Joint City / County Health Scrutiny Committee

Tuesday, 13 December 2016 at 10:15

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

AGENDA

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.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Julie Brailsford (Tel. 0115 977 4694) or a colleague in Democratic Services prior to the meeting.

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

(4) A pre-meeting for Committee Members will be held at 9.45 am on the day of the meeting.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
8 November 2016 at 10.15am

Nottinghamshire County Councillors

Councillor P Tsimbiridis (Chair)
Councillor Chris Barnfather
Councillor Richard Butler
Councillor Jim Creamer
Councillor John Clarke
Councillor Stan Heptinstall MBE
Councillor Mike Pringle
Councillor Stuart Wallace

Nottingham City Councillors

Councillor A Peach (Vice- Chair)
A Councillor M Bryan
Councillor E Campbell
Councillor C Jones
Councillor G Klein
Councillor B Parbutt
Councillor C Tansley
A Councillor M Watson

Officers

David Ebbage - Nottinghamshire County Council
Martin Gately - Nottinghamshire County Council
Jane Garrard - Nottingham City Council

Also in attendance

Officers

Dr Stephen Fowlie- Deputy Chief Executive, NUH
Helen Jones - Nottingham City Council
Jo Kirk - East Midlands Clinical Networks and Senate
Paul McKay - Nottinghamshire County Council
Nikki Pownall - Nottingham CCG

MINUTES

The minutes of the last meeting held on 11th October 2016, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES

Apologies were received from Councillor Watson

MEMBERSHIP

It was noted that the following changes took place for this meeting only:-

Councillor Barnfather replaced Councillor Cutts
Councillor Wallace replaces Councillor Handley
Councillor Creamer replaced Councillor Bosnjak
Councillor Pringle replaced Councillor Harwood
Councillor Heptinstall replaced Councillor Williams

DECLARATIONS OF INTEREST

There were no declarations of interest.

EAST MIDLANDS CLINICAL SENATE AND STRATEGIC CLINICAL NETWORKS

Jo Kirkby, Head of Clinical Network gave a short presentation on East Midlands Clinical Networks and Clinical Senate Annual Report from 2015/16.

During discussion the following points were raised:

- East Midlands Clinical Networks supports health systems to improve health outcomes of their local communities by connecting commissioners, providers, professionals, patients and the public across a pathway of care to share best practice and innovation, measure and benchmark quality and outcomes, and drive improvement.
- It focuses on cardiovascular disease, cancer, maternity and children, mental health, dementia and neurological conditions. It also has local priorities – respiratory, end of life, diagnostics and learning disability.
- A lot of work around Children and Maternity is to do with Mental Health and especially around the transformation and transition which is a key time for young people who then move into the adult phase of their life.
- 66% of patients with mental health issues are not receiving the full range of services which are available to them. Research has also found that patients could die 10-11 years earlier than if they did not suffer from mental illness so prevention and early intervention is crucial as well as promoting what services are out there.
- The 2015/16 Annual Report highlights the achievements of the Clinical Networks and Clinical Senate as well as recognising the challenges and obstacles faced.
- 2015/16 was a time of change and transition. The Five Year Forward View, published the previous year, advocated the need for a prevention focus, the redesign of urgent and emergency services, and with patients gaining control of their care.
- Information relating to neurological conditions has been produced and communicated with the neurological rehabilitation programme guidance which CCG's would need.
- Members were pleased that the work with young people and mental health is going in the right direction.

RESOLVED to

Note the contents of the report.

NUH EMERGENCY DEPARTMENT TARGETS

Dr Stephen Fowlie, Deputy Chief Executive Officer and Medical Director of NUH gave a short presentation to Members on the performance against targets of the Nottingham University Hospitals (NUH) Emergency Department.

