,780,000	£ 6,780,000
BCF Total		**£ 33,639,484**	**£ 54,905,000**	**£ 59,132,000**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

The funds identified here for investment to deliver specified performance improvements and system integration will be ring-fenced for that purpose only. A governance structure for pooled budgets will be established to oversee local and county-wide performance, including use of the contingency fund. The Performance sub-group will propose the criteria for rules and principles around monitoring, reporting, and the management of variances from plan.

Nottinghamshire will take a three staged approach, which will be influenced by the maturity of the relevant scheme, and mitigating action required:

1. Initially, the responsible organisation will fund where the pressures in the system are (across health and social care)
2. Scope within the BCF fund in 2015/16 to develop services (enhancing capacity within existing schemes where appropriate)
3. Contingency fund outside of the BCF if schemes are not delivering the required change, or achieving the BCF targets

Contingency plan:		2015/16	Ongoing
Outcome 1: risk that interventions to reduce DToCs are not successful	Planned savings (if targets fully achieved)	3,083,460	3,083,460
	Maximum support needed for other services (if targets not achieved)	3,083,460	3,083,460
Outcome 2: risk that avoidable emergency admissions 65+ are not reduced 10% in year 1 and 10% in year 2.	Planned savings (if targets fully achieved)	2,694,884	2,694,884
	Maximum support needed for other services (if targets not achieved)	2,694,884	2,694,884
Outcome 3: risk that permanent admissions of older people (aged 65 and over) to residential and nursing care home are not reduced (including a proportion of the local indicator)	Planned savings (if targets fully achieved)	957,190	957,190
	Maximum support needed for other services (if targets not achieved)	957,190	957,190
Outcome 4: risk that the proportion of older people (65 and over) still at home 91 days after discharge from hospital into reablement / rehabilitation services does not increase	Planned savings (if targets fully achieved)	177,253	177,253
	Maximum support needed for other services (if targets not achieved)	177,253	177,253

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
7 Day Service Provision and Access									
North Nottinghamshire									
Intermediate Care Rapid Response	Community	£ 1,585,000	£ -	£ -	£ -	£ 1,585,000	£ -	£ -	£ -
7 Day Access to Services	Various	£ -	£ 200,000	£ -	£ -	£ 400,000	£ -	£ -	£ -
Mental Health Liaison	Mental Health	£ -	£ 380,000	£ -	£ -	£ 380,000	£ -	£ -	£ -
Mid-Nottinghamshire									
Primary Care Services: Care homes advanced nurse practitioner Improved primary care access - urgent primary care.	Primary care and TBA	£ -	£ -	£ -	£ -	£ 1,000,000	£ -	£ 1,500,000	£ -
South Nottinghamshire									
7 day working	GP/Community Services Provider	£ -	£ -	£ -	£ -	£ 1,500,000	£ -	£ 900,000	£ -
GP Access	GP practices	£ -	£ -	£ -	£ -	£ 1,842,979	£ -	£ 686,589	£ -
Supporting Integration									
North Nottinghamshire									
Personalised Care	Primary Care	£ -	£ 280,000	£ -	£ 140,000	£ 560,000	£ -	£ 300,000	£ -
Reablement Services	Community	£ 937,000	£ -	£ -	£ -	£ 802,000	£ -		£ -
Discharge/Assessment	Community/Mental Health	£ 310,000	£ 250,000	£ -	£ -	£ 810,000	£ -	£ -	£ -
Mid-Nottinghamshire									
Locality intermediate care teams - proactive care multi-disciplinary teams, low and enhanced intermediate care and the self care hub. PRISM virtual wards. Use of risk stratification tool to target high risk patients. Also includes care navigator - establishing a directory of services for health and social care to maintain people at home.	TBA	£ 3,500,000	£ -	£ 1,000,000	£ -	£ 11,000,000	£ -	£ 1,000,000	£ -
Note: The Mid-Nottinghamshire CCGs' transformation plan is forecast to commence in 2015/16. Full recurrent costs of the local integrated care teams will be incurred in 2015/16, and this is reflected in the table above, but there will be a lag in the consequent greater recurrent financial benefits, which are forecast for 2016/17 onwards.									
South Nottinghamshire									
Personalised care - Tailored care for vulnerable and older people	GP practices	£ -	£ -	£ 519,596	£ -	£ 1,800,000	£ -	£ 1,039,192	£ -
Community Geriatrician	Acute	£ -	£ -	£ -	£ -	£ 100,000	£ -	£ 45,857	£ -
Community Hub Development	Community Services Provider	£ -	£ -	£ -	£ -	£ 90,000	£ -	£ 82,153	£ -
Community Programme	Acute	£ 500,000	£ -	£ 237,561	£ -	£ 500,000	£ -	£ 237,561	£ -
Reablement Services	NCC/CHP	£ 123,721	£ -	£ 74,233	£ -	£ 1,200,000	£ -	£ 720,000	£ -
Transforming Patient Satisfaction									
North Nottinghamshire									
Respite Services	Various	£ 325,000	£ -	£ -	£ -	£ 325,000	£ -	£ -	£ -
Improving Care Home Quality	NCC	£ -	£ 125,000	£ -	£ 60,000	£ 250,000	£ -	£ 130,000	£ -
Telehealth	Community	£ -	£ 285,000	£ -	£ 140,000	£ 470,000	£ -	£ 250,000	£ -
Mid-Nottinghamshire									
Self care service - dedicated and targetted support for patients to self-care and to identify the information and access to support services that they need to enable them to become more involved in their own care and maintain their well-being.	TBA	£ -	£ -	£ -	£ -	£ 160,000	£ -	£ -	£ -
Communications (social marketing). Support for sustained and targeted communications support	CCGs	£ -	£ -	£ 167,000	£ -	£ 100,000	£ -	£ 450,000	£ -
South Nottinghamshire									
Enhanced support to care homes	Community Services Provider	£ -	£ -	£ -	£ -	£ 500,000	£ -	£ 89,673	£ -
Support for Carers	TBC	£ 767,000	£ -	£ 460,200	£ -	£ 666,150	£ -	£ 399,690	£ -
Telehealth	Community Services Provider/GP Practice/Acute	£ -	£ 70,298	£ 10,581	£ -	£ 70,298	£ -	£ 10,581	£ -
Protecting Social Services									
North Nottinghamshire									
Protecting Social Care Services	NCC	£ 2,227,000	£ -	£ -	£ -	£ 2,277,000	£ -	£ -	£ -
Mid-Nottinghamshire									
Protecting social care services	NCC	£ 6,245,000	£ -	£ -	£ -	£ 6,245,000	£ -	£ -	£ -
South Nottinghamshire									
Protecting Social Care Services	NCC	£ 7,645,000	£ -	£ -	£ -	£ 7,645,000	£ -	£ -	£ -
Intermediate Care Bed Based	Care Homes/Community Services Provider	£ -	£ -	£ -	£ -	£ 2,698,800	£ -	£ 407,750	£ -
Addtional Support to Social Care	NCC	£ 214,565	£ -	£ 128,739	£ -	£ 214,565	£ -	£ 128,739	£ -
Facilitating Discharge									
Mid-Nottinghamshire									
Specialist intermediate care team	TBA	£ -	£ -	£ -	£ -	£ 3,800,000	£ -	£ 1,800,000	£ -
South Nottinghamshire									
Early Supported Discharge	Community Services Provider/Acute	£ 500,000	£ -	£ 500,000	£ -	£ 500,000	£ -	£ 300,000	£ -
Home Care/OT	Community Services Provider/NCC	£ 400,494	£ -	£ 240,296	£ -	£ 400,494	£ -	£ 240,296	£ -
Equipment Services	Voluntary	£ 135,714	£ -	£ 81,428	£ -	£ 135,714	£ -	£ 81,428	£ -
Intermediate Care at Home	Community Services Provider	£ -	£ -	£ -	£ -	£ 500,000	£ -	£ 300,000	£ -
Infrastructure, Enablers, and Other Developments									
North Nottinghamshire									
Disabilities Facilities Services	District/Borough Councils	£ 748,172	£ -	£ 448,903	£ -	£ 532,000	£ -	£ 319,200	£ -
Mid-Nottinghamshire									
Developments to support the implementation of the Better Together scheme, including: Information management and technology Organisational Development Implementation support	TBA	£ -	£ -	£ -	£ -	£ 125,000	£ 1,600,000	£ -	£ -
Disabilities Facilities Services	District/Borough Councils	£ 1,226,502	£ -	£ 735,901	£ -	£ 1,539,000	£ -	£ 923,400	£ -
South Nottinghamshire									
Transformation Programme Management	CCGs	£ 250,000	£ -	£ -	£ -	£ 650,000	£ -	£ -	£ -
Disabled Facilities Grant	District/Borough Councils	£ 1,470,018	£ -	£ 768,600	£ -	£ 1,133,000	£ -	£ 679,800	£ -
County-wide across Nottinghamshire									
Social Care Capital	NCC	£ 2,939,000	£ -	£ -	£ -	£ 1,964,000	£ -	£ -	£ -
Other projects yet to be fully planned up	TBA	£ -	£ -	£ -	£ -	£ 1,061,000	£ -	£ 636,600	£ -
The funds identified here for investment to deliver specified performance improvements and system integration will be ring-fenced for that purpose only. A governance structure for pooled budgets will be established that oversees local and county-wide performance, including use of the contingency fund. The Performance sub-group will propose the criteria for rules and principles around monitoring, reporting, and the management of variances from plan. *In addition to the schemes listed above, CCGs across Nottinghamshire are also working up further schemes to support the BCF outcomes and metrics that are not currently included in the pooled BCF arrangements.*									
Total		£ 32,049,186	£ 1,590,298	£ 5,373,039	£ 340,000	£ 57,532,000	£ 1,600,000	£ 13,658,510	£ -

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

All schemes within the Nottinghamshire BCF plan will contribute towards the nationally and locally set performance metrics - schemes are aligned to the national conditions on the "Finance - Schemes" sheet:
- Delayed Transfers of Care
- Avoidable Emergency Admissions
- Admissions to residential and care homes
- Effectiveness of Reablement
- Reduction in direct admissions into long term care from hospital settings (local)

Nationally set metrics will be measured as defined in the technical guidance. For the Avoidable Emergency Admissions, the target has been set only in-line with the improvements in performance anticipated in relation to the BCF plan schemes, i.e. for our resident population aged over 65 years (and not children, young people or younger adults).

The local metric is measured in the following way:
- numerator: Admissions to long-term residential and nursing care from an acute setting
- denominator: Admissions to residential and nursing care : Permanent admissions of older people (aged 65 and over) to residential and nursing care homes
- expressed as a rate per 100 admissions

This metric targets a vulnerable cohort in our population and links with our objectives of keeping people as independent as possible for as long as possible. It also relates to the priorities in Nottinghamshire's Health and Wellbeing Strategy. Data will be collected quarterly.

In the development of this plan, a subgroup of the Nottinghamshire BCF Working Group was formed to consider the metrics and financial benefits - the BCF Performance Subgroup. Membership of the group includes Nottinghamshire County Council (adult social care and public health), CCGs, District/ Borough Councils, and acute and community providers. This group will continue to monitor performance against the metrics for the duration of the BCF period, and escalate as appropriate to the Nottinghamshire Better Care Fund Working Group. Additionally each local planning group will oversee performance within their planning area against the BCF metrics and a number of locally identified key metrics such as:
- nursing home admissions (and those directly from hospital)
- residential home admissions (and those directly from hospital)
- DTOCs, reason G (patient or family choice)

Target setting of the DTOC indicator involved trend analysis and benchmarking of the level of delayed transfers by provider, using nationally available data. Trend analysis was used as part of a forecasting process and also as a measure of consistency of data capture and reporting. The benchmarking analysis identified that variation is seen within the volume of delayed days per patient in North, Mid, and South Nottinghamshire. Joint work is taking place to explore causes of the variation, taking account of health and social care configuration to reduce the volume and length of delays in discharge.

The level of ambition has been re-assessed using the BCF 'Ready Reckoner' (95% CI level) and has subsequently been increased in line with the revised version. Granular reporting will take place to monitor performance against agreed milestones to demonstrate the effectiveness of schemes that underpin the reduction of delayed transfers of care.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We will use the nationally developed indicator, however, will continue to monitor existing measures until this is in place, such as the Friends and Family Test, provider satisfaction data, Personal Social Services Adult Social Care Survey, and the Carers Survey. Baseline data and targets are shown for these metrics in the table below:

		E.A.5 – proportion of people reporting poor patient experience of inpatient care	E.A.7 - proportion of people reporting poor patient experience of general practice and out of hours service	3A - Overall satisfaction of people who use services with their care and support	3D - The proportion of people who use services and carers who find it easy to find information about services	Percentage of users satisfied that the adaptations met their identified needs
Bassetlaw CCG	Baseline	123	3.3	N/A	N/A	N/A
	Target	123	3.3	N/A	N/A	N/A
Newark and Sherwood CCG	Baseline	148	7.2	N/A	N/A	N/A
	Target	147	7	N/A	N/A	N/A
Rushcliffe CCG	Baseline	162.7	6.1	N/A	N/A	N/A
	Target	157.2	5.7	N/A	N/A	N/A
Mansfield and Ashfield CCG	Baseline	144.6	6.2	N/A	N/A	N/A
	Target	143	6	N/A	N/A	N/A
Nottingham North & East CCG	Baseline	162.7	4.7	N/A	N/A	N/A
	Target	157.2	4.5	N/A	N/A	N/A
Nottingham West CCG	Baseline	162.7	3.6	N/A	N/A	N/A
	Target	157.2	3.5	N/A	N/A	N/A
Notts CC	Baseline	N/A	N/A	64.7	70.3	N/A
	Target	N/A	N/A	65.50	78.00	N/A
Disabled Facilities Grants	Baseline	N/A	N/A	N/A	N/A	None
	Target	N/A	N/A	N/A	N/A	75%

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

BCF Working Group is co-chaired by representatives from the CCGs and Nottinghamshire County Council, Mick Burrows (Chief Executive, Nottinghamshire County Council) and Dr Paul Oliver (Clinical Lead and Chair, Nottingham North and East CCG). This group will assume overall responsibility for achievement of the BCF plan.

Local planning groups for North, Mid and South Nottinghamshire are responsible for agreement, planning and implementation of schemes and metrics within their planning areas. They will oversee the delivery of each local scheme and address variations in performance.

The BCF Performance Subgroup was specifically formed to consider the metrics and financial benefits within the Nottinghamshire BCF plan with involvement from key stakeholders. Targets have been aligned with locally agreed targets for each CCG.

