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

<u>The Current Model of Care</u>
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.

<u>Design Principles</u>
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

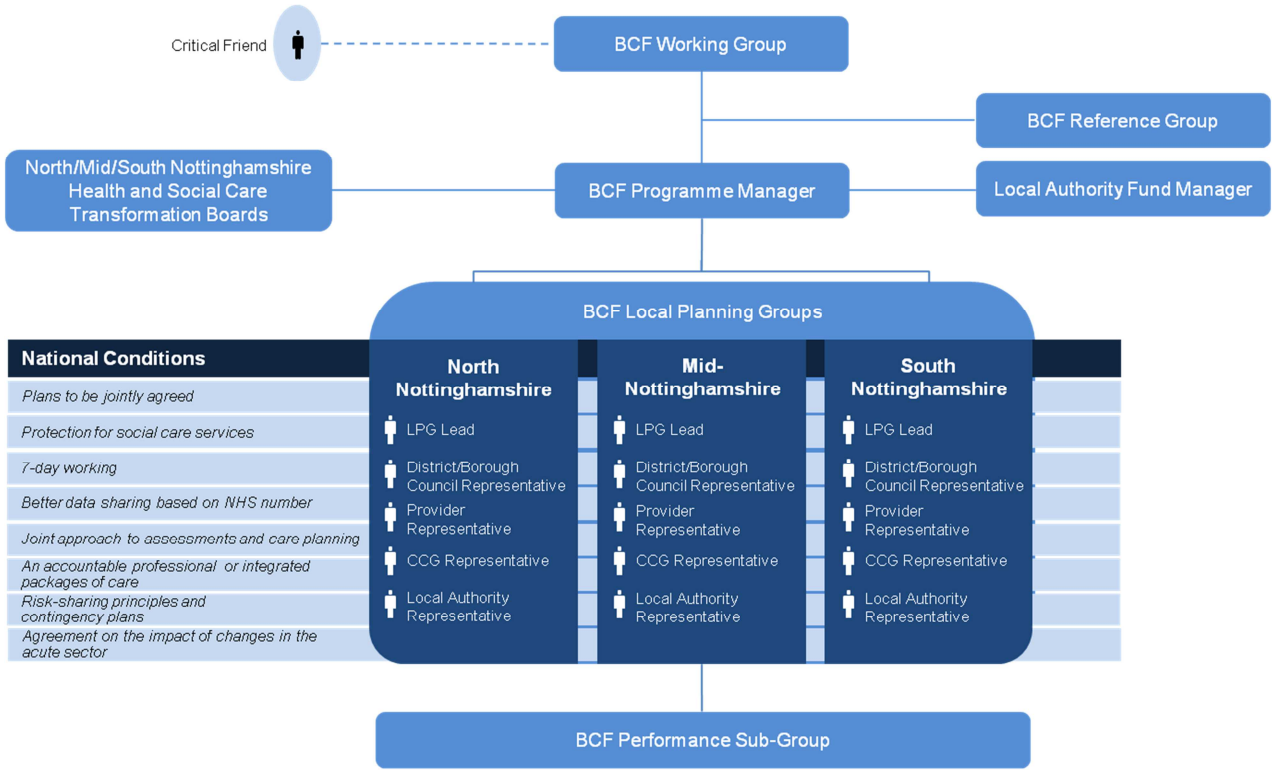
A county-wide BCF Working Group has been mobilised to oversee the development and delivery of a county-wide Nottinghamshire plan for pooled budget(s) under the terms of the BCF. The Working Group is co-chaired by the Chief Executive of Nottinghamshire County Council and a CCG Clinical Chair, and includes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