During discussion the following points were raised:

- The year on year demand has again increased by 3.3% with ED visits and admissions from ED has gone up a small margin of 0.1%. NUH are working with partners to try and reduce these figures.
- The hospital sought help from the Emergency Care Improvement Programme who came up with a system diagnosis. This included assessment before admission, today's work today, home first/discharge to assess and strengthened system leadership & accountability.
- The standard performance for patients to be seen within the 4 hours is 95%. NUH in 2015/16 was 86.8%. Between the summer months of June to July 2016, the performance dropped to its lowest figure of 70%. Since the summer, performance has gradually improved.
- Visits to other establishments have taken place by directors, from this, changes have happened in relation to models of care and conditions in general at the hospital.
- A large recruitment campaign has resulted in an intake of nursing staff to ED. The turnover is no different to other establishments. The hospital are determined to turn this slip in performance around.
- Trained GPs are in place from the beginning of the process to assess each patient before they gain admission to ED. This will hopefully reduce the number of visits by patients who could seek alternatives.
- Members queried whether inappropriate attendance could be a reason to the high number of visits, but NUH responded saying diverting patients to alternative provision has been very mixed and patients still choose to come to ED.
- Integrated urgent care project bringing together 111, mental health, urgent care centre, primary care and ED.
- New technology for bed/capacity management is now in place, and NUH try to free beds as soon as possible. Beds can be located more easily using the new tracking system which is in place.
- There is no answer in regards to the dip of performance over the summer period. The hospital are currently analysing the data over that period to find out why it occurred.
- NUH is in regular contact with other Trusts and what models of care they use to seek alternative methods.
- A big push to reduce delayed transfers of care, a shared commitment to ensuring that patients do not go directly to long term care from an acute bed setting.

The Chair thanked Dr Fowlie for his attendance and requested a further update in 6 months' time.

RESOLVED to

1) Update Members on any progress in 6 months' time.

2) That the contents of the report be noted.

PLANNING FOR WINTER PRESSURES

Nikki Pownall, Nottingham City CCG and colleagues from Nottingham City and Nottinghamshire County Council briefed Members on how the NHS and partners were planning for the upcoming winter conditions.

During discussion, the following points were raised:-

- The City Council have a particular issue with external homecare providers. The City Council have increased their hourly rate with homecare providers which now matches that of the County Council. This will hopefully help with the funding gap.
  Improved rota providers and increased the number of trained seniors to reduce care packages in a timely way. Additional funding has been approved through the Better Care Fund and a more system approach for joint working with the County.
- There are currently no delays in the County with Social Care. A lot of work has gone into achieving that performance level. A more system based approach to try and deal with most queries at the front door stage which is the Customer Contact Centre, from there they are fed down to relevant teams or diverted on to the appropriate partner.
- There are still a number of main risks relating to maintaining the patient flow across the health and social care system, cold weather & associated spike in respiratory cases, influenza, staff retention and sustainability during the busiest months and major system change.
- A multi-agency approach to communicate campaigns, press releases and social media content scheduled throughout winter.
- A flu vaccination campaign has recently been launched in which over 50% of NUH staff have already had the vaccination.
- All providers have managed outbreak plans to avoid and contain any impact to do with Norovirus.
- Detailed Bank Holiday planning making sure all providers are fully staffed and operational through Christmas and the New Year.
- A recent feature to the 111 system, patients are now able to make GP appointments by ringing up this service. This has needed a lot of planning, and is being carried out nationally and only recently has it commenced.
- Priorities for 16/17 to do with the flu strategy are to improve the uptake in 2,3 and 4 year olds, pregnant women and healthcare and social care staff. Also financial incentives for providers.

RESOLVED to

1) Note the contents of the report
2) A further update to the Committee be provided in the New Year

WORK PROGRAMME

Martin Gately undertook to look into the issue of NUH payment delays on behalf of the Committee.

RESOLVED to note the contents of the work programme and suggested updates.

The meeting closed at 12.55pm.