The BCF plan has been approved by:
- Health and Wellbeing Board
- the six Nottinghamshire CCGs
- Nottinghamshire County Council
- Local planning groups, which include members of the above and also representation from acute and community providers, and District/Borough Councils

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

N/A

Outcomes and metrics

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	649.18	N/A	600.54
	Numerator	970		950
	Denominator	149420		158191
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. This should correspond to the published figures which are based on a 3 month period i.e. they should not be converted to average annual figures. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	83.20	N/A	86.49
	Numerator	630		653
	Denominator	755		755
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	395.43	389.25	382.64
	Numerator	20084	22409	14800
	Denominator	634884	639656	644651
		(April 2013 - November 2013) 8	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	173.65	165.67	154.24
	Numerator	16613	7979	7479
	Denominator	797235	802680	808159
		(April 2012 - March 2013) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *Please see previous sheet for details of local metrics (including baselines and targets) to be used for monitoring performance until a national metric is developed*		See previous sheet	N/A	See previous sheet
		(State time period and select no. of months) 1		*(State time period and select no. of months)* 1
Local measure *Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes*	*Metric Value*	64.97	38.04	34.53
	Numerator	217	369	328
	Denominator	334	970	950
		(April 2012 - March 2013) 12	*(April 2013 - March 2014)* 12	*(April 2014 - March 2015)* 12

* Baseline figures for the four national metrics figures are available on the NHS England BCF webpage (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/)

Description of Planned Changes – Schemes

Please note: *In addition to the schemes listed in this document, CCGs across Nottinghamshire are also working up further schemes to support the BCF outcomes and metrics that are not currently included in the pooled BCF arrangements. Further details can be found on the page 6 of this document, and in Part 1 of the plan.*

Theme	Schemes	Timescale for Delivery
1. 7 Day Service Provision and Access	**NORTH NOTTINGHAMSHIRE**	
	Intermediate Care Rapid Response – provides immediate support to people to avoid hospital admission	Year 1
	7 Day access to services – across GP and community providers to support hospital discharges	Year 1
	Mental Health Liaison – working 24/7 across the Bassetlaw hospital site	Year 1
	MID-NOTTINGHAMSHIRE	
	Primary care services: Care homes advanced nurse practitioner Improved primary care access - urgent primary care	Year 2
	SOUTH NOTTINGHAMSHIRE	
	7 day working - Develop a seven day offer of access to GP/community services	Year 2
	GP Access – work with the Urgent Care Board to develop access to Primary Care services	Year 2

Theme	Schemes	Timescale for Delivery
2. Supporting Integration	**NORTH NOTTINGHAMSHIRE**	
	Personalised care - Tailored care for vulnerable and older people – a comprehensive and co-ordinated package of care for patients over 75	Year 1
	Reablement Services – Independence and Reablement within the Hospital, enhanced Reablement services	Year 1
	Discharge/Assessment – multi agency single point of assessment for patients	Year 2
	MID-NOTTINGHAMSHIRE	
	Locality intermediate care teams - proactive care multi-disciplinary teams, low and enhanced intermediate care and the self-care hub. Virtual wards. Use of risk stratification tool to target high risk patients. Also includes care navigator - establishing a directory of services for health and social care to maintain people at home.	Year 1/2
	SOUTH NOTTINGHAMSHIRE	
	Personalised care - Tailored care for vulnerable and older people – a comprehensive and co-ordinated package of care for patients over 75	Year 2
	Community Geriatrician – Geriatric/Health Care of Older People provides comprehensive geriatric assessment in community settings, linking with primary care and community services in a planned approach. Consultant geriatricians provide expertise to multi-professional teams working with complex patients and provide case review and direct patient care with smooth access to secondary care as appropriate. Also provide education, training and mentorship for staff and advice to support the development of services. Supports a reduction in unnecessary hospital attendances	Year 2
	Community Hub Development – develop the GP/social care/mental health input to the Hub model	Year 2
	Community Programme – To meet people's needs as close to their normal residence as possible, by creating efficient, evidence-based health and social care systems which are perceived as seamless by patients, users and carers	Year 1/2
	Reablement services – additional social work posts and to develop reablement/intermediate care approaches to support the discharge of older people from hospital	Year 1/2

Theme	Schemes	Timescale for Delivery
3. Transforming Patient Satisfaction	**NORTH NOTTINGHAMSHIRE**	
	Respite Services – service users patient satisfaction	Year 1
	Improving Care Home Quality: - Overarching housing and care home strategy for older people - Care home residents risk stratification and lead clinicians for each home - Leadership training for care home sector - Workforce plan for care homes - Training programmes for care home staff	Year 1/2
	Telehealth – to support patients to manage their own care	Year 1
	MID-NOTTINGHAMSHIRE	
	Self-care service – dedicated and targeted support for patients to self-care and to identify the information and access to support services that they need to enable them to become more involved in their own care and maintain their well-being.	Year 2
	Communications (social marketing) –To enable local people to access appropriate services by identifying ways that can help them choose the right care at the right time, by specifically targeting resources to identified target groups.	Year 2
	SOUTH NOTTINGHAMSHIRE	
	Enhanced support to care homes - Community based, multi-disciplinary in-reach services (which compliments healthcare delivered by the GP) which proactively addresses the health needs of residents in residential and nursing care homes. Offering holistic assessment and timely responsive support to meet the health and end of life care needs of residents. Promoting improved collaborative working between the care home, primary care and community services. To deliver improved case management, that focuses attention away from reactive care, emergency call-outs and crisis management.	Year 2
	Support for Carers – provides carer support including short breaks, respite	Year 1
	Telehealth – to support patients to manage long term conditions through the 'Flo' Telehealth model	Year 2

Theme	Schemes	Timescale for Delivery
4. Protecting Social Services	**A range of schemes across the county, including:**	
	Protecting social services - Care for the elderly in the community - Intermediate care services reviewed and enhanced - Community model developed and implemented - Community nurse support to Primary Care - Review and enhance Community Matron model	Year 1/2
	Community Capacity - Rapid response (includes additional homecare) – to provide interim home care services to people in hospital awaiting discharge due to a delay in the start of their regular homecare services	Year 2
	Support to Social Care - Memory Assessment Service – supports social care input to early diagnosis for dementia scheme - Mental Health Intermediate Care Services - specialist intermediate care teams in each CCG for older people with Mental Health problems and dementia. - Advocacy services - Support to the Multi Agency Safeguarding Hub	Year 1/2
	Intermediate Care Bed Based – development of approach following new pilot at Gedling Village	Year 2

Theme	Schemes	Timescale for Delivery
5. Facilitating discharge	**NORTH NOTTINGHAMSHIRE**	
	Equipment Services – to support increased demand for equipment to support people to remain in their own home and to facilitate discharge	Year 1
	MID-NOTTINGHAMSHIRE	
	Specialist intermediate care team	Year 2
	SOUTH NOTTINGHAMSHIRE	
	Early Supported Discharge – work with NUH and community services to develop early discharge systems and approaches	Year 1
	Equipment Services – to support increased demand for equipment to support people to remain in their own home and to facilitate discharge	Year 1
	Home Care/Occupational Therapy – additional support for interim homecare, occupational therapy to support assessment	Year 1

Theme	Schemes	Timescale for Delivery
6. Infrastructure, Enablers and Other Developments	**A range of schemes across the county, including:**	
	Developments to support the implementation of the Better Together scheme in Mid Nottinghamshire including: - Information management and technology - Organisational Development - Implementation support	Year 2
	Transformation Programme across South Nottinghamshire – to provide strong leadership across the South CCGs to lead the development of joint integration projects across Health and Social Care to oversee the strategic development and implementation of the integration agenda.	Year 2
	Disabilities Facilities Services - to support adaptations to dwellings occupied by disabled people	Year 2
	Other Projects to be fully developed and scoped	Year 2

Other Schemes Additionally Supporting BCF Outcomes and Metrics

An overview of additional schemes in place or under development, funded recurrently or non-recurrently in 14/15 in Nottingham North and East, Rushcliffe and Nottingham West CCGs that will also support achievement of BCF outcomes and metrics.

Metric	Additional schemes that will be supporting achievement of BCF outcomes and metrics		
	NNE CCG	**Rushcliffe CCG**	**NW CCG**
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	- Care Home Community Model provided by CHP - Family Mosaic - Community 2	- Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP	- Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP - Care Homes Pharmacist permanent
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	- Integrated Health and Social Care phase 1 – Adult Community Care Teams - Integrated Health and Social Care phase 2 – Social Care Integration - 48 hour follow up for older people following an emergency admission	- Integrated adult care support from community services delivered through community wards - Phase 2 integration with social care and MHSOP - 48 hour follow up for older people following an emergency admission	- 48 hour follow up for older people following an emergency admission - Expand the community ward multi-disciplinary team to including social care and mental health support - Expand the scale and scope of the Retirement Living Integration Project with Broxtowe Borough Council and deliver the project plan
Delayed transfers of care from hospital per 100,000 population (average per month)	- GP Same Day/Urgent Care Pilot - First Responder Service in Community Hub - Care Home Community Model provided by CHP	- Integrated adult care support from community services delivered through community wards - Phase 2 integration with social care and MHSOP	- Enhanced care home support provided by CHP - Expand the community ward multi-disciplinary team to including social care and mental health support - Expansion of proactive care/case management models for LTC - Additional support for carers to support older people to remain at home

	- Care Coordination Team		
Avoidable emergency admissions (composite measure)	- GP Same Day/Urgent Care Pilot - First Responder Service in Community Hub - Care Home Community Model - Integrated Health and Social Care phase 1 – Adult Community Care Teams - Specialist Parkinson's Disease Nurse Service - Family Mosaic - Community 2	- Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP - Enhanced primary care service specification and proactive LTC management - Integrated adult care support from community services delivered through community wards - Phase 2 integration with social care and MHSOP	- Implement the national Direct Enhanced Service focussing on reducing avoidable admissions in the over 75s - Increase primary care rehabilitation service to educate care home staff to prevent falls - Actively target interventions and information e.g. promotion of the slips, trips and falls booklet, at areas identified in the rapid needs assessment as having poorest outcomes for older people - Proactive case management of LTC - expansion
	- Crisis response services - Electronic Palliative Care Co-ordination System (under development) - EMAS South Falls Service (underdevelopment)		
Patient, service user and carer experience (composite measure)	- PPE work across the CCG - CCG People's Council - GP Practice Patient Participation Groups - Family Mosaic - Community 2	- Patient Clinical Cabinet - Patient Active Group - Practice Participation Groups	- GP Practice Patient Participation Groups - Patient Reference Group - Events Planner - Deliver the agreed priorities of the Broxtowe Health Partnership Older Persons Sub group that focuses on ending loneliness, compassionate communities including inter-generation projects - Hold "carers weeks" road show events at least twice per year

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes (local metric)	- Integrated Health and Social Care phase 1 – Adult Community Care Teams - Care Home Community Model - Chronic Care Management pilot - Care Home Community Model provided by CHP	- Integrated adult care support from community services delivered through community wards - Phase 2 integration with social care and MHSOP - Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP	- Enhanced care home specification for general practice to go live 1st April 2014 - Enhanced care home support provided by CHP - Expand the existing services for long term conditions including education, psychological support and for people with long term neurological conditions - Additional support for carers to support older people to remain at home

Nottinghamshire County Council

SEVEN DAY SERVICES

Evidence is presented below for key hospital- and community- based services that are linked to preventing discharge or assisting flow for consideration by local planning groups.

Local planning groups are asked to:

- Evaluate how local services compare to national / local evidence
- Consider the fit with planned services and the financial implications[1]
- Consider how existing stakeholder and public feedback can inform the plans for seven day services and whether additional engagement activity is necessary
- Ascertain key information about the existing workforce[2], [3]
    - workforce planning
    - training needs
    - culture change
- Ascertain current activity levels for the key services identified below and determine whether there is sufficient capacity within the system[4]

FURTHER WORK THROUGHOUT THE BCF PERIOD

There are a number of tasks that cannot be completed prior to the 4th April BCF deadline but nevertheless should take place:

- Review the NHS IQ seven day services toolkit and ascertain if / what further work needs to be done[5]
- Review NHS IQ commissioned evaluation of the 13 Early Adopters who are testing new models of seven day services and care[6]
- Review the Academy of Medical Royal Colleges / University of Birmingham (Professor Julian Bion) evaluation of the impact of high intensity specialist led acute care (HiSLAC)[7]

[1] NHS Services, Seven Days a Week Forum Summary of Initial Findings (December 2013) - to align with the Urgent and Emergency Care Review.
[2] Centre for Workforce Intelligence (2013) Workforce Briefing. What does 24/7 Working mean for the health and social Care workforce?
[3] NHS Services, Seven Days a Week Forum Summary of Initial Findings (December 2013) – to align with the Urgent and Emergency Care Review.
[4] NHS Services, Seven Days a Week Forum Summary of Initial Findings (December 2013) - to align with the Urgent and Emergency Care Review.
[5] Not yet available – release date TBC, after testing with the Early Adopter sites
[6] NHS Services, Seven Days a Week Forum Summary of Initial Findings (December 2013)
[7] NHS Services, Seven Days a Week Forum Summary of Initial Findings (December 2013)

Nottinghamshire County Council

HOSPITAL BASED SERVICES

In keeping with modern services the NHS too needs to move toward providing a fully integrated 7-day service that treats patients based on how unwell they are as opposed to the time of day or day of the week. In Dec 2013 Professor Sir Bruce Keogh published the *NHS services, seven days a week review* which stated:

"Emergency inpatients MUST be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision maker… The MDT will vary by specialty but as a MINIMUM will include: Nursing, Medicine, Pharmacy, Physiotherapy and for medical patients Occupational Therapy… Other professionals that may be required include but are not limited to: Dieticians, Podiatrists, Speech and Language Therapy and Psychologists and Consultants in other specialist areas such as Geriatrics… Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, CT, MRI, echocardiography, endoscopy, bronchoscopy and pathology…"[8]

Service	Hours currently available			Working towards			Supporting evidence	Desired Benefits
	North	Mid	South	BCF Year 1	BCF Year 2	Beyond BCF		
Hospital discharge team / Hospital social worker	7 day limited service / Extended hours full service	Extended hours limited service	Extended hours limited service	7 day limited service	7 day full service	7 day full service	• "Arrangements for patients leaving hospital will operate on a 7-day basis. Health and social care services in the community will be organised and integrated to enable patients to move out of hospital on the day they no longer require an acute hospital bed."[9]	• Hospital discharge services speed up patient discharge, saving at least £120 a day.[10] • Structured discharge planning is effective in reducing future re-admissions[11] • Delay of discharge is a common complaint from family and carers, extended hours and prompt discharge plans from social workers could improve this[8] • Reduce length of stay and risk of readmission[12]. • The input of social workers out of hours and on the weekends in acute admission can greatly reduce the number of delayed discharges, and in

[8] : NHS England – NHS services seven days a week – Professor Sir Bruce Keogh (Dec 2013)
[9] Future Hospital – Caring for medical patients (sept 2013)
[10] Personal Social Sciences Research Unit for Department of Health (2010) National evaluation of POPPs.
[11] The Kings Fund (2010) Avoiding hospital admissions: What does the research evidence say?
[12] : Urgent and Emergency care: A prescription for the future (July 2013)

Service	Hours currently available			Working towards			Supporting evidence	Desired Benefits
	North	Mid	South	BCF Year 1	BCF Year 2	Beyond BCF		
								some case prevent admission in the first place, this has large cost saving implication for trusts[13] • Hospital based social services can enable hospitals to make more efficient and more effective use of ASCH&PP resources.[14] • improved flow of patients through the hospital with empty beds on a Monday. Discharges increased twofold, from 6 to 17 patients on Sundays. The length of stay of patients reduced an average of 11 hours[15].
Pharmacy (for discharge planning and assessment)	7 day limited service	7 day limited service	Extended hours limited service	7 day limited service	24/7	24/7	• "Emergency inpatients MUST be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision maker… The MDT will vary by specialty but as a MINIMUM will include: Nursing, Medicine, Pharmacy, Physiotherapy and for medical patients OT"[16]	• A pilot study where 24 hour access to pharmacy was implemented in Oxford found timelier discharges, a reduction in the risk of missed medications and improved safety and accuracy of prescribing[17].

[13] :Epsom and St Helier University Hospitals NHS Trust and Surrey County Council Adult Social Care - Social care presence on the acute medical unit, seven days a week, improves discharges from hospital (2013)
[14] Bywaters, P., McLeod, E. (2003). Social care's impact on emergency medicine: a model to test. Emerg Med J 2003;20:134–137
[15] :NHS Improving quality - Reducing the variation of care at weekends – A test of change approach at Torbay hospital (2013)
[16] NHS England – NHS services seven days a week – Professor Sir Bruce Keogh (Dec 2013)
[17] : NHS improving quality – seven day residency pharmacy model – Oxford University Hospitals NHS Trust (2013)

Service	Hours currently available			Working towards			Supporting evidence	Desired Benefits
	North	Mid	South	BCF Year 1	BCF Year 2	Beyond BCF		
Physiotherapy	7 day limited service	Extended hours limited service / 7 day limited service / 7 day full service	7 day limited service	7 day limited service	7 day limited service	7 day full service		• A seven day physio service allows for more prompt assessment of patients, reduces time of stay for patients, and therefore has huge cost saving and bed flow implications for trusts[18] [19] • Improved outcomes and shorter lengths of stay for orthopaedic and #NOF patients being operated on Thursday and Friday[20], [21], [22]
Dietetics / nutrition / Occupational therapy / Speech and language therapy / podiatry	Extended hours full service	7 day limited service	Extended hours limited service / 7 day limited service	7 day limited service	7 day limited service	7 day limited service	• "Other professionals that may be required include but are not limited to: Dieticians, Podiatrists, Speech and Language Therapy"[15] (with regards to assessment of all emergency admissions within 14 hours) • All hospital inpatients on admission and all outpatients at their first clinic appointment should be screened for signs of malnutrition (does not specify that this needs to be performed by a dietician, no direct evidence that it improves clinical outcome) [23]	• Improved outcomes and shorter lengths of stay[24] • In a pilot study offering 7 day OT services patients had better access to timely assessment – with 100% of inpatients meeting the NICE quality standard of having assessment by a specialist team member within 24 hours of admission (an improvement from 85%) consequently patient satisfaction in the service was higher[25] • Having on-call SALT services over the weekend, in combination with OT and Physio allows for a greater number of weekend discharges[26]

[18] :Brighton Paradza- Delivering eQIPP through seven day working physiotherapy service for cardio-thoracic surgery patients (2006)
[19] :Cardiff and Vale university health board – Extended day and seven day physiotherapy service in acute medicine (Nov 2009)
[20] :DoH – 7 Day working, examples of innovation and good practice : Golden Jubilee National Hospital (2011)
[21] :NHS Improvements – 7 day working, examples of good practice : Wansbeck General Hospital, Hexham General Hospital & North Tyneside General Hospital (2009)
[22] Future Hospital – Caring for medical patients (sept 2013)
[23] :NICE Guidelines: Nutrition Support for Adults, Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition (Feb 2006)
[24] :NHS Improvements – 7 day working, examples of good practice : Wansbeck General Hospital, Hexham General Hospital & North Tyneside General Hospital (2009)