Chairman

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

13 December 2016

Agenda Item: 4

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

ENVIRONMENT, WASTE AND CLEANLINESS AT NOTTINGHAM UNIVERSITY HOSPITALS

Purpose of the Report

1. To introduce the latest data on Environment, Waste and Cleanliness at Nottingham University Hospitals (NUH).

Information and Advice

2. The Joint Health Committee regularly examines issues of Environment, Waste and Cleanliness at NUH.

3. In late July, NUH issued a statement indicating that there had been some early signs of improvement from Carillion in some of the areas which required urgent attention, including the availability of cleaning materials and linen. Carillion also introduced a new 'bank' to cover unexpected staff absences and have adapted some working practices so that services are more responsive to the needs of NUH wards and clinical areas. NUH satisfaction levels are based on the 'lived' experience of patients and staff, and this indicates that there remains much work to do to ensure the consistent delivery of the necessary standards across all services. At the same time, Carillion reactively stated that it was committed to providing a high standard of service to the Trust, and wishes to work closely with the Trust to tackle any identified problems. Carillion will continue to monitor clinical teams' experience of their services.

4. In August, Unison issued a statement saying it believes that Carillion was failing to deliver on cleaning services. In response, NUH issued a statement that the Trust Board requires urgent improvements from Carillion in response to declining cleanliness standards and inconsistent standards across a range of services including linen provision, availability of equipment and portering. It reported that there had been no general increase in infections over the period standards of cleanliness have deteriorated. The Trust Board is monitoring Carillion's performance monthly and is considering the future of the contract with Carillion.

5. Information on standards of cleanliness was last brought before the Joint Health Committee on 13 September 2016, when Members heard that the contract with Carillion did include financial sanctions and that monitoring cleaning was using up the valuable time of nursing staff. Members were concerned that there was no particular evidence that contracted out

cleaning was any better than in-house cleaning – particularly with regard to managing cleaning staff.

6. Members were reassured by NUH that there would be improvement from Carillion within a reasonable timescale. Members also heard that Carillion hold similar contracts with other healthcare providers and these have also experienced problems.

7. In November NUH issued a statement that NUH and Carillion are jointly exploring a managed exit from the Carillion contract. It reported that Estates and Facilities staff would remain employed by Carillion until such time as future arrangements are agreed by both parties, which it anticipates to be in January 2017.

8. A presentation from Nottingham University Hospitals (NUH) is attached as an appendix to this report.

9. Dr Stephen Fowlie, Medical Director for NUH will attend the Joint Health Committee to deliver the presentation and answer questions.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee consider and comment on the information provided.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

A cleaner, safer and healthier environment

NUH

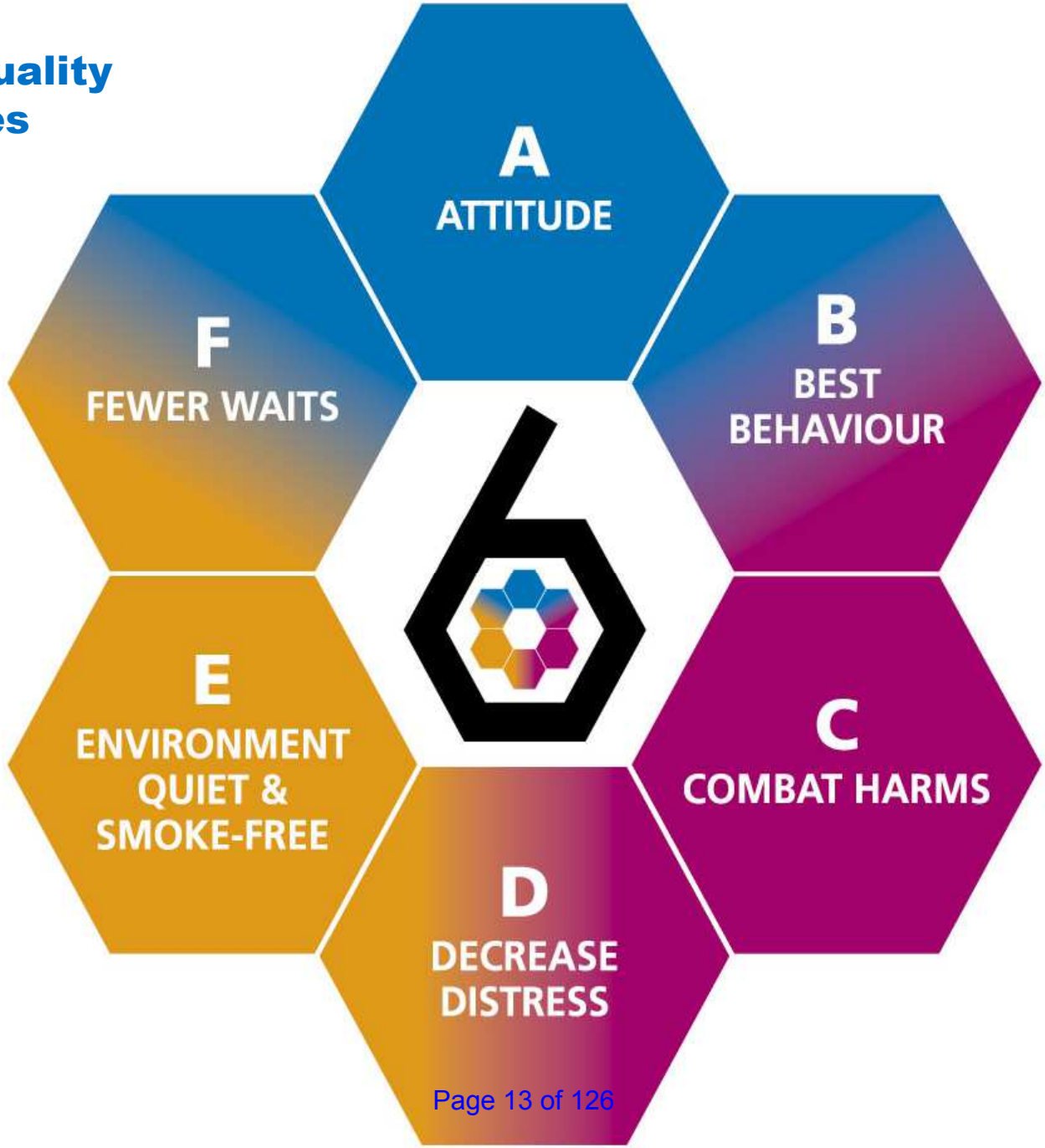
Dr Stephen Fowlie
Medical Director

December 2016

Agenda

- 16/17 quality priorities
- Carillion contract
- Smoking
- Car parking
- Quieter wards

16/17 quality priorities



Carillion

- Running E&F services since July 2014, including cleaning, catering, car park management, laundry, portering and maintenance

- 5 year contract (option to extend by 3 years, subject to satisfactory performance)

- Circa 1,200 Carillion staff
- NUH Contract Management Team

Inconsistent standards

- Cleanliness audits (internal & external) showed deterioration early ‘16 after spell of improvement
- Growing concerns from patients & staff during ’16 about cleaning & wider services provided by Carillion
- Independent cleaning assessment concluded unacceptable standards (Oct ‘16)

Managed contract exit

- NUH Board requires significant changes to the arrangements with Carillion to improve standards
- NUH & Carillion jointly exploring a managed exit from the contract
- Staff will remain employed by Carillion until future arrangements are agreed (likely January 2017)

Smoke-free (1)

- Ward-based New Leaf advisors at QMC and City (facilitating nurse referrals to cessation services)
- Promotion of stop smoking services via New Leaf, Smoke Free Life Notts & Trust Pharmacy
- Targeted staff comms (signposting to cessation & reminding colleagues not to smoke in uniforms)

Smoke-free (2)

- Proactive CPO: 100/month on-the-spot fines for littering associated with smoking
- Developing new advice cards available at hospital entrances
- New signage (including at tram stop)

Dedicated tram entrance

- Over 2,200 passengers daily

- Planning approval for platform to hospital bridge
- Building works from Jan ’17; opens summer ’17

- Minimal parking disruption expected during works
- Patient/volunteer involvement