Service	Hours currently available			Working towards			Supporting evidence	Desired Benefits
	North	Mid	South	BCF Year 1	BCF Year 2	Beyond BCF		
Acute care liaison service (dementia / mental health)	Extended hours full service	Extended hours full service	Extended hours full service	24/7	24/7	24/7	• Commissioners ensure strong links between urgent care centres and other health/social care services as part of broader unscheduled care system. Potential forms of integration with other services include: access to support for mental health assessments 24 hours a day, seven days a week[27] • local mental health services need to be available 24 hours a day, 7 days a week for urgent and emergency access[28]	• Majority of patients were discharged home (43%) with low readmission rates within 30 days of discharge[29] • Feedback from the Integrated Health and Social Care Team Lead suggests that[30]: a. Referrals are dealt with much more quickly than before b. Answers to the referrer's questions are dealt with more quickly c. Speeds up hospital discharge and reduces length of stay d. More appropriate care for cohort of patients • Cost saving in terms of activity not needing to be commissioned[31], [32]
Tissue viability	Extended hours full service			7 day full service	7 day full service	7 day full service	• NHS Outcomes Framework 2014/15 – indicator 5.3, Proportion of patients with category 2, 3 and 4 pressure ulcers	
x-ray	7 day full service	Extended hours full	B/Extended hours	7 day full service	7 day full service	7 day full service	• Seven-day consultant presence in the radiology department is	• Appropriate use of imaging can reduce length of stay[36]

[25] : NHS Improving Quality- Improving access to stroke rehabilitation through a seven day therapy service on the stroke unit - Torbay and Southern Devon Health and Care Trust (2010)
[26] : DoH – 7 Day working, examples of innovation and good practice : Good Hope Hospital, Heartlands Hospital, Solihull Hospital (2011)
[27] NHS Commissioning Support for London (2010) A service delivery model for urgent care centres: Commissioning advice for PCTs
[28] Department of Health (2014) Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis (supported in the NHS Mandate 2014-15)
[29] local evaluation (Bassetlaw)
[30] local evaluation (Bassetlaw)
[31] local evaluation (Bassetlaw)
[32] Centre for Mental Health (2012) Liaison Psychiatry in the Modern NHS

Service	Hours currently available			Working towards			Supporting evidence	Desired Benefits
	North	Mid	South	BCF Year 1	BCF Year 2	Beyond BCF		
		service/ 7 day full service	full service				envisaged[33] • "Where imaging will affect immediate outcome, emergency surgical patients have access to CT, plain films and US within 30 minutes of request"[49] • All patients being admitted to a trust that accepts medical and surgical emergencies should have access 24 hours a day, seven days a week to interventional radiology[34]. As interventional radiology is now at the forefront of the management of many life-threatening emergencies[35]	• Reduce waiting list times for outpatient imaging through freeing up of equipment during the week[37] [38] • Timely imaging improves outcomes [39], [40] • Utilizing equipment and optimizing available resources[41], [42], [51]. • Performing CT in ED could reduce the number of avoidable hospital admissions
Computerised tomography (CT)	7 day full service	Extended hours limited service/ 7 day limited service	7 day limited service/ Extended hours full service	7 day full service	7 day full service	7 day full service		
Magnetic resonance imaging (MRI)	7 day full service	7 day limited service/ 7 day full service	7 day limited service/ Extended hours full service	7 day full service	7 day full service	7 day full service		
Radiology (Including	7 day full	Extended hours	7 day full	7 day full	7 day full	7 day full		

[36] :Juan C. Batlle, Peter F. Hahn, James H. Thrall, Susanna I. Lee, (2010) *Patients Imaged Early During Admission Demonstrate Reduced Length of Hospital Stay: A Retrospective Cohort Study of Patients Undergoing Cross-Sectional Imaging* J Am Coll Radiol;7:269-276.
[33] NHS England – NHS services seven days a week – Professor Sir Bruce Keogh (Dec 2013)
[34] :RCS (2011) Emergency Surgery Standards for unscheduled care
[35] :The Royal College of Radiologists – Standards for providing 24 hour interventional radiology services (2008)
[37] : DoH- 7 day working, examples of innovation and good practice (2011)
[38] :7 Day Working Examples of Innovation and Good Practice – Torbay Hospital (2011)
[39] : National Institute for Health and Clinical Excellence (2007). *Head Injury: Triage, assessment, investigation and early management of head injury in infants, children and adults.* http://www.nice.org.uk/nicemedia/live/11640/36255/36255.pdf
[40] :NICE (2008) Metastatic spinal cord compression
[41] : DoH – Implementing 7 day working in imaging departments: Good practice guidance - 2011
[42] : Taxpayer's Alliance – NHS machines utilisation of high-value equipment at NHS trusts - 2009

Service	Hours currently available			Working towards			Supporting evidence	Desired Benefits
	North	Mid	South	BCF Year 1	BCF Year 2	Beyond BCF		
Angiography)	service	limited service/ 7 day limited service/ 7 day full service	service	service	service	service		
Ultrasound	7 day limited service	Extended hours limited service/ 7 day limited service	Extended hours limited service	7 day limited service	7 day full service	24/7	• "Hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, CT, MRI, echocardiography, endoscopy, bronchoscopy and pathology"[43]	• A 7 day ultrasound service would allow for earlier exclusion of DVTs, and therefore reduce the need and cost for prescription anti-coagulants
Echocardiography	Extended hours full service	-	-	7 day limited service	7 day limited service	7 day limited service	• "Pathology, physiology and especially cardiac physiology and medical physics… are key priority areas to deliver services seven days a week"[44] • National recommendations state that all hospitals should have access to out-of-hours endoscopy services[63] [45].	• Improved outcomes for patients with an upper GI bleed,[45] massive Haemoptysis and inhalation of foreign bodies • Improved patient experience for working age adults[46]
Endoscopy	Extended hours full service	Extended hours limited service/ Extended hours full	-					

[43] NHS England – NHS services seven days a week – Professor Sir Bruce Keogh (Dec 2013)
[44] NHS England – NHS services seven days a week – Professor Sir Bruce Keogh (Dec 2013)
[45] : British Society of Gastroenterology
[46] : Royal Liverpool & Broadgreen University Hospitals NHS Trust - Expanding Endoscopy services seven days a week to meet emergency and non-emergency demand

Service	Hours currently available			Working towards			Supporting evidence	Desired Benefits
	North	Mid	South	BCF Year 1	BCF Year 2	Beyond BCF		
		service						
Bronchoscopy	Extended hours full service	-	-					
Pathology	7 day full service	7 day limited service/ 7 day full service	Extended hours limited service/ 7 day limited service	7 day full service	7 day full service	7 day full service	• Services should be organised so that clinical staff and diagnostic and support services are readily available on a 7-day basis[47]. • In any hospital which sees emergency patients blood must be available from blood bank 24hrs a day, seven days a week[48]	• Prompt diagnostic results can avoid admission and unnecessary cost to the trust[49] • Reduced risk of misdiagnosis[49].

[47] DoH – 7 Day working, examples of innovation and good practice : Golden Jubilee National Hospital (2011)
[48] DoH- 7 day working, examples of innovation and good practice (2011)
[49] : R. Goudie, M. Goddard -Review of Evidence on What Drives Economies of Scope and Scale in the Provision of NHS Services, Focusing on A&E and Associated Hospital Services (June 2011)

CONSULTANT WARD ROUNDS

Service	Area	Number of ward rounds on Saturday	Number of ward rounds on Sunday	Number of ward rounds on Bank Holidays	Working towards	Evidence
Consultant ward rounds – acute intake wards	North	2	2	2	Every patient reviewed at least once every 24 hours	• Patients should receive a quality of care dictated by their health status, not by the working pattern of providers[50 51 52]. • Consultants should work in AMU over 2-4 day blocks to allow for continuity of care[53] Benefits to patients and trusts: • Improved chance of survival (10% higher deaths for emergency admissions at the weekend)[54]. • lower 28 day readmission rate.' [55] • prompt diagnosis and timely intervention[56] • Allows for establishment of ceiling of care and resuscitation status as necessary[56] • earlier discharges of patients and reduced length of stay[57] • Senior cover on weekends provides educational opportunities to junior staff members[58 8]
	Mid	EAU 3 rounds per day Other wards – 1 per weekend (Sat or Sun)	EAU 3 rounds per day Other wards – 1 per weekend	-		
	South	2 consultants on B3 and D57 between 8am and 12pm for continuous review. 12pm-10pm 1 consultant to review on both wards. Extra 12pm to 4pm consultant cover on known busy Bank Holidays. LJU – cons 8am-8pm continuous review.	2 consultants on B3 and D57 between 8am and 12pm for continuous review. 12pm-10pm 1 consultant to review on both wards. Extra 12pm to 4pm consultant cover on known busy Bank Holidays. LJU – cons 8am-8pm continuous review.	2 consultants on B3 and D57 between 8am and 12pm for continuous review. 12pm-10pm 1 consultant to review on both wards. Extra 12pm to 4pm consultant cover on known busy Bank Holidays. LJU – cons 8am-8pm continuous review.		

[50] : RCP (2007) The right person in the right setting – first time
[51] : Dr. Foster Hospital guide – Fit for the future? (2012)
[52] NHS England – NHS services seven days a week – Professor Sir Bruce Keogh (Dec 2013)
[53] NHS England – NHS services seven days a week – Professor Sir Bruce Keogh (Dec 2013)
[54] : P Aylin, A Yunus, A Bottle, A Majeed, D Bell (2010) *Weekend mortality for emergency admissions. A large, multicentre study.* BMJ
[55] : The Royal College of Physicians. (2012) An evaluation of consultant input into acute medical admissions management in England.
Available at: http://www.rcplondon.ac.uk/sites/default/files/an-evaluation-of-consultant-input-into-acute-medical-admissions-management-in-england-2012.pdf
[56] : Royal College of Physicians – Delivering a 12 hour, 7 day consultant presence on the acute medical unit (Oct 2012)
[57] : McNeill G, Brahmbhatt D, Prevost A, Trepte N. What is the effect of a consultant presence in an acute medical unit? *Clinical Medicine* 2009:3:214-8.
[58] : Northumbria Healthcare NHS Foundation Trust – Implementing seven day services across a large geographically challenged trust

Service	Area	Number of ward rounds on Saturday	Number of ward rounds on Sunday	Number of ward rounds on Bank Holidays	Working towards	Evidence
Consultant ward rounds – Geriatric medicine	North	-	-	-	Every patient reviewed at least once every 24 hours	• Hospital inpatients should be reviewed by an on-site consultant at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient's care pathway[59] [60] Benefits to patients and trusts: • improves clinical effectiveness and general hospital performance[61] [62] • Allows greater possibility of weekend discharge, decreasing inpatient length of stay [62] • reduce errors and the cost of litigation to the trust[62] • Improved chance of survival[63] [64].
	Mid	1 per weekend	1 per weekend	-		
	South	1 per ward (for new and sick patients and weekend discharges)	1 per ward (for new and sick patients and weekend discharges)	1 per ward (for new and sick patients and weekend discharges)		

[59] : Academy of Medical Royal Colleges- Seven day consultant present care (Dec 2012).
[60] : Future Hospital – Caring for medical patients (sept 2013)
[61] : Harari, D., Martin, F. C., Buttery, A., O'Neill, S. & Hopper, A. (2007). The older person' assessment and liaison team "OPAL": evaluation of comprehensive geriatric assessment in acute medical inpatients. Age and Ageing, 36: 670-675
[62] : Academy of Medical Royal Colleges – The benefits of consultant delivered care (Jan 2012)
[63] : London Health Programmes – Adult emergency services: Acute medicine and emergency general surgery (A case for change) Sept 2011
[64] : Fremantle et al - Is weekend hospitalisation associated with an additional risk of death? A prognostic model derived from over 14 million hospitalisations in the National Health Service in England in 2009/10. (2010)

Older people often have complex health care needs which require a range of health and social care interventions, including hospital admissions when necessary.[65] Keogh[66] points out that seven day services are:

> *"not just about hospitals; it is about the whole system. One part cannot function efficiently at the weekend if other parts don't. Progress will be contingent on improving primary and social care services at weekends if we are not to dilute the efficiencies of the standard working week in secondary care."*

Key standards for community services include[67]:

- Multi-Disciplinary Team review (3):
  - Informed by existing primary and community care records
  - Appropriate staff must be available for the treatment / management plan to be carried out
- Mental health (7):
  - Effective links between liaison team and out of hours services where liaison teams do not provide 24 hour cover
- Transfer to community, primary and social care (9):
  - Support services in the hospital and in primary, community and mental health settings must be available seven days a week
  - Transport services must be available to transfer, seven days a week.

The evidence for which community services have a successful impact is sparser than for hospital services and much of the evidence presented below does not specifically relate to seven day services.

The Kings Fund (2014)[68] has identified the main steps as:

- reduce complexity of services
- wrap services around primary care
- build multidisciplinary teams for people with complex needs, including social care, mental health and other services
- support these teams with specialist medical input and redesigned approaches to consultant services – particularly for older people and those with chronic conditions
- create services that offer an alternative to hospital stay
- build an infrastructure to support the model based on these components including much better ways to measure and pay for services
- develop the capability to harness the power of the wider community.

This approach requires locality-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social care services.

Prevention / Step-up

Better management, including self-management of long term conditions, a swift response to acute illness, and improved community health provision to care home residents may help reduce the numbers of hospital admissions.[69]

[65] SCIE. SOCIAL CARE TV: AVOIDING UNNECESSARY HOSPITAL ADMISSIONS: THE HEADLINES
[66] NHS Services, Seven Days a Week: Clinical Standards
[67] NHS Services, Seven Days a Week: Clinical Standards
[68] Kings Fund (February 2014) - Community services How they can transform care

Step-down

Factors influencing length of stay include:

- Sufficient capacity and seven day availability of community-based resources such as primary care and social care[70] [71]
- lack of senior clinical review and timely access to therapies.[72]
- reduced co-ordination between services.[73]
- Hospital staff culture[74]
- No delays to assessment or funding[75]

The Academy of Medical Royal Colleges (2013)[76] conducted a survey of their members in relation to the non-hospital based services that are regularly required at weekends to facilitate discharge. Key themes included the importance of access to community beds, step-down facilities and home care services in order to facilitate the transfer of care of the patient from the hospital to the community. Facilities for early outpatient review or ward assessment for patients discharged at weekends may also help support safe discharge.

[69] SCIE. Social care TV: Avoiding Unnecessary Hospital Admissions: The Headlines
[70] NHS Services, Seven Days a Week Forum Summary of Initial Findings (December 2013)
[71] Kings Fund (February 2014) - Community services How they can transform care
[72] NHS Services, Seven Days a Week Forum Summary of Initial Findings (December 2013)
[73] NHS Services, Seven Days a Week Forum Summary of Initial Findings (December 2013)
[74] Kings Fund (February 2014) - Community services How they can transform care
[75] Kings Fund (February 2014) - Community services How they can transform care
[76] Academy of Medical Royal Colleges (2013) Seven Day Consultant Present Care Implementation Considerations

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
Intermediate care – bed based	Extended hours limited service	Extended hours limited service	Extended hours limited service/7 day full service	7 day limited service	7 day limited service	7 day limited service	• Improved opportunity for patients to decide on their future before being admitted to long-term care, and also to improve value for money[77] • Improved outcomes and functional improvements for patients than in a general hospital.[78] Outcomes for hip fracture patients did not differ between patients admitted to a rehabilitation hospital or a nursing home in terms of the number returning home and functional ability.[79] (See also assessment beds)
Intermediate care – home based	7 day limited service	7 day limited service	7 day limited service	7 day limited service	7 day limited service	7 day limited service	• Improved outcomes for service users with majority remaining at home, which is consistent with both the South Nottinghamshire services.[80]
Assessment beds	No extended service	No extended service	No extended service	7 day limited service	7 day limited service	7 day limited service	• significantly reduces acute bed use.[81] • increased independence and has similar cost-effectiveness compared to post-acute care in general hospitals[82] • fewer days in hospital over 3 and 12 months but no more/less likely to be institutionalised[83] • no adverse effects for service users (death and hospital readmission) [84], [85] • less likely to be institutionalised (acute setting)[86]

[77] Audit Commission (2011). Joining Up Health and Social are; Improving value for money across the interface.

[78] Young J, Green J, Forster A., Small, N.,Lowson, K., Bogle, S., George, J., Heseltine, D., Jayasuriya, T., and Rowe, J (2007). Postacute care for older people in community hospitals: a multicenter randomized, controlled trial. Journal of the American Geriatrics Society, 55:1532-5415

[79] Kramer AM, Steiner JF, Schlenker RE, Eilertsen TB, Hrincevich CA, Tropea DA, Ahmad LA, Eckhoff DG. (1997). Outcomes and costs after hip fracture and stroke. A comparison of rehabilitation settings. JAMA. 1997 Feb 5;277(5):396-404. Abstract – accessed online 16th July 2013 at http://www.ncbi.nlm.nih.gov/pubmed/9010172

[80] National Audit of Intermediate Care 2013 – Local Data for Mid and South Nottinghamshire

[81] Kings Fund (February 2014) - Community services How they can transform care

[82] Young J, Green J, Forster A, Small N, Lowson K, Bogle S, George J, Heseltine D, Jayasurriya T, Rowe J. (2007) Postacute care for older people in community hospitals: a multicenter randomized, controlled trial. J American Geriatr Assoc.; 55: 1995-2002.