Quieter wards

- **Noise (other patients)**

  71.6 (vs 70.4 last year) [target >75]

- **Noise (staff)**

  86.9 (vs 86.8 last year) [target >88]

Some progress in Q1&2, but more to do

Actions to date

- **Other patients**

- Limiting patient movement between wards >10pm
- Ear plugs
- Managing patients with dementia & delirium

- **Staff**

- Shoes
- Doors/bins
- Mobile/nurses' station phones

Renewed focus

- Trust-wide campaign
- New signage for ward entrances
- From reducing ‘noise at night’ to ‘quieter wards’ (all times of the day)

Questions

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

13 December 2016

Agenda Item: 5

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

DAYBROOK DENTAL PRACTICE REPORT FINDINGS

Purpose of the Report

1. To introduce a briefing on the findings of the report examining breaches of infection control procedures at Daybrook Dental Practice by Mr Desmond D'Mello.

Information and Advice

2. In June 2014, NHS England was contacted by a whistleblower at the Daybrook Dental Practice who had concerns about the standards of clinical care being provided to patients. The whistleblower provided NHS England with supporting evidence, including covertly filmed footage of dentist, Mr Desmond D'Mello.

3. Having reviewed the evidence, NHS England immediately ordered an interim suspension of Mr D'Mello and commenced an investigation into clinical practices at the dental surgery.

4. The investigation team also consulted with clinical experts in Public Health England, who undertook a clinical analysis of the potential risk to patients. This identified that patients seen by Mr D'Mello may have been placed at a low risk of infection from blood borne viruses (hepatitis B, hepatitis C and HIV), due to apparent multiple failures in cross-infection control standards whilst undergoing dental treatment. Based on this clinical advice, Public Health England has recommended screening for all patients who may have been treated by Mr D'Mello, and NHS England has worked with partners to make the necessary arrangements for this. However, testing results revealed no greater incidence of infection than might be found in a typical sample of the population.

5. NHS England led a detailed investigation into this matter, with support from clinicians at Public Health England. As part of this, Mr D'Mello was reported to the General Dental Council and suspended by the GDC. Fifty six allegations were made against Mr D'Mello, and all but one of them were proved by the GDC. The allegations included:

    - Not changing gloves between patients
    - Not putting on a new surgical mask for each patient
    - Failing to wash hands between patients
    - Not sterilising dental equipment after each use
    - Issuing antibiotics to patients without any diagnosis, or checking whether they had any allergies

6. Mr Gavin Scott, the chair of the GDC panel examining Mr D'Mello's case in August 2016, said that the dentist's behaviour was "fundamentally incompatible with being a dental professional." Further, he indicated that D'Mello's failings constituted "a contemptible circus of gravely hazardous practice which placed his patients at a serious risk of infection."

7. Dr Ken Deacon, Medical Director NHS England, North Midlands will attend to brief the Joint Health Committee and answer questions. A written briefing from Dr Black is attached as an appendix to this report.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee consider and comment on the information provided.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers
Nil

Electoral Division(s) and Member(s) Affected
All

16th November 2016

Briefing for Joint Nottingham City and Nottinghamshire County Health Scrutiny Committee

Update in respect of Daybrook Dental Practice / Mr D'Mello.

Presented by: Dr Ken Deacon, Medical Director, NHS England (North Midlands)

1. Introduction
2. Background
3. Regulatory Action
4. Patient Screening Exercise
5. Contract Review
6. Lessons Learned and changes made.
    a. Whistleblowing
    b. Identification of Poor Practice
    c. Infection Control

1. <u>Introduction</u>

- This report is to provide an update to members of the committee in respect of Daybrook Dental Practice / Mr Desmond D'Mello.
- Dr Doug Black, formerly Medical Director of NHS England (Derbyshire and Nottinghamshire) provided a report to the committee in December 2014.
- This report intends to provide a summary, and overview of events since Dr Black's previous report, rather than to repeat significant parts of the previous report.

2. <u>Background</u>

- Mr D'Mello worked at Daybrook Dental Practice.
- There had been a number of concerns about his clinical performance over a period of time.
- These concerns were dealt with through the PCT processes which existed at the time; Mr D'Mello usually made the changes required of him to address the performance concerns at the time. Until 2014 these concerns never reached a threshold for either a consideration of removing his contract, nor to remove him from the Dental Performers List.
- In July 2013 a referral was made from NHS England to the national clinical assessment service, for a detailed assessment of his practice. This referral was accepted, and the preliminary case conference took place in September 2013.
- On 27th November 2013 the CQC inspected the practice, and found the practice to be compliant with all standards met except 'Assessing and monitoring the quality of service provision. Specifically the standards relating to infection control were met.
- In February 2014, NCAS carried out their assessment of Mr D'Mello's practice. Although some areas for improvement were identified, these did not relate to infection control practices.
- In June 2014 a member of practice staff (acting as a whistle-blower) provided NHS England with evidence suggesting serious failings in respect of infection control practices.

- NHS England suspended Mr D'Mello from the Dental Performers List immediately, and the General Dental Council (GDC) imposed an interim suspension from August 2014.
- Subsequently a large public information and patient testing exercise has taken place.
- Mr D'Mello has been removed from the Dental Performers List, and subsequently the GDC dental register.

3. Regulatory Action

- Dr D'Mello was suspended from the Dental Performers List in June 2014, when the allegations from the whistle-blower were received. This action prevented him from working as an NHS dentist.
- He was suspended by the GDC in August 2014. This action prevented him from working as a dentist (NHS or private) in the UK.
- He was removed from the Dental Performers list by NHS England in September 2015
- He was erased from the dental registered by the GDC in August 2016.
- At the same hearing the GDC found significant failings and misconduct on the part of a dental nurse also working at the practice, and imposed conditions on her continued registration.

Both NHS England and the GDC, in their cases, placed great weight on the previous assessments of Mr D'Mello's practice, and how these contrasted with the evidence provided by the whistle-blower. During the CQC inspection in November 2013, and during his NCAS assessment, Mr D'Mello was able to demonstrate understanding of and ability to comply with the relevant infection control standards. Effectively both bodies concluded that:

- Mr D'Mello understood what is required of a dentist, and was capable of meeting these requirements.
- But wilfully chose not to do so when not observed.

4. Patient Screening Exercise

- Since 2006 patient registration was abolished, as part of dental contract changes.
- This means records can only be kept for a limited time after a patient's last treatment.
- Which meant accurately identifying all patients treated by Mr D'Mello was impossible
- Therefore a nationwide media announcement was made to encourage testing for blood borne viruses.
- 12000 households were sent letters, where there was a record of somebody at that address being previously treated at the practice.
- Around 4500 patients were tested for blood borne viruses
- There were no newly diagnosed cases of Hepatitis B or HIV
- There were 5 newly diagnosed cases of Hepatitis C.
- 5 undiagnosed cases in a population of 4500 is very similar to the unknown diagnosis rate expected in the wider population. In other words, the rate of people who had Hepatitis C but did not know they had it, was the same as would be expected in this number of people, even had they been picked at random. It is impossible to prove or disprove a causal link to the dental treatment provided.

5. Contract Review

- The dental contract differs from the General Practice Contract. The GP contract is based on a capitation payment for each patient registered with the practice. In contrast, the dental contract is based on Units of Dental Activity (UDAs).
- Provided a practice fulfils the number of UDAs in its contract, there is no simple legal mechanism to reduce the number of UDAs.
- The contract relates to the whole practice, and how the practice distributes the UDAs between different practitioners (and indeed how many they employ) is a matter for the contract holder to decide.
- The number of UDAs allocated to practices was determined during a 'reference period' in 2005; existing practices were allocated a number of UDAs. Practices can voluntarily rescind some of their allocation, or it can be reduced if they are failing to deliver the contracted activity. It is otherwise not usually possible to reduce the number of UDAs without the agreement of the contract holder.
- Based on the reference period Mr D'Mello was given a contract for around 30000 UDA. At the outset of the contract there were 3 dentists employed at the practice, but at the time of the whistle-blower's allegations only 2.