[83] Fleming, S.A., Blake, H., Gladman, J.R.F., Hart, E., Lymbery, M.,Dewery, M.E., McCloughty, H., Walker, M., Miller, P. (2004). A randomised controlled trial of a care home rehabilitation service to reduce long-term institutionalisation for elderly people. *Age and Ageing* 2004; 33: 384–390

[84] Crotty, M., Whitehead, C.H., Wundke, R., Giles, L.C., Ben-Tovim, D., Phillips, P.A. (2005). Transitional care facility for elderly people in hospital awaiting a long term care bed: randomised controlled trial. BMJ, doi:10.1136/bmj.38638.441933.63

[85] Fleming, S.A., Blake, H., Gladman, J.R.F., Hart, E., Lymbery, M.,Dewery, M.E., McCloughty, H., Walker, M., Miller, P. (2004). A randomised controlled trial of a care home rehabilitation service to reduce long-term institutionalisation for elderly people. *Age and Ageing* 2004; 33: 384–390

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
							• similar physical outcomes to normal care but increased satisfaction and short-term gains in mental functioning.[87] • The majority of service users discharged home (30%[88] to 60%[89]), 16% hospital and 15% admitted to residential care. [90] • After 30 days, the majority of patients discharged home remained at home (89%)[91]: • At 90 days, 53% of service users discharged home had maintained the dependency of their setting and 21% had increased the dependency of their setting[92] • Data on functional ability (Bartel Index) shows that there were improvements in patient functional ability. [93]
Crisis response service / home from hospital	7 day full service	7 day full service/7 day limited service	7 day full service	7 day full service	7 day full service	7 day full service	• Reduced hospital admissions[94], bed days[95],[96], and social care spend[97]. Models such as this, and the use of the 'discharge to assess' approach, can also reduce the need for nursing home and residential care.[98] • An Audit Commission recommended service for improving value for money[99] • Positive user and carer feedback[100]

[86] Hutchinson, S.G., Tarrant, J., Severs, M.R. (1998). INNOVATIONS IN CLINICAL PRACTICE: An inpatient bed for acute nursing home admissions. Age *and Ageing* 1998; 27: 95-98
[87] Boston, N.K., Boynton, P.M., and Hood S. (2001). An inner city GP unit versus conventional care for elderly patients: prospective comparison of health functioning, use of services and patient satisfaction. Family Practice, 18, 141-148
[88] South of County Assessment Beds Evaluation 2012-2013
[89] Residential Intermediate Care Service at Westwood: Assessment Beds. Reablement Programme Evaluation 2012-2013
[90] Residential Intermediate Care Service at Westwood: Assessment Beds. Reablement Programme Evaluation 2012-2013
[91] Residential Intermediate Care Service at Westwood: Assessment Beds. Reablement Programme Evaluation 2012-2013
[92] South of County Assessment Beds Evaluation 2012-2013
[93] Residential Intermediate Care Service at Westwood: Assessment Beds. Reablement Programme Evaluation 2012-2013
[94] Reablement Programme Q4 position 2012-2013: NHS Nottinghamshire County - Crisis support services in the South of the County (UCSS and CICSS)
[95] NHS IQ 2013 A seven day integrated admission avoidance service to improve care for older people (Oxleas Joint Emergency Team (JET)
[96] Reablement Programme Q4 position 2012-2013: NHS Nottinghamshire County - ED Avoidance and Support Service (EDASS)
[97] NHS IQ 2013 A seven day integrated admission avoidance service to improve care for older people (Oxleas Joint Emergency Team (JET)
[98] Kings Fund (February 2014) - Community services How they can transform care
[99] Audit Commission (2011). Joining Up Health and Social are; Improving value for money across the interface.
[100] NHS IQ 2013 Providing care closer to home for frail and older people (Pan Gwent Frailty Service)

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
service							• More weekend discharges and reduced length of stay across elderly beds[101] • Earlier diagnosis and timely interventions when they are needed[102] • Rapid access to health and social care support, enabling people to remain at home and avoid admission to hospital when this is not necessary. 2771 admissions have been avoided since April 2011[103] • Activity from 2012/13 shows that the majority of patients remained at home (50%) on discharge and at 90 days [104] , [105]. Between 27-38% remained at home without a care package, whilst 35-65% where in receipt of a care package[106]
Community ward	-	7 day limited service	Extended hours limited service	7 day full service	7 day full service	7 day full service	• An Audit Commission recommended service for improving value for money[107] • Identifies people at high predicted risk of unplanned hospital admission living in the local population and proactively manages them to avoid unplanned admissions.[108] • Reduction in the number of delays experienced in receiving care.[109] • Increase in the number of people receiving urgent care in a familiar primary care setting. [110] • Reduction in number of referrals between different points within the urgent care system. [111] • Increase in ability to design services around person's need.[112] • Reduction in unnecessary ambulance journeys.[113]

[101] NHS IQ 2013 Providing care closer to home for frail and older people (Pan Gwent Frailty Service)
[102] NHS IQ 2013 Providing care closer to home for frail and older people (Pan Gwent Frailty Service)
[103] NHS IQ 2013 A seven day integrated admission avoidance service to improve care for older people (Oxleas Joint Emergency Team (JET))
[104] Reablement Programme Q4 position 2012-2013 NHS Bassetlaw - Rapid Response Therapy Team
[105] Reablement Programme Q4 position 2012-2013: NHS Nottinghamshire County - Lings Bar Hospital Enhanced Community Support Service
[106] Reablement Programme Q4 position 2012-2013: NHS Nottinghamshire County - Crisis support services in the South of the County (UCSS and CICSS)
[107] Audit Commission (2011). Joining Up Health and Social are; Improving value for money across the interface.
[108] Interview with Dr. Geraint Lewis. January 2011.- IPC (2013) Research for Preventative Approaches to Reducing Older People's Need for Care (Nottinghamshire County Council)
[109] Interview with Dr. Geraint Lewis. January 2011.- IPC (2013) Research for Preventative Approaches to Reducing Older People's Need for Care (Nottinghamshire County Council)
[110] Interview with Dr. Geraint Lewis. January 2011.- IPC (2013) Research for Preventative Approaches to Reducing Older People's Need for Care (Nottinghamshire County Council)
[111] Interview with Dr. Geraint Lewis. January 2011.- IPC (2013) Research for Preventative Approaches to Reducing Older People's Need for Care (Nottinghamshire County Council)
[112] Interview with Dr. Geraint Lewis. January 2011.- IPC (2013) Research for Preventative Approaches to Reducing Older People's Need for Care (Nottinghamshire County Council)
[113] Interview with Dr. Geraint Lewis. January 2011.- IPC (2013) Research for Preventative Approaches to Reducing Older People's Need for Care (Nottinghamshire County Council)

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
							• Reduction in A&E workloads and staff costs.[114] • Reduction in duplication of work by people being passed to other organisations.[115] • Reduction in the time people spend unnecessarily in a hospital bed. [116]
Intensive Recovery Intervention Service (IRIS)	Extended hours limited service	Extended hours limited service	Extended hours limited service	Extended hours limited service	7 day full service	7 day full service	• Facilitates discharge[117], [118] • Prevents admissions to hospital and residential and nursing care[119], [120], [121] • Prevents increases in the intensity of care packages[122] • Enables ward closures[123] • Increases probability of remaining at home[124] • Positive feedback from service users and stakeholders
Mental health crisis response service	Extended hours full service	7 day limited service	7 day full service	7 day full service	7 day full service	7 day full service	• local mental health services need to be available 24 hours a day, 7 days a week for urgent and emergency access[125] • Reduced consumption of health and social care resources[126], [127] • Improved economic and social outcomes for older people [128]
Falls teams	No	No	No	7 day	7 day	7 day	• Improved patient outcomes and reduced risk of falls[129] [130], [131]

[114] Interview with Dr. Geraint Lewis. January 2011.- IPC (2013) Research for Preventative Approaches to Reducing Older People's Need for Care (Nottinghamshire County Council)
[115] Interview with Dr. Geraint Lewis. January 2011.- IPC (2013) Research for Preventative Approaches to Reducing Older People's Need for Care (Nottinghamshire County Council)
[116] Interview with Dr. Geraint Lewis. January 2011.- IPC (2013) Research for Preventative Approaches to Reducing Older People's Need for Care (Nottinghamshire County Council)
[117] NHS IQ 2013 Spreading an older people mental health intermediate support model across Lancashire
[118] Reablement Programme Q4 position 2012-2013: NHS Nottinghamshire County
[119] NHS IQ 2013 Spreading an older people mental health intermediate support model across Lancashire
[120] Local evaluation (Nottinghamshire)
[121] Reablement Programme Q4 position 2012-2013: NHS Nottinghamshire County
[122] NHS IQ 2013 Spreading an older people mental health intermediate support model across Lancashire
[123] Local evaluation (Nottinghamshire)
[124] Local evaluation (Nottinghamshire)
[125] Department of Health (2014) Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis (supported in the NHS Mandate 2014-15)
[126] Age UK (2011). Effectiveness of day services *Summary of research evidence*
[127] JOINT STRATEGIC NEEDS ASSESSMENT FOR NOTTINGHAMSHIRE 2012 Adults and Vulnerable Adults 2. Vulnerable and Seldom Heard Groups
[128] Marmot et al. 2003 cited in NICE public health guidance 16 (2008) Mental wellbeing and older people
[129] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
	extended service	extended service	extended service	limited service	limited service	limited service	• Reduced the risk of hospital admission [132] • Falls prevention is cost effective. The economic evidence for vitamin D and calcium supplements is contradictory and there is no evidence for osteoporosis and vision screening[133], [134] • Supports elderly people to live safely and independently, and could be tailored to meet individuals' needs and preferences.[135] • Reduced nursing-home admissions - in populations with increased death rates, interventions were associated with reduced nursing-home admission.[136] • Housing adaptations reduce the costs of homecare (saving £1,200 to £29,000 a year) [137]
District nursing	Extended hours limited service	Extended hours limited service	Extended hours limited service	Extended hours limited service	7 day limited service	7 day limited service	• Commissioners should ensure that there are strong links between urgent care and other health and social care services, including community nursing and integrated health and social care[138]
Outpatient	N/A	Extended	Extended	7 day	7 day	7 day	• Improved patient choice and satisfaction[139], [140], [141]

[130] Cameron ID, Handoll HHG, Finnegan TP et al. Co-ordinated multidisciplinary approaches for inpatient rehabilitation of older patients with proximal femoral fractures (Cochrane review) In: The Cochrane Library, Issue 3, 2003.
[131] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35
[132] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35
[133] Health England Report No. 2 (2009). Prevention and Preventative Spending
[134] *Falls and fractures: effective interventions in health and social care* Department of Health (2009)
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[137] Lang and Buisson (2008) Annual Cost of Care Home Report.
[138] NHS Commissioning Support for London (2010) A service delivery model for urgent care centres: Commissioning advice for PCTs
[139] Kayley, J. (2008) Effective practice in community IV therapy. British Journal of Community Nursing. 13; 7: 323-4, 326-8
[140] O'Hanlon S et al (2008) Delivering intravenous therapy in the community setting, Nursing Standard 22; 31: 44-48
[141] Local evaluation – Sherwood Forest Hospitals

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
Parenteral Antibiotic Therapy		hours limited service	hours limited service	limited service	limited service	limited service	• Reduced risk of hospital acquired infection[142] • Improved antimicrobial stewardship[143] • QIPP efficiency gains from early discharge or avoided hospital admissions. OPAT episodes of care are estimated to cost around 50% of equivalent inpatient costs.[144] • Avoided hospital admissions[145] • Reduced length of stay [146], [147]
Tissue viability	No extended service	No extended service	No extended service	Extended hours limited service	7 day limited service	7 day limited service	• NHS Outcomes Framework 2014/15 – indicator 5.3, Proportion of patients with category 2, 3 and 4 pressure ulcers • Cost effective[148] • Reduced risk of pressure ulcer damage and more appropriate management in care homes [149]
Continence promotion		No extended service	No extended service	Extended hours limited service	7 day limited service	7 day limited service	• Less than half of adults with moderate or severe urinary incontinence seek help.[150] SIGN recommendations include: o Offered information and advice on treatment in primary and secondary care o Access to trained health professionals • Reduced hospital admissions and length of stay[151] • Reduced care home admission[152]
Specialist services that	The following services are expected to support care homes:			7 day full service	7 day full service	7 day full service	• Issues within care homes include:

[142] O'Hanlon S et al (2008) Delivering intravenous therapy in the community setting, Nursing Standard 22; 31: 44-48
[143] Department of Health. Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) (2011) Antimicrobial stewardship: Start smart - then focus.
[144] Chapman ALN et al (2009) Clinical efficacy and cost effectiveness of outpatient parenteral antibiotic therapy (OPAT): a UK perspective. J Antimicrob Chemother64:1316.
[145] Local evaluation – Sherwood Forest Hospitals
[146] Local evaluation – Sherwood Forest Hospitals
[147] Local evaluation – Nottingham University Hospitals
[148] Local evaluation (Bassetlaw) Tissue Viability Service
[149] Local evaluation (Bassetlaw): Tissue Viability Service
[150] SIGN (2004). Management of urinary incontinence in primary care: A national clinical guideline (79)
[151] Hospital Episode Statistics (HES) (2009/2010)
[152] Thom et al (1997) Medically recognized urinary incontinence and risks of hospitalization, nursing home admission and mortality Age and Ageing 26:367-374

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
support care homes	• District nursing • Community ward • Falls teams • Specialist nurses • Physiotherapy / occupational therapy / pharmacy / podiatry / SALT						o Infection control and cleanliness o Medication management o Staffing and leadership o Tissue viability o Falls o End of life care • Plausible that they are cost effective, and improve health outcomes. [153], [154], [155] • Reduction in hospital admissions[156]
Specialist Nurse Services (COPD, Heart Failure, respiratory, and dementia outreach)	No extended service	No extended service	No extended service	No extended service	No extended service	No extended service	• There should be primary care–led management of long term conditions which may reduce the number of unscheduled care episodes[157]
Equipment - ICES	7 day limited service	7 day limited service	7 day limited service	7 day limited service	7 day limited service	7 day limited service	• DOH recommended intervention [158] • Support people to live independently for longer[159], [160] • To prevent accidents in the home, local authorities can[161]: o implement guidance from the NICE (2010)[162] and the Safe At Home programme,[163] which includes:

[153] University of Nottingham – Medical Crisis in Older People (MCOP) (2011). Discussion paper series: Nurse Practitioners in UK care homes
[154] Local evaluation – Care Homes pharmacist (Nottingham West)
[155] Local evaluation – Care Homes pharmacist (Nottingham West)
[156] Reablement Programme Q4 position 2012-2013: NHS Nottinghamshire County - Care Home crisis services (CHUCS and M&A Care Home bid)
[157] Quality of Care for Older People with Urgent and Emergency Care needs "Silver Book"
[158] Department of Health (2004). Avoiding and diverting admissions to hospital - a good practice guide
[159] Kings Fund (2013) Improving the public's health: A resource for local authorities
[160] National Housing Federation (2013). *Providing an Alternative Pathway: The value of integrating housing, care and support*. London: National Housing Federation. Available at: www.housing.org.uk/publications/browse/providing-an-alternative-pathway
[161] Kings Fund (2013) Improving the public's health: A resource for local authorities

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
							▪ installing safety gates for stairs and doorways, window restrictors, and cupboard locks ▪ providing non-slip bath/shower mats, corner cushions, and fireguards ▪ training relevant staff (including health visitors and family support workers) and community members to run their own schemes o prioritise high-risk groups, targeting interventions at: ▪ those with children under five ▪ those living in rented or overcrowded conditions o those on low incomes.
Transport	7 day full service	7 day full service	7 day full service	7 day full service	7 day full service	7 day full service	• Transfer to community, primary and social care (9):[164] o Transport services must be available to transfer, seven days a week. • Timely transport home / to appointment • Appropriate use of resources .[165] • Reduced hospital length of stay.[166] • Reduced reliance on unplanned travel options.[167]
Access to ASCH&PP services -	No extended service	No extended service	No extended service	7 day limited service[168]	7 day limited service	7 day limited service	• Improved function and reduced need for home and community care services[169], [170], [171] [172], [173], [174], [175]

[162] National Institute for Health and Clinical Excellence (NICE) (2010). *Preventing Unintentional Injuries among under-15s in the Home: Costing report*. NICE public health guidance 30. London: NICE. Available at: http://guidance.nice.org.uk/PH30/CostingReport/pdf/English

[163] Errington G, Watson M, Hamilton T, Mulvaney C, Smith S, Binley S, Coupland C, Kendrick D, Walsh P (2011). *Evaluation of the National Safe At Home Scheme – Final Report for the Royal Society for the Prevention of Accidents*. Nottingham: University of Nottingham. Available at: www.rospa.com/homesafety/safeathome/final-evaluationreport.pdf

[164] NHS Services, Seven Days a Week: Clinical Standards

[165] Audit Scotland (2011) Transport for Health and Social Care

[166] Audit Scotland (2011) Transport for Health and Social Care

[167] Audit Scotland (2011) Transport for Health and Social Care

[168] Developing link with Intermediate Care teams

[169] Ryburn B, Wells Y, Foreman P. Enabling independence: restorative approaches to home care provision for frail older adults. *Health Social Care Commun* 2009; 17: 225–34.