- One of the concerns arising from the investigations into Mr D'Mello's conduct is whether a high UDA level should have alerted the system to the risk of poor practice.
- This concern prompted a review of 'high UDA' contracts.
- Mr D'Mello's contract was the 21st largest (of 296) in Derbyshire and Nottinghamshire.
- There is no formal guidance as to an appropriate number of UDAs per dentist.
- A reasonable workload will obviously vary according to whether practitioners are full time or part time, and the amount of private practice carried out in addition to the NHS work.
- A review of high UDA contracts took place, and did not identify specific concerns relating to contract size.
- An analysis was also carried out into the UDA levels held by dentists who had been referred into the Performance Advisory Group of NHS England (the first stage of the formal performance management process) or to the GDC.
- No correlation was identified between a practice's UDA per dentist level, and the chance of performance concerns leading to referral to either PAG or the GDC.

6. Lessons learned and changes made.

6a. Whistleblowing

At the time this incident arose, NHS England were not a prescribed person as defined by the relevant legislation.

NHS England though did try to protect the confidentiality of the whistle-blower, accepting that there was no formal process in place.

Unfortunately the GDC did inadvertently breach the confidentiality of the whistle-blower.

In April 2016 NHS England became a prescribed person for whistle-blowers under the Public Interest Disclosures Act, and so now has more formalised procedures for dealing with concerns raised by whistle-blowers. This does give additional protections to the individuals concerned.

6b. Identification of Poor Practice

There was an unusual combination of events here, which were very different from the performance problems we usually see.

In normal circumstances when concerns about performance:

- The majority of practitioners are trying to do a good job
- Sometimes they cannot, for a variety of reasons.
- If they have insight and are supported they will often improve.
- Usually assessments of practice and capability are reliable – and give a good reflection of the individual's capability.
- Other members of staff often act as a 'safety net'. If one practitioner is having difficulties, others will either support them, or raise concerns about them.

In this case:

- The dentist was capable of working correctly
- He wilfully chose not to do so, knowing that this would put his patients at risk. (The GDC stated 'Mr D'Mello's knowledge of correct procedure was clearly well established')
- The GDC stated 'Mr D'Mello knew how to achieve compliance with the standards in place and, therefore, his deliberate failure to comply with those standards was particularly egregious behaviour'.
- The dental nurse was aware that what he was doing was unacceptable, and was complicit in it.
- In her evidence to the GDC she reported that Mr D'Mello deliberately suspended cross infection procedures.
- She decided not to report this, as she considered her responsibility to her employer to outweigh that to her patients
- The GDC condemned her action as 'deplorable'

In performance cases (rather than 'misconduct' cases) it is almost unheard of for a clinician to intentionally and systematically provide poor care. In the case of Daybrook a dentist deliberately provided poor care, managed to mislead inspectors and regulators, and the dental nurse colluded with him in this enterprise.

This combination of events means it has been very difficult to extract generalised 'lessons learned from this case.

A number of changes made throughout the system do improve the chances of detecting such behaviour, but it is impossible to completely mitigate against the risk of such a 'rogue dentist' particular if their support staff colludes with them. It is not possible to observe the entirety of any clinicians practice, and behaviour can change when observed.

- The CQC have increased the clinical input into their inspections – there is always a dentist as part of the inspection team. The dentist specifically examines compliance with the Code of Practice for the prevention and control of infections. (This includes discussions with staff, and checking steriliser logs etc.)
- All complaints about doctors and dentists received by NHS England are subject to impartial clinical review; if the reviewer identifies concerns this will trigger referral into the formal performance pathway.

- NHS England becoming a prescribed person for the purposes of the Public Interest Disclosure Act. This opens up a specific avenue for members of staff to report concerns as 'whistle-blowers'
- As part of their inspection regime the CQC ensure that practice staff are familiar with