[170] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35

[171] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
START							• Improved safety for older people[176] • Cost effective[177] • Reduced falls[178] • Reduced the risk of hospital admissions [179] [180] • reduced nursing-home admissions - in populations with increased death rates, interventions were associated with reduced nursing-home admission.[181], [182], [183]
Access to ASCH&PP services - Homecare	No extended service	No extended service	No extended service	7 day limited service	7 day limited service	7 day limited service	
Access to ASCH&PP services - Meals at	No extended service	No extended service	No extended service	No extended service / 7 day	No extended service / 7 day	No extended service / 7 day	

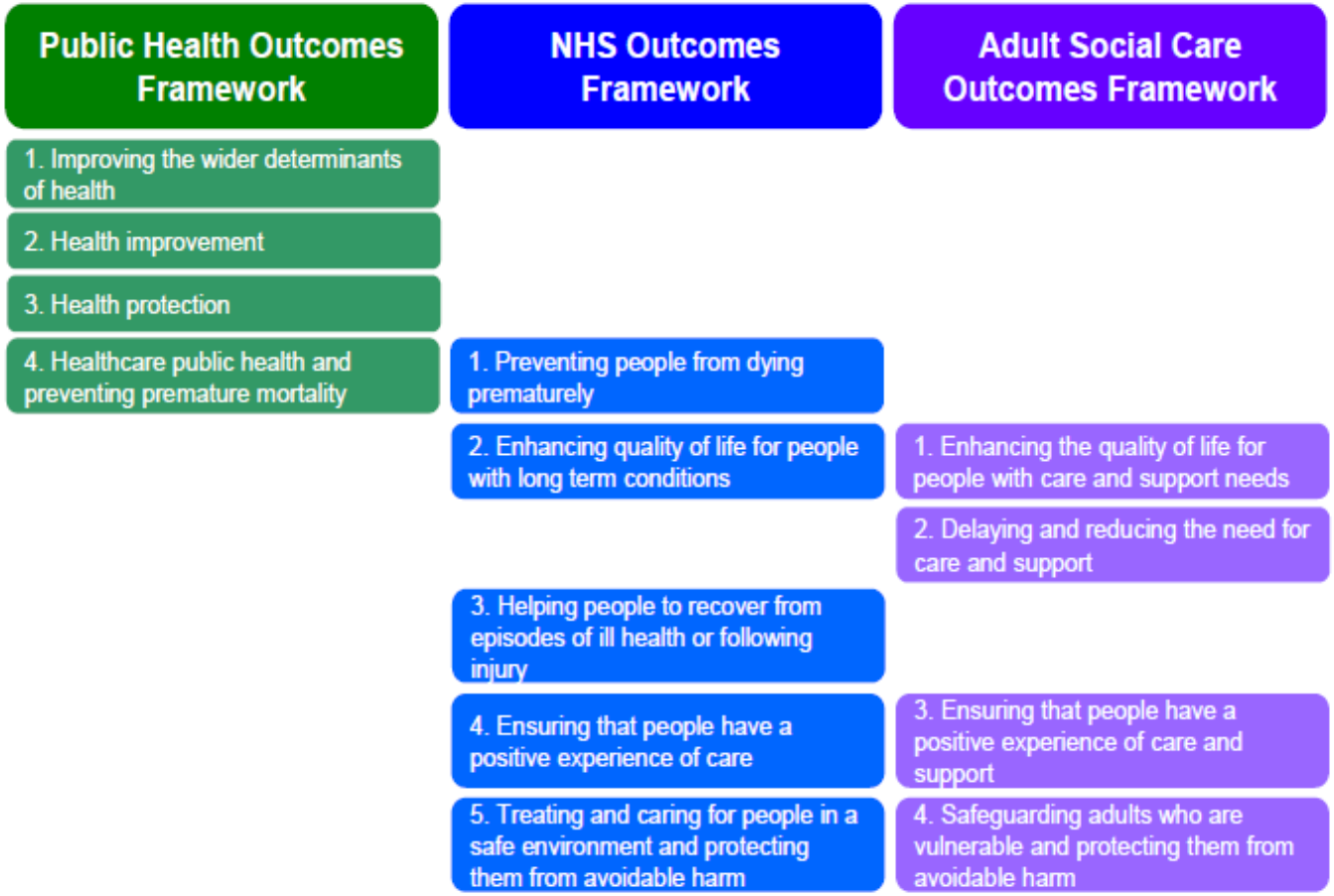
[172] Lewin G et al (2006) *Programs to promote independence at home: How effective are they?* Australia: Silver Chain
[173] Kent el at (2000). External Evaluation of the Home Care Reablement Pilot Project. De Montfort University
[174] Newbronner L, Baxter M, Chamberlain R *et al* (2007) *Research into the Longer-Term Effects of Reablement Services*. York: Social Policy Research Unit, University of York
[175] Care Services Efficiency Delivery (CSED) Programme (2007) *Homecare Re-ablement Workstream: Discussion Document*
[176] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35
[177] Whole Systems Partnership (2011). The reablement agenda: challenges and Opportunities: Brief Overview and Analysis.
[178] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35
[179] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35
[180] Fleming SA, Blake H, Gladman JR et al. A randomised controlled trial of a care home rehabilitation service to reduce long-term institutionalisation for elderly people. *Age Ageing* 2004; 33(4): 384-90.
[181] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35
[182] Elkan, R., Kendrick, D., Dewey, M., Hewitt, M., Robinson, J., Blair, M., Williams, D., Brummell, K. (2001). Effectiveness of home based support for older people: systematic review and meta-analysis. *BMJ* 323:1–9
[183] Beswick, A.D., Rees, K., Dieppe, P., Avis, S., Gooberman-Hill, R., Horwood, J., Ebrahim, S. (2008). Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis. *Lancet* 371: 725–35

Service	Hours available to new referrals			Recommended level of cover			Desired Benefits
	North	Mid	South	BCF year 1	BCF year 2	Beyond BCF	
home				limited service for hospital discharge	limited service for hospital discharge	limited service for hospital discharge	
Physiotherapy				7 day limited service	7 day limited service	7 day limited service	• Improved functioning and reduced reliance on on-going care packages.[184]
Occupational therapy				7 day limited service	7 day limited service	7 day limited service	NICE Guidance[185] • Offer regular sessions that encourage older people to construct daily routines to help maintain or improve their mental wellbeing. The sessions should also increase their knowledge of a range of issues, from nutrition and how to stay active to personal care. • Offer tailored, community-based physical activity programmes. These should include moderate-intensity activities (such as swimming, walking, dancing), strength and resistance training, and toning and stretching exercises. • Advise older people and their carers how to exercise safely for 30 minutes a day on 5 or more days a week, using examples of everyday activities such as shopping, housework and gardening. (The 30 minutes can be broken down into 10-minute bursts.) • Promote regular participation in local walking schemes as a way of improving mental wellbeing. Help and support older people to participate fully in these schemes, taking into account their health, mobility and personal preferences. • Involve occupational therapists in the design of training offered to practitioners.

[184] Reablement Programme Q4 position 2012-2013: NHS Nottinghamshire County - Integrated Physiotherapy Service

[185] Public health guidance, Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care PH16 - Issued: October 2008

OUTCOME FRAMEWORKS



Department of Health (2012) Improving health and care: The role of the outcomes frameworks

Nottinghamshire County Council

OUTCOME FRAMEWORKS IN RELATION TO SEVEN DAY SERVICES IMPACT

Public Health Outcomes Framework (2013-16)		NHS Outcomes Framework (2014/14)		Adult Social Care Outcomes Framework (2014/15)	
Domain	**Indicator**	**Domain**	**Overarching Indicator / Improvement areas**	**Domain**	**Overarching Measure / Outcome Measure**
1		1		1	1A Social care-related quality of life 1B People manage their own support as much as they wish so that they are in control of what, how and when support is delivered to match their needs
2	2.24 Injuries due to falls in people aged 65 and older	2	2.1 Ensuring people feel supported to manage their condition 2.2 Improving functional ability in people with long-term conditions 2.3 reducing time spent in hospital by people with long-term conditions 2.4 Enhancing quality of life for carers 2.5 enhancing quality of life for people with mental illness 2.6 Enhancing quality of life for people with dementia	2	2A Permanent admissions to residential and nursing care homes 2B proportion of older people who were still at home 91 days after discharge from hospital into residential / reablement services 2C delayed transfers of care from hospital, and those which are attributable to adult social care 2F dementia - a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life
3		3	3.5 Improving recovery from fragility fractures 3.6 Helping older people to recover their independence after illness or injury	3	3A overall satifcation ofo people who use services with their care and support 3B overall satisfcation of carers with social services 3E improving people's expernience of integrated care
4	4.9 Excess under 75 mortality rate in adults with serious mental illness 4.11 Emergency readmissions within 30 days of discharge from hospital 4.13 Health related quality of life for older people 4.14 Hip fractures in people aged 65 and over	4	4.4 Improving access to primary care services 4.6 Improving the experience of care for people at the end of their lives 4.7 Improving experience of healthcare for people with mental illness 4.9 Improving people's experience of integrated care	4	

Public Health Outcomes Framework (2013-16)		NHS Outcomes Framework (2014/14)		Adult Social Care Outcomes Framework (2014/15)	
Domain	Indicator	Domain	Overarching Indicator / Improvement areas	Domain	Overarching Measure / Outcome Measure
	4.16 Estimated diagnosis rate for people with dementia				
		5	5.2 Incidence of healthcare associated infection 5.3 proportion of patients with category 2,3 and 4 pressure ulcers 5.4 Incidence of medication errors causing serious harm		

Bassetlaw
A Community of Care and Support.

Vision	Better care for the frail and elderly	More and better care and support at home and in places nearby.	A high quality personal and efficient service from local doctors, nurses and other professionals, who they work for will not matter.	A high quality local Hospital with 7 day working, easy access, and essential services like a 24 hour Emergency Department, and consultant-led maternity unit.	Same day local care, with access to the right health care professional.	More support for independent living with enhanced sheltered housing choices.	Patients with a mental health condition to receive an excellent service.	Care homes to be an integral part of our local community
Outcomes	**Improved access to services for people with urgent problems, including clear information and alternatives to face to face appointment where appropriate.**	**Improved community services built around the primary care team and caring for more people in their own homes.**	**Improved care home quality, more clinical input, co-ordinated care and transparency.**	**Improved access to mental health services focusing on urgent problems, vulnerable patients and integration with primary health care teams**	**Improved discharge processes focusing on early senior review, access to alternative services and appropriate care planning.**			
Program	**Urgent Care**	**Care for Elderly in Community**	**Care Homes**	**Mental Health Services**	**Supporting people after acute illness**			
Program Goals	• Improved model of same day care in Retford and Worksop • Improved model of same day care for villages. • Improved care out of hours.	• Improved intermediate care • New model of community based geriatric care (inc. Care Homes). • Primary Care Teams co-ordinating person centred care.	• New enhanced range of accommodation for older people. • Quality assurance framework across nursing and residential sector. • Alternative short-term service in care home setting. • New support living arrangements shared links and respite.	• Improved link between physical and mental health services. • Increased emphasis on prevention and early intervention. • Increased integration with primary care teams.	• Independence & Re-ablement unit. • Re-ablement pathways. • Community based assessment.			
Supporting Projects	• Increased capacity in primary urgent services. • Joint working to sustain A&E service. • Review of our of hours model.	• Primary care led team-working • Developing community geriatric service. • Identification and care planning for most vulnerable. • Improved communications and records sharing. • Responsible clinician. • Improved access to intermediate care services.	• Develop a care home quality dashboard/transparent quality assurance. • Care plans for patients with medical input. • Pharmacy and community service input. • Enhanced dementia nurse specialist access. • Develop alternatives to care homes where appropriate.	• 24 hour access to mental health services in A&E. • Identification and care plans for frequent users and vulnerable patients. • Integration and record sharing with primary care. • Improve focus with mental health problems and increased physical illness risk.	• Enhanced early senior review an discharge planning with early involvement of patients and social care team. • Improved access to intermediate care and alternatives to acute hospital beds. • Communication around delayed discharges and identification of barriers. • Discharge to assess model. • Care plans for vulnerable patients and clearer community input to ATC and A&E.			
Shared Values	Trust each other	Collaborate for the patient and service user	Be transparent	Share resources	Invest Our Time	Talk to local people and our staff	Build long term solutions.	Quality and Safety comes first	Our community is more important than any one organisation.	Share Skills	Provide Leadership	Encourage people to innovate.

Newark and Sherwood Clinical Commissioning Group | Mansfield and Ashfield NHS Clinical Commissioning Group | Nottinghamshire Healthcare NHS Trust | Sherwood Forest Hospitals NHS Foundation Trust | Nottinghamshire County Council

Mid-Nottinghamshire NHS Integrated Care Transformation Programme (ICTP)

Presentation to the Nottinghamshire County Council Health and Wellbeing Board

June 5th 2013

Transformation Partnership – leadership vision

- During 2012 and in light of economic and demographic pressures, Health and Social Care leaders agreed that a whole-system strategic service review was required to identify options for a sustainable health economy across Mid-Nottinghamshire.
- Both Commissioners and Providers of services to the locality have agreed that the work must focus on meeting population health needs, and that whilst organisational impacts will be differential, they must not take precedence over reaching a system-wide solution.
- It was recognised early on that to create a whole system solution would require **fully integrated hospital, community, primary and social care**
- This requires incremental and transactional service improvement, but also **transformational change**.
- Patients, not organisations, must be at the centre of the transformation; and able to manage their own care where possible and easily access the right services at the right time.
- The first phase of work comprising detailed analysis of current baseline, together with clinical leadership to scope new ways of working that meet population health needs completed in April. This has produced a **"blueprint" for how services should look in 3 to 5** years. This now needs wider stakeholder engagement to support implementation over 1 to 2 years.

What do we mean by integrated care ?

Definition

Integrated care refers to a way of organising services whereby the patient's journey through the system of care is made as simple as possible. It is:

"*Care, which imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless." (Lloyd and Wait (2005)*

Five principles

- Integrated care must focus on those patients for whom current care provision is disjointed and fragmented, mainly complex patients with co-morbidities.
- Effective clinical leadership must exist, to promote changes in clinical behaviour.
- The interaction between generalist and specialist clinicians must promote real clinical integration.
- There must be integrated information systems that allow the patient's journey to be mapped across a care pathway at any moment in time.
- Financial and non-financial incentives must be aligned to provide the conditions to ensure that care delivery is of high quality and cost-effective.

What do we know about our local services ?

Through discussions with care professionals, patients and their representatives and carers the following were established as key challenges to how care is delivered to the public:

•Poor communication across organisations and a lack of integration of services;

•A lack of understanding of the services available and how to access these services;

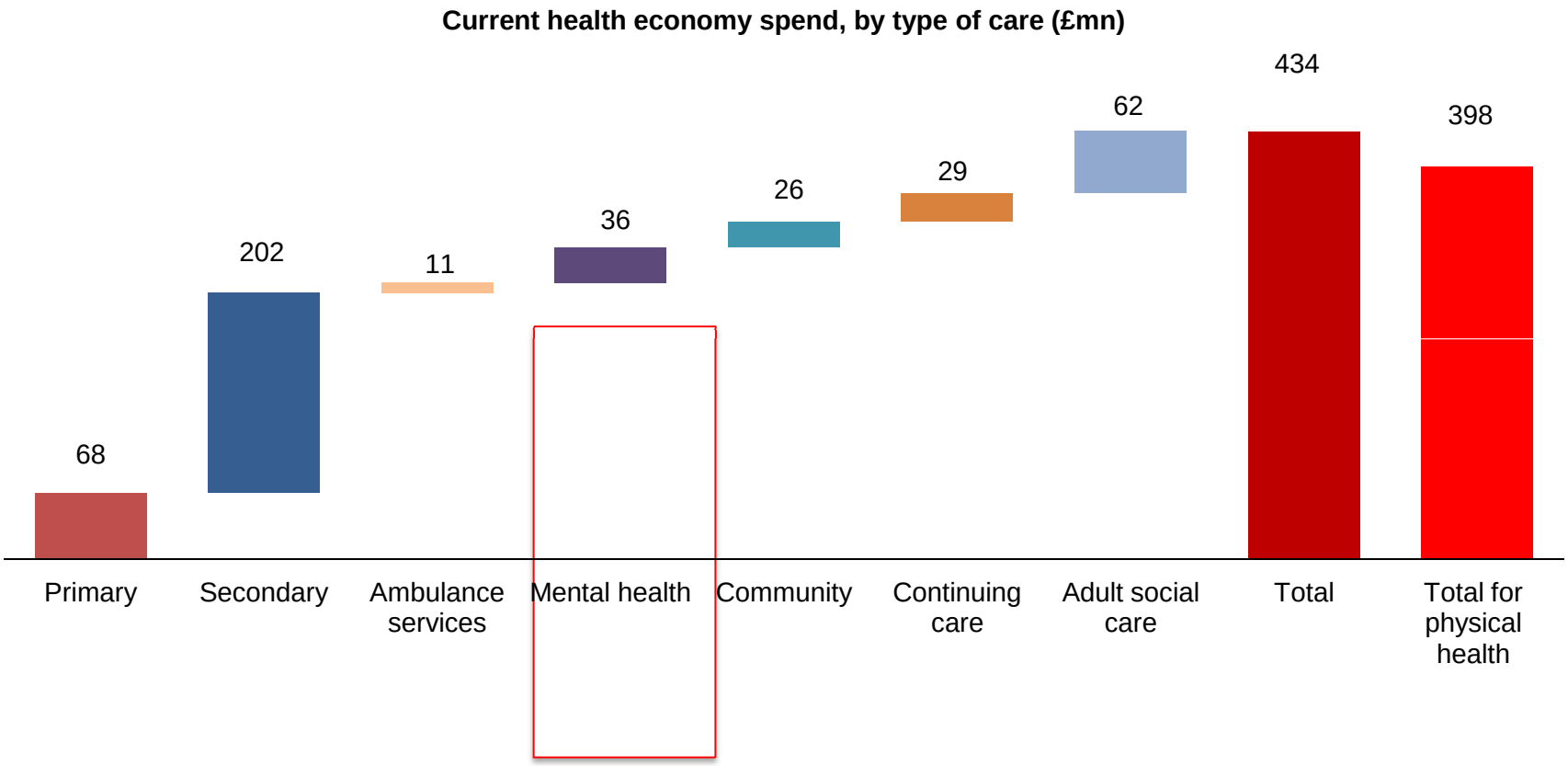
•A lack of focus on prevention and treatment of patients in an out of hospital community setting

•A significant increase in the number of frail and elderly people in the population who require higher levels of care

•A significant increase in the number of births, putting an increased demand on services

•The relatively low proportion of local people accessing the local acute hospitals for elective services

How much do we currently spend on local services ?



Sources: Newark and Sherwood CCG Integrated Plan, Community data, CCGs' 'Plan on a page' documents, Audit Commission Value-for-money profiles

Why do this work now ?

The population of over 75s in Nottinghamshire is set to increase by 25% by 2020. For Mid Nottinghamshire alone, the impact of the projected population growth in 2013/14 amounts to;

- Circa **4,000 additional A and E attendances**
- Circa **2,200 additional non-elective admissions**
- Circa 23,000 additional occupied bed days = **66 additional beds**

Whilst the current overall spend across this health economy is £434m, by the end of FY12/13, there will be a financial gap of **£19m.** Population growth and costs of provision are due to increase far ahead of funding, meaning that:

- Long term conditions currently account for 50% of GP consultations and 70% of hospital in-patient bed stays. The number of people with long term conditions is expected to rise by over 250% by 2050
- In 5 years, the **£19m** gap will have grown to **£70m, i**n 10 years, the gap will be **£140m**

The current health and social care system of provision is unsustainable

Blueprint proposals– Maternity and children's care

Initiative	Quality benefit	Measure
Short stay paediatric assessment unit – offers assessment as opposed to admission	Consultant led, but with community nurse support, providing better decision-making. Less stressful for patients as fewer and shorter hospital stays	Reduce short stay admissions by up to 70%
Short stay ante-natal assessment unit – 24 hours	Less time in hospital, enhanced delivery outcomes, and additional support to complex social care needs	Reduce short stay admissions by up to 50%
Paediatric referral optimisation	Increased clinical input to reduce inappropriate referrals and un-necessary emergency admissions. Less stressful for patients and improved support for GPs.	Reduce emergency admissions by 20%. Make better use of out-patients clinics
Integrated Children and Young Peoples Health Care Programme	Providing co-ordinated support to enable children and young people with complex needs to lead normal lives, improve safeguarding outcomes and the social, health and economic prospects of carers	Reduced emergency admissions and in-patient lengths of stay

Implementing these initiatives could give rise to financial savings of £4m p.a.

Blueprint proposals– Elective services

Initiative	Quality benefit	Measure
Review and improve referral processes	Reduction in inappropriate referrals frees up clinic time for better use. May result in more patients being able to access local services where they are viable and high quality	Where referral rates exceed national average, they will be normalised
Service viability review	**Ensure that services are commissioned on basis of best outcomes, and that patients can receive the right highest quality secondary services in their locality with appropriate tertiary support/referrals as required**	**More high quality secondary care services provided from local hospital facilities**

A work in progress, but ……

Implementing these initiatives could give rise to financial savings of £7m p.a.

Blueprint proposals – Urgent Care; responding to crises for the whole population

Initiative	Quality benefit	Measure
Crisis Hub/clinical navigator	Improves patient experience, removing their problems navigating around providers, and keeps them at home where possible Avoid un-necessary A and E attendances	Reduce A&E attendance by 12% and admissions by 10%
Integrated urgent care service at Newark and Mansfield – "single front door" – primary, social, community and A&E/MIU and assessment/ clinical decision units	More clarity for staff/patients on appropriate care pathway when in crisis, and better experience from reaching right destination quickly Less variation in service and more capacity through joint working with secondary and primary care	Productivity improvement across A&E and GP out of hours of 20% Reduction in NEL length of stay =3,500 bed days
GP Provision – same in the early evening as early morning	Fewer sub-acute patients will present early evening where the demand profile is significantly greater than the regional average	Reduction in A&E attendances and resultant admissions
Streamlining urgent care referrals – enhanced role for ambulance service	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings should result in more patients being treated at home/in the community, rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances and admissions

Implementing these initiatives could give rise to financial savings of £10m p.a., but will require re-investment in community and other services

Blueprint proposals…. Integrated pro-active care for frail elderly and those with long term conditions

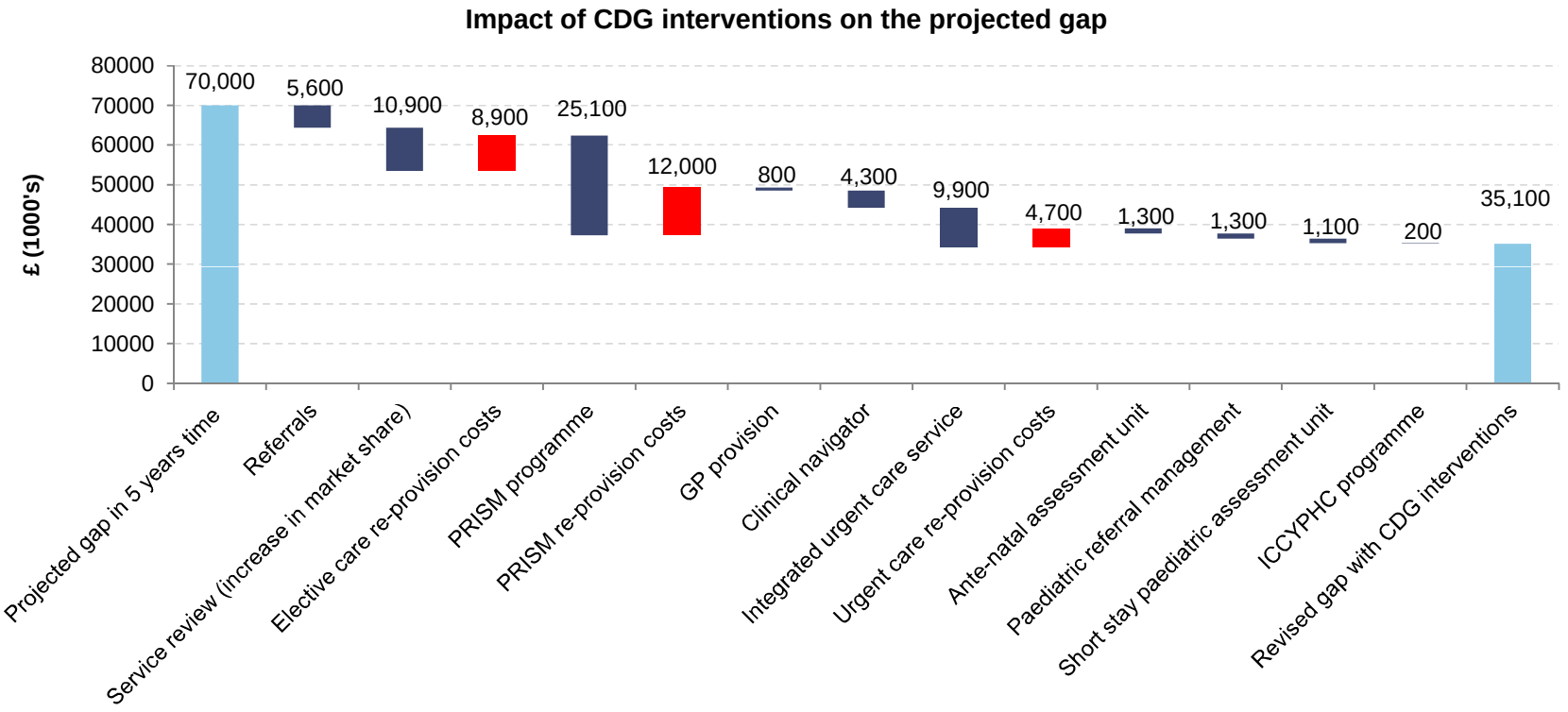
Initiative	Quality benefit	Measure
Enhance domiciliary and intermediate care	Patients able to live more independently, stay at home longer, and have emotional, physical and social care needs assessed together	Reduce hospital admissions and re-admissions and length of stay Reduce nursing/care home use
PRISM – Profiling Risk Integrated Care Self Management	By identifying and case-managing at risk citizens within the community, emergency admissions will be reduced and the outcomes for the frail elderly and those with long-term conditions (including cancer) will be improved Patients and carers will be more involved in managing their own care and will feel less isolated	Reduce admissions by up to 30% and re-admissions by 10% Reduce length of stay by 30% Reduce prescribing costs by £1m Reduce residential care demand by 25%
Extend the integrated community discharge service	Better patient and carer experience Reduction of hospital acquired complications Prompt and pro-active identification of end of life care Patients discharged for assessment where possible – reducing burden of S2 and S5 assessments	Increased discharges to home and reduced time from discharge to home Reduced patients in long term care Reduced average length of stay
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment should reduce hospital acquired complications, maintain function level of patients and improve end of life care	Reduce number of admissions from care homes, and length of stay for care home admissions

Implementing these initiatives could give rise to net financial savings of £13m p.a., but will require circa £12m re-investment in community and other services

Summary financial impact of blueprint proposals

Financial Savings

The graph below provides a breakdown, by intervention, of the estimated savings (against current model / cost of provision) to be made through the delivery of the future model of care. In summary, the interventions identified will reduce the potential 5 year financial gap of **£70m** to **£35.1m**.



Source: PwC analysis – This analysis is based on the PRISM programme achieving a 30% reduction in admissions

What does integrated care look like in practice?

Already piloted in Newark and Sherwood, the locality based "virtual ward" or multi-disciplinary team (MDT) comprising:

- Community matrons
- District nurse
- Occupational therapist
- Physiotherapist
- Mental health worker
- Social worker
- Health care assistants
- Voluntary/third sector workers
- Ward co-ordinator/manager

Underpinned by …..

- Increased provision of intermediate care beds (Step up and Step down)
- Community based clinics (e.g. cardiovascular disease, COPD, diabetes) with secondary consultant specialist support
- Rapid Assessment and Intervention Service
- Care homes integrated into the “virtual wards”, so patients treated as if they were in their own home
- Specialist case managers for COPD, heart failure, diabetes and care homes
- GP practice teams integrated and aligned with “virtual ward teams”
- Improving provision of carer support, information and education
- Engagement of voluntary sector services to improve patient/carer support

How does integrated care make a real difference ? A case study ….

Pat's story;

- 60 year old lady, endocrines disease, recurrent pneumonia (due to complex lung and heart disease), anxiety and previous history of alcohol abuse
- Risk score of 98% risk of admission – admitted every winter for the last 4 years with recurrent chest symptoms
- Discussed at MDT and admitted to "virtual ward" – input from respiratory physio, OT, mental health worker and community matron
- Learnt new breathing techniques, knows when to use rescue antibiotics and has a number to call when she feels she needs assessment/advice
- Biggest change to her ability to cope with her illness at home has been work done to reduce her anxiety. Mental health worker has worked with her and her family to help them deal with panic symptoms
- Risk of admission dropped to 73%; she has not been admitted to hospital for over 4 months now, even though she has had 2 chest infections

Some testimonials from the PRISM integrated care pilot……

Community Matron;

- *“ One of my patients had been regularly calling 999 and being admitted to hospital. He is in his 80s and his needs are really social rather than medical. We discussed how we could best give this gentleman the care he really needs. Within 60 minutes our Ward Social Worker had arranged a respite bed. Instead of hours spent on the phone trying to refer, things happened immediately”.*

Social Worker;

- *It’s just fantastic how quickly I can get services in place for my patients – from hours spent previously via phone and e mail trying to refer PRISM integrated care allows it to happen immediately”.*

Nurse;

- *Sitting in the MDT meeting today, listening to all these people involved in caring for your patients, was such a humbling experience. I feel so proud to be part of this project – I think it’s probably the most important thing I’ve ever been involved in as a nurse”.*

Patient;

- *(Before) I only had my GP and Community Matron. I didn’t want to bother people. I felt I would never get better. (Now) I have had less hospital visits, I understand my body better, am determined to carry on, feel more confident and supported.*

Integrated care – the headlines

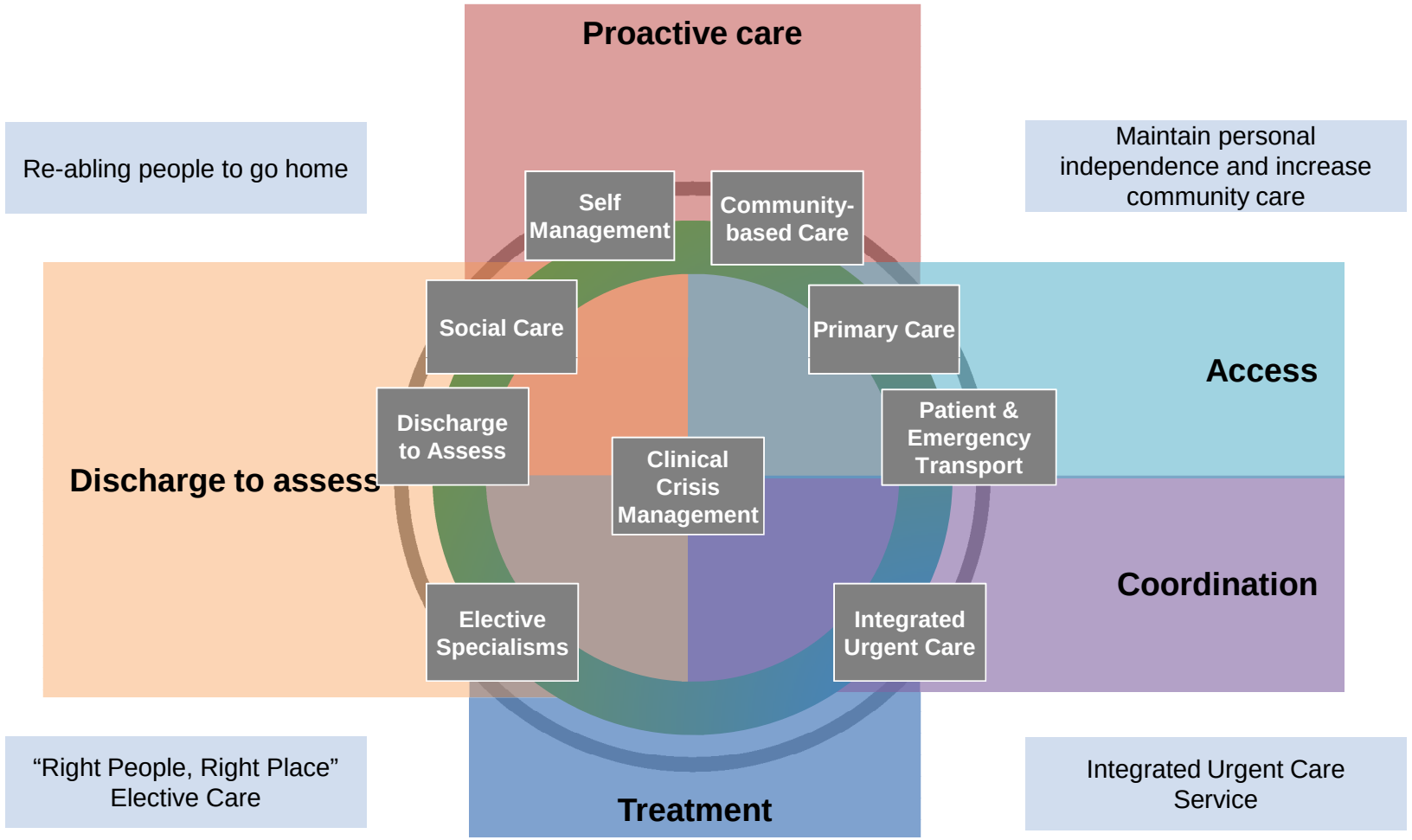
Before	The future
Different people looking after various conditions for a single patient	Integrate care across the whole system and embed care planning and shared decision making in to everyday practice
Hospital often the only option for a patient when their condition worsens	Incorporate a population wide approach to care and not just a reactive response
Services only available within office hours with little or no joined up arrangements out of hours	Deliver services where patients need them and make access available seven days a week

Systematically implement;

Risk profiling, integrated services, care planning and self-management

Fewer unplanned admissions, better patient outcomes and satisfaction, improved quality of care

Future Model of Care for Health and Social Care Services



Conclusions

Truly integrated health and social care in Mid Nottinghamshire should;

- Enable care to be at home or close to home wherever possible, thus optimising patient and carer independence
- Improve the experience of patients in crisis – offering a “single front door” approach where all of the services come together; acute, community, mental health, primary and social care
- Significantly reduce acute hospital admissions, freeing up in excess of 100 acute beds
- Provide opportunities to use our best quality local hospital facilities to increase sub-acute and intermediate care capacity
- Bridge at least 50% of the projected financial gap based on current population health projections
- Create a more highly skilled workforce, with time to innovate

Next steps - learning from other systems

Positive precursors for success of the Transformation Partnership

- Foundation of joint working between health and social care exists
- Shared understanding of integration
- Joint desire to deliver vision regardless of organisational challenges
- Strategy fits with JSNA

Possible challenges

- Cultural differences between professional groups
- Different workforce terms and conditions
- Technology solutions for data/information sharing
- Differential financial pressures

Ensuring success ….learning from other systems

- Establish joint governance and accountability early on
- Have a high tolerance of risk to achieve the vision – don't be scared to press on even if every detail isn't worked through
- Use front-line teams to design services and don't miss simple and inexpensive innovations that can have a major impact
- Invest in organisational development and change management to overcome cultural and organisational differences, financial and other risks
- Base the strategy on benefits to patients … then specify, communicate, monitor delivery, and iterate

And …..

- Health and Wellbeing Board actively engaged to ensure that transformation is evidence based and responds to local community's needs through joined-up provision

Next steps - timescales

A detailed delivery "roadmap" is being prepared, but key steps include;

Immediately

- Individual organisations continue to work through the impacts of the new integrated care models e.g. financial, workforce, estate
- Care professionals and stakeholder/citizens representatives to take forward detailed design of new services and pathways

Summer 2013

- Engagement exercises to run alongside development of new models of care
- CCG and Local Authority commissioning forum to be established to develop appropriate commissioning/contracting models
- On-going evidence-based analysis of outcomes of new care model
- System-wide estate and ICT strategy to be developed

2014 onwards

- Changes to be implemented from years 2015/15, with whole system changed embedded within 5 years

South Nottinghamshire Integrated Care

Benchmarking and Better Care scheme analysis

17 January 2014
Draft

pwc

Introduction

This pack is designed to give a very high level view on the benefits that may be associated with Better Care fund schemes in the three county CCGs. We have done this in two ways – by looking at the overall ambition of the schemes compared with other areas where we have worked and by benchmarking current performance to give an indication of the scale of improvement possible.

We have benchmarked the relevant trusts using the following indicators:

1. Delayed transfers of care
2. Admissions per 100,000 patients
3. Average length of acute stay

When analysing these indicators, we have looked at national benchmarks but also compared them with them with the following health economies , where we have done work and know the scale of their ambitions:

- Mid Nottinghamshire
- Northamptonshire
- Lincolnshire

Other health economies have much higher targets but expect to make a higher investment

Metric	Example 1	Example 2	Example 3	Facilitated by
A&E attendances	Decrease 10% for over 75s Decrease 20% for over 65s	12% reduction overall	30% reduction for over 65s	Proactive community support teams to support frail and elderly. Crisis response team for patients at risk of being admitted. Support to primary care and ambulance service to direct to most appropriate care location. Community discharge programmes
Emergency admissions	Decrease by 20% for over 65s	9.5% reduction	30% reduction for over 65s	
Readmissions	n/a	10% reduction in 30 day rate	n/a	
Reduction in long term care	15% reduction for over 65s	25% reduction in long term care	30% reduction in residential home spend	
Length of Stay	Reducing average length of stay from 7 to 5 for over 75s	12.6% reduction in overall bed days	23% reduction for one trust 8% for another	
Investment	**£9m**	**£14m**	**£35m**	

Significant savings may be possible based on other economies targets even with lower investment

Approach

We have estimated the benefits achievable from the Better Care schemes in the three county CCGs using similar schemes that we have seen elsewhere. We have scaled these to the level possible in South Notts using three different methods: population, number of acute admissions and level of investment.

We have made use of the following standard groupings rather than looking at the individual interventions as many of them work together.

1. Support to thrive (S2T)
2. Transfer to assess (T2A)
3. Choose to admit (C2A)

	South Notts benefits	Est benefits scaled by pop	Est benefits scaled by acute admissions	Est benefits scaled by expected investment
Support to thrive	Tbc	£2m-3m	£2m - £3m	£0m-2m
Transfer to assess	Tbc	£20m - £30m	£20m - £30m	£2m-£4m
Choose to admit	Tbc	£15m – £25m	£15m - £25m	£3m-£5m

Looking at the size of the population and the number of acute admissions you would expect very large benefits to be possible if schemes were implemented similar to ones that we have seen elsewhere. However these schemes all required significant investment and using this as a scaling factor makes the benefits more modest – although still higher than current plans.

Note that this analysis makes no consideration of the varying level of current performance and so opportunity in other areas.

The high DTOC figures are in line with the national median at NUH but below upper quartile performance

Delayed transfers of care

The table to the right shows that South Notts has a relatively reasonable monthly average DTOC per 100 admission than the three other acute trusts under consideration and also England as a whole. Only the two trusts in Lincolnshire have performed better than NUH. For non-acute trusts, South Notts has a higher DTOCs per 100 admission than all other areas.

NUH is in line with the national median and so has some room for improvement – 2 per 1000 admissions compared with the upper quartile. It is low compared with some other health economies that are targeting significant savings in this area ,suggesting that it is unrealistic savings to expect savings of £5m + as they have.

Area	Acute Trusts	Monthly avg DTOCs (Sep to Nov 2013)	Monthly avg admission	Monthly avg DTOCs per 100 admission
South Notts	NUH	988	16,019	6
Mid Notts	Sherwood Forest	875	6,922	126
Northants	Northampton General	884	8,020	11
Lincs	United Lincs	648	12,730	5
	Northern Lincs & Goole	181	8,701	2
England		119,844	1,262,136	9

Acute trusts quartiles	Monthly average delayed transfers of care per 100 admissions (Sep to Nov 2013)
Upper quartile (better performing trusts)	4
National median	6
Lower quartile (worse performing trusts)	10
National mean	8

Area	Non acute Trusts	Monthly avg DTOCs (Sep to Nov 2013)	Monthly avg admission	Monthly avg DTOCs per 100 admission
South Notts	NHT	1,140	356	320
Northants	Northants Healthcare	396	201	197
Lincs	Lincs Community	163	150	109
	Lincs Partnership	132	100	132

NUH is a high performer in terms of length of stay

Average length of acute stay

We have identified 15 trusts as a comparable peer group to NUH. We selected these peers based as those most similar in terms of volume and case mix.

NUH is a high performer on this metric – it is significantly better than the national average and in the upper quartile compared with its peers. This suggests a limited opportunity for improved performance overall but there may still be specific specialties or types of patient that could be targeted so it is worth considering this more detailed analysis.

Peers	Mean Los
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	**3.9**
England	5.2
Peers upper quartile	4.0
Peer median	4.2
Peer lower quartile	4.5

	Peer trusts
1	BARTS HEALTH NHS TRUST
2	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
3	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
4	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST
5	LEEDS TEACHING HOSPITALS NHS TRUST
6	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
7	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
8	**NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST**
9	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
10	MID YORKSHIRE HOSPITALS NHS TRUST
11	SOUTH LONDON HEALTHCARE NHS TRUST
12	UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST
13	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST
14	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
15	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

NHS
Nottingham North and East
Clinical Commissioning Group

NHS
Rushcliffe Clinical Commissioning Group

NHS
Nottingham City
Clinical Commissioning Group

NHS
Nottingham West
Clinical Commissioning Group

Greater Nottingham's vision of integrated care for older people

Nottingham University Hospitals NHS
NHS Trust

Nottingham CityCare Partnership

Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

Nottinghamshire County Council

Nottingham City Council

County Health Partnerships NHS
Providing health services in your community

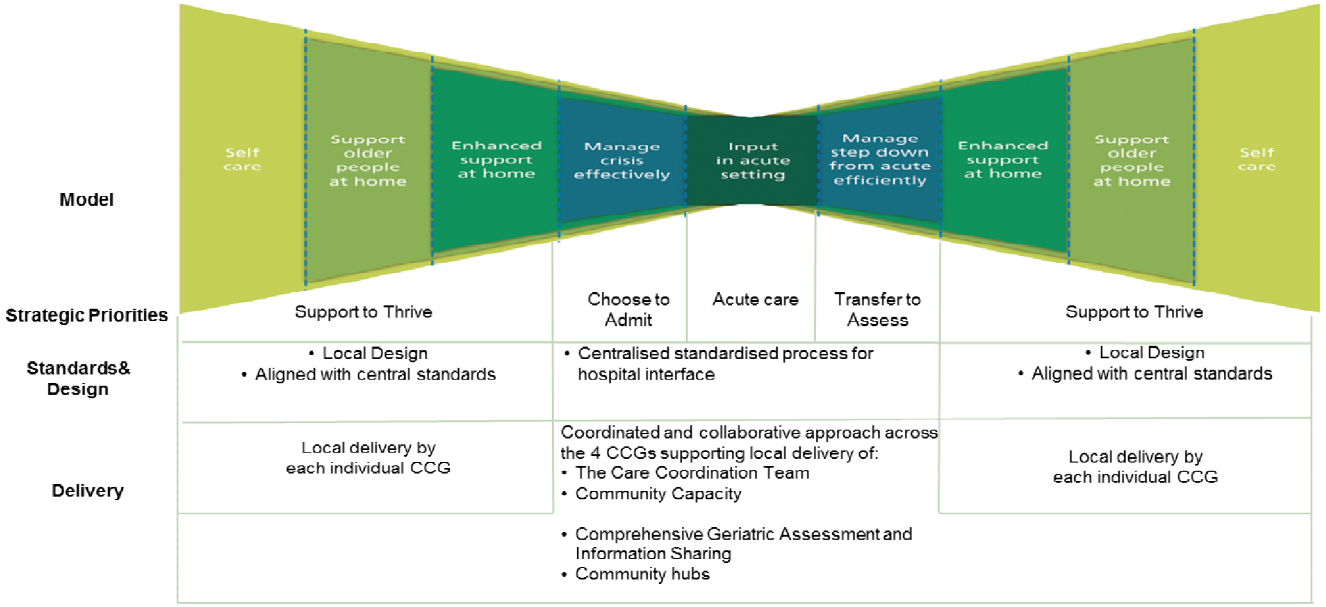
Greater Nottingham – Integrated care for older people

Frail Older People Programme
Greater Nottingham

Contents

Greater Nottingham – Integrated care for older people

The Greater Nottingham health and social care economy (CCGs, local authorities, practices and citizens) has come together to develop a vision for integrated care for its older people. Although integrated care is the aspiration for all citizens, a decision was made to focus on older people because of the growing numbers of older people and an increase in the complexity of their needs. It is anticipated that improving the co-ordination and delivery of services for older people will improve services for other citizens as well.



The model (the 'Bow Tie') has been designed to maintain independence where possible and manage crises effectively when necessary. It builds on the three strategic priorities of '*Support to Thrive*', '*Choose to Admit*' and '*Transfer to Assess*'. The model reflects the requirement for integrating provision at a local level whilst acknowledging the demands of a single acute provider shared by multiple commissioners. The primary collaborative work between the CCGs and the acute provider to date has been a focus on the admission and discharge pathways. The key interface between local service provision (*Support to Thrive*) and '*Choose to Admit*' and '*Transfer to Assess'* will be through the development of community hubs and a care co-ordination team. These in turn will be supported by a standardised process for Comprehensive Geriatric Assessment (CGA), which has planned deliverables in March 2014, and additional community capacity that will be delivered from December 2013.

The work is being overseen by the Strategy and Implementation Group for Nottingham South (SIGNS). This is a group of commissioners and providers that was formed in February 2013 to set the strategy for frail older people across CCG boundaries and oversee its implementation.

Frail Older People Programme
Greater Nottingham

The drivers for integrated care – The national context

A number of concurrent pressures and challenges have come together necessitating a new approach to health and social care provision if quality is to be maintained and cost controlled. Examples include a shift from acute provision to care closer to home. This in-turn will require a new focus on prevention over intervention and independence over dependence on services. As a result, local health and social care systems are increasingly looking at integrated care as a solution.

"Integrated care and support needs to extend beyond traditional perceptions of 'healthcare' and 'social care' and into areas involving early intervention, prevention, self-care and promoting and supporting independent living."

Integrated Care and Support: Our Shared Commitment – National Collaboration for Integrated Care and Support (May 2013)

The challenges facing health and social care nationally include:

- Rapidly rising demand attributable to a growing population, a greater proportion of frail and elderly people (often with complex multiple health and social care needs and long term conditions), cost inflation and new treatments becoming available that are able to preserve and prolong life;
- Funding for health services not rising in line with demographic demand and significant reductions in social care funding. Cost pressures on the NHS are projected to grow at around four per cent a year up to 2021/22. If NHS funding is held flat in real terms then the NHS in England would experience a funding gap of between £44 and £54 billion in 2021/22, this would be reduced to a shortfall of £28 to £34 billion if QIPP savings are achieved (Nuffield Trust; A decade of Austerity, 2012);
- A desire by clinicians and leaders to deliver safer care, with better clinical and social outcomes for the population – and as such to deliver better value care (net outcomes per pound spent) with the considerable, but finite, resources available;
- Improving the experience of care, greater integration of health and social care is needed to mitigate the impact of fragmented health and care provision on patient experience. Citizens tells us that there are gaps in service provision, poor transitions between care settings and failures in communication. The Health and Social Care Act places a duty on providers to work more closely together to address these issues; and
- £7.6bn (14%) real-terms reduction in funding from 2010/11 to 2014/15, estimated at 2010 spending review (Financial Sustainability of local authorities, National Audit Office, 2013).

The drivers for integrated care – The local context

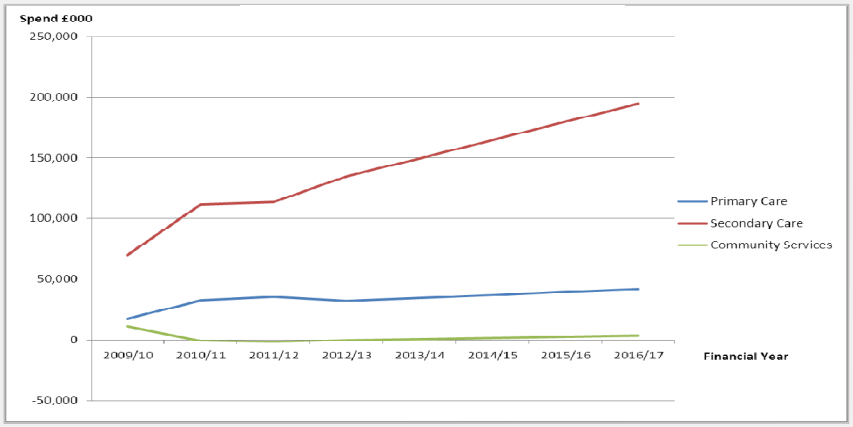
Challenges for Greater Nottingham

The national pressures identified are also being felt locally in Greater Nottingham. A combination of an increasing and ageing population (85,000 over 75's this year rising to over 100,000 by 2025), the shifting expectations amongst citizens around the time and type of care they receive, and a predicted increase in demand, are all placing significant pressure on the health and social care economy.

These challenges are alongside the tough financial pressures with health budgets only seeing small increases and social care budgets decreasing in real terms. For example: Nottingham City Council must save £20m during 2013/14, Nottingham University Hospital Trust (NUH) £50m during 2013/14 and Nottinghamshire County Council £154m over a four year period.

As the following chart depicts, current healthcare spend in the region is heavily focused on secondary care (and is projected to continue to do so in the future if recent trends continue) whilst spend on community and primary care has barely changed. As a result, the disparity between community, primary and secondary care spend has been increasing resulting in negligible investment in the community sector and primary care to assist them to innovate and actively promote the reality of integrated care.

Projected Healthcare Spend – Cumulative Movement Year on Year – Nottingham County PCT



(Source: Financial Update from Nottinghamshire Collaborative Commissioning Congress; Sep 2013).
(NB: Notts County PCT has been reorganised into the CCGs of Nottingham West, Nottingham North and East, Rushcliffe, Newark and Sherwood, and Mansfield and Ashfield).

Changes to meet the challenges

In order to tackle these combined challenges, the organisations involved in the delivery of health and social care in Greater Nottingham recognise that a braver and more radical solution of integrated care is required that will address the following local issues:

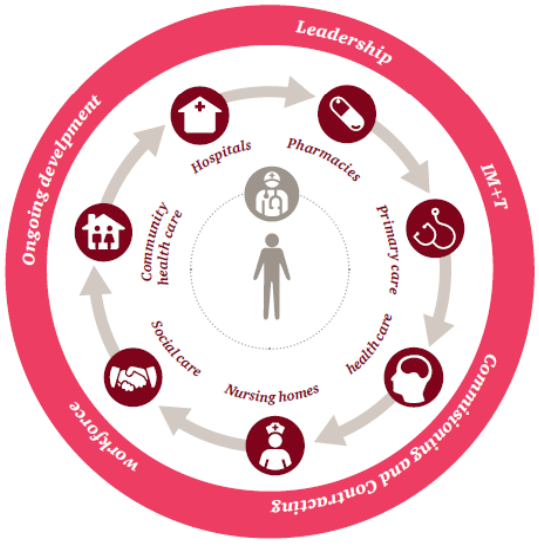
- Citizens being admitted into hospital or long term residential care when alternative services could/should have met their needs;
- Citizens remaining in hospital when they no longer need acute services; and
- Citizens who need the care of old age specialists in an appropriate ward in hospital not always receiving it.

Frail Older People Programme
Greater Nottingham

The drivers for integrated care for older people – A citizen's perspective

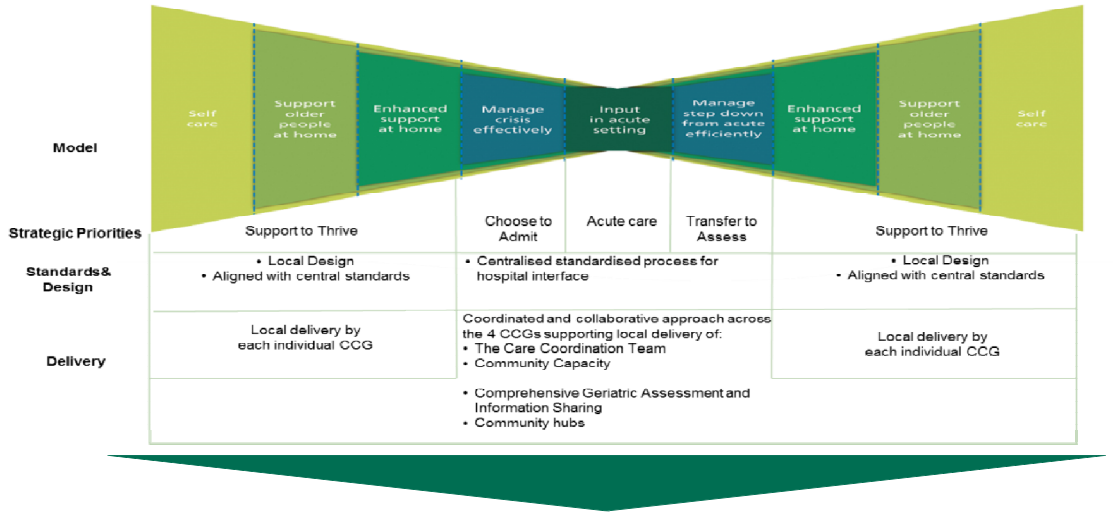
Greater Nottingham's vision of integrated care for older people is important, but it is how outcomes are met and are experienced by the citizen that really matters. The model underpinning integrated care in Greater Nottingham has been designed with the needs of the citizen at its core. Some of the key requirements from a citizen's perspective are summarised below.

The citizen is at the centre of Greater Nottingham's vision



Strategic priorities of Integrated Care	Citizen's requirement of care
Support to Thrive	• My health and social needs are identified as early as possible. • I am supported to manage my own condition at home. • I know where to go and who to contact when I need care.
Choose to Admit	• Community services are there for me if I need support at home or overnight. • When I am unwell I am assessed using Comprehensive Geriatric Assessment. • I will be directed to the right place in the first instance. • Hospital is there for me if I need specialist clinicians to manage my medical conditions until I am stabilised or I need an operation.
Transfer to Assess	• I leave hospital as soon as it is medically safe to do so. • I will only be transferred to long term care or a nursing home if that is the best place to meet my needs.

The model and strategic priorities of Greater Nottingham's vision of integrated care for older people



The care of frail older people is one of the main strategic priority areas identified by the Greater Nottingham care economy and this is reflected in Greater Nottingham's vision for older people:

'Right Care, Right Place, First Time'

Delivery of the vision is through a co-ordinated and collaborative approach, which has been adopted across all of the CCGs and City and County Councils following three strategic priorities:

1. ***'Support to Thrive'*** – Enabling citizens to remain independent in their own homes for as long as possible. Delivered through multiple proactive initiatives, health and social care needs will be identified at the earliest possible opportunity and support will be provided to the individual to enable self-care at home;

2. ***'Choose to Admit'*** – The coordination and delivery of services in the community and at the front door hospital interface to prevent unnecessary admissions into hospital. Coordinated through community hubs (a single point of access) and delivered by multidisciplinary teams; and

3. ***'Transfer to Assess'*** – The coordination and delivery of services in the community and at the back door hospital interface to facilitate early transfer as soon as the citizen is medically safe for transfer. Coordinated through community hubs (a single point of access) and delivered by multidisciplinary teams.

The strategic priorities of Greater Nottingham's vision of integrated care for older people

'*Support to Thrive*'

This strategic priority is currently being implemented at a local level with CCG, Council and third Sector support. Due to local circumstances, progress has advanced at different rates for each CCG area but as of November 2013, the focus of SIGNS will start to move towards the 'Support to Thrive' elements of the model and will support the design of local services complementing and effectively interfacing with 'Choose to Admit' and 'Transfer to Assess'.

'Choose to Admit' and 'Transfer to Assess'

The delivery of the two strategic priorities that deal with the interface to NUH is being coordinated via four projects that are due to be implemented on a phased basis between October 2013 and March 2014, consistently across the four CCGs.

1. **Community Hubs** will be based in each CCG and serve as a single point of access for community team referrals following a crisis (i.e. managing referral to the acute) and for the Care Coordination team to contact when ready to discharge. From March 2014, community hubs will take responsibility for coordinating a response to meet the on-going needs of citizens and manage and allocate local health, social care and third sector capacity;

2. The **Care Coordination Team** is based in the acute hospital and will work as one team to coordinate and case manage all supported transfers of care out of NUH;

3. The **Community Capacity** project will assess Greater Nottingham's need for increased community capacity. Initial capacity analysis has shown that there are 32 older citizens who remain in hospital each day when their needs could be met in a community setting if the services were available. This translates into a requirement for additional beds and home based services. By December 2013, an additional 21 community beds will be commissioned that are staffed to meet the needs of the most complex patients as part of an integrated community service. A more strategic review of the on-going needs for community services beyond March will be carried out before then; and

4. **Comprehensive Geriatric Assessment (CGA) and Information Sharing** are the underpinning priorities that support the process changes across the interface with NUH and community hubs. Under the new model the Care Coordination Team at NUH will pass information on patient needs to the community hubs via an electronic referral on SystmOne. The needs of patients will be assessed based on the 5 domains of CGA. By March 2014 there will be an implementation plan on how to record and share CGA across primary care, social care, NUH and community services.

The principles of Greater Nottingham's vision of integrated care for older people

The four Greater Nottingham CCGs are working with both the City and County Councils and their community providers: CityCare Partnership and County Health Partnerships, to deliver an integrated service through collaborative and co-ordinated approaches.

Collectively a set of shared principles have been developed that align to the SIGNS strategy and address all elements of the bow tie model through a service redesign that is centred on the citizen. These principles are locally owned and implemented within each CCG.

Shared principles supporting the Greater Nottingham vision for Integrated Care for Older People

• An integrated and sustainable Health and Social care service through collaboration with local authority, district council and voluntary sector	• Simplified citizen journey through the implementation of a single integrated adult care pathway	• Virtual Ward model of care: risk stratification tool; MDT's held at each practice; integrated care teams; extended working with mental health services and social care	• Older people enabled to take care of themselves and live independently in their own homes for longer with less reliance on intensive care packages
• 48 hour follow up for frail older patients following an unplanned admission	• Enhanced support for care home residents	• Enhanced support for patients leaving Lings Bar Hospital	• Coordinated response to end of life care
• Crisis response service to support avoidable admissions to hospital	• Clear navigation across health care with key decision making points: community hubs and care coordination team	• Systematic support for long term condition management, for example, implementation of Assistive Technology	• Citizen and carer support, including self-care management, as part of *'support to thrive'.*

The two examples that follow show how the model for integrated care for older people and its key principles are being planned to be implemented at CCG level (or are currently in place) and apply to the wider adult (over 18) population by Nottingham City CCG and by the County CCGs.

How Nottingham City CCG is planning to implement the vision of integrated care for older people

Nottingham City CCG – Adult Integrated Care

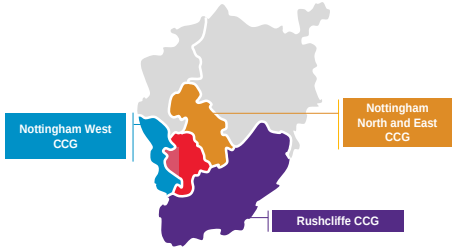
Nottingham City CCG, Nottingham City Council and CityCare Partnership are working together to integrate care as part of the Adult Integrated Care Programme. Collectively they have developed a model that aligns to the SIGNS strategy by addressing all the elements of the 'Bow Tie' model through a service redesign that is centred on the citizen. The overall aim is to:

- Simplify the citizen journey;
- Enable older people to take care of themselves and live independently in their own homes for longer with less reliance on intensive care packages; and
- Develop an integrated and sustainable Health and Social care service.

Three key projects will help to deliver this model of care in City CCG:

- The **Coordinated Care** project has created 8 new Care Delivery Groups (CDGs) that will be established from January 2014. These groups of key health and social care professionals will be aligned to a specific geographical area that will enable them to work together around the citizen's needs, share information and combine experience to continuously improve the care they provide. The CDGs will comprise of multi-disciplinary neighbourhood teams linked to GP practices and supported by a care coordinator. This new model will change how health and social care services are commissioned and delivered at a local level. Access to services will be simplified to ensure that citizens receive appropriate support and that navigation around health and social care services is simplified.
- The **Independence Pathway** project involves the planned transformation of the reablement and rehabilitation pathways to allow citizens to remain as independent as possible. Four pathways are being developed that reflect the complexity of the citizen's conditions and needs; Self Care, Reablement, Community Beds and Urgent Response. They will be easily accessible to the citizen through a single front door after a referral from a health or social care professional.
- The **Assistive Technology** project is distinct to the programme but it is recognised that the project needs to support the new model of Coordinated Care. A joint health and social care strategy has been developed to support an early intervention and prevention approach. Commissioning of the service will be done jointly to ensure that assistive technology is embedded into the pathways that enable the citizen to remain independent.

The three South of County CCGs and their work on integrated care for older people



Integrated Care and the South of County CCGs – examples of current services

Across the three South of County CCGs there are a range of local services being delivered to support the strategic priority of '*Support to Thrive'* and integrated care.

There is also an exploration of a proposed service delivery model for acute community care for the County CCGs working in collaboration with the County Council (this work is called 'Blurring the Boundaries'. It is currently being considered and it is anticipated that a decision will be made on whether to implement it in the coming months.

Example of work being considered

Blurring the Boundaries – *acute community care*

The South of County CCGs and the County Council have commissioned the development of a service specification that could deliver the local components of '*Choose to Admit'* and '*Transfer to Assess*' as well as components of the South's intermediate care service (e.g. intermediate care beds). The specification is in an early stage of development and is being considered for approval. This service is referred to as 'acute community care' and has the following definition:

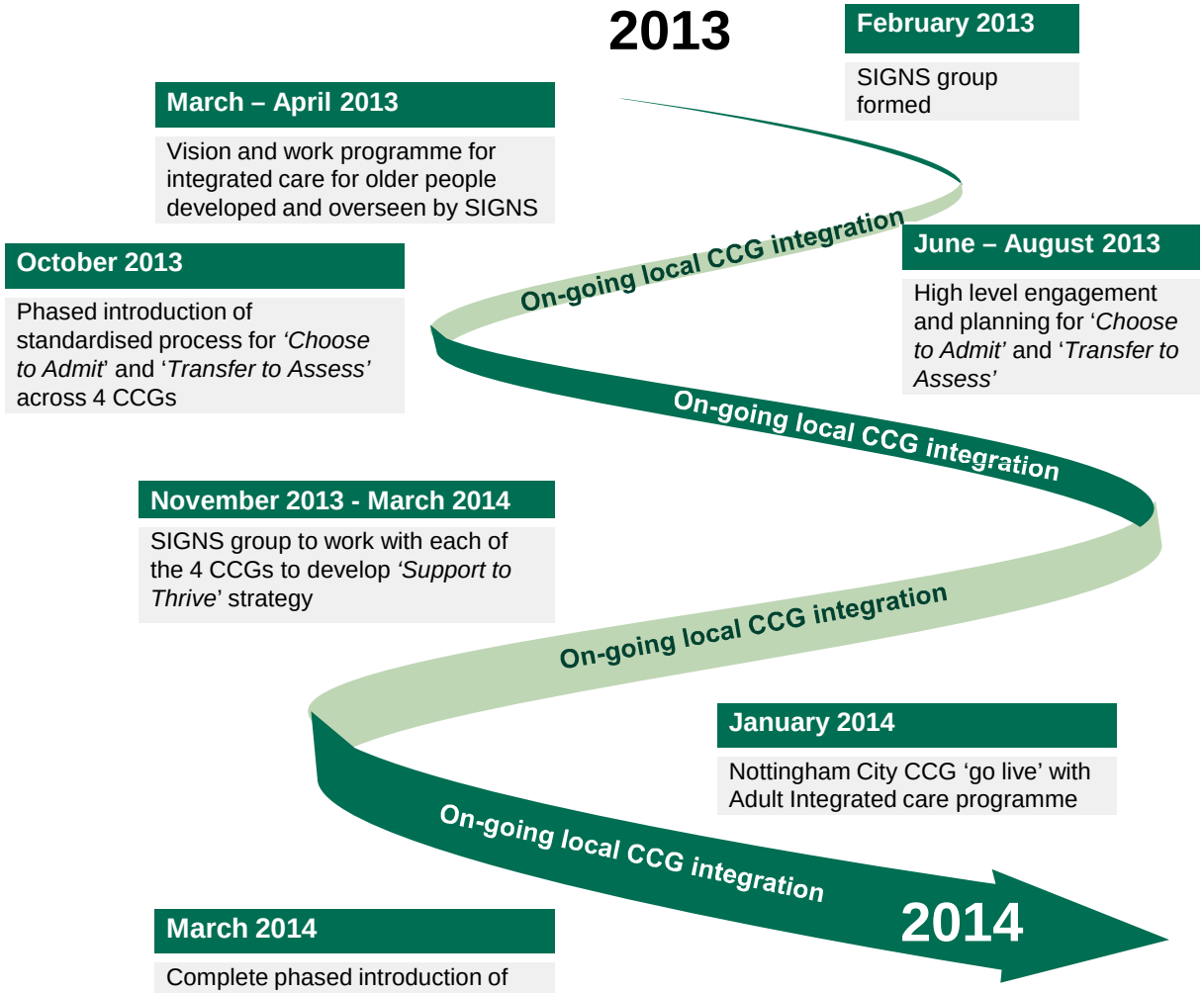
"A range of integrated services to promote faster recovery from illness, prevent unnecessary Acute Hospital admission and premature admission to long term residential care, that supports timely discharge from hospital and maximise independent living."

There are currently a range of different services provided in the South of County that deliver intermediate care and reablement. The main drive for Blurring the Boundaries is to consolidate these services and providers into a single contractual form incentivising them to work together and working to an agreed pain share/gain share mechanism against a range of service specific outcome measures.

Examples of key aspects of the proposed service model include the following:

- The acute community care service would be time limited (up to 6 weeks) with the potential for citizens to be discharged earlier;
- The service would deliver an episode of assessment, treatment and rehabilitation for citizens;
- It would be delivered by a range of health and social care practitioners including access to 24-hour care delivered either at home, in a registered nursing home or in a community hospital setting;
- The balance of home/bed based support would be determined by the lead provider for Acute Community Care services who should consider the balance/range and cost of available 24 hour beds within the locality; and
- The use of bed based services is likely to be for those people who initially need a level of observation, and support and continuous care at all times not available through a home based package.

Greater Nottingham's timeline for integrated care for older people and next steps



Progress has been made across Greater Nottingham on integrated care but translating the vision into a reality for all citizens requires on-going collaborative working and commitment.

The next stage of work is crucial and needs to include:

- A system wide approach around financial implications, risks and benefits;
- A focus on leading the cultural shift required;
- Assuring the quality of care;
- Identifying and agreeing commissioning and contracting models;
- Approaches to sharing patient information; and
- Workforce support and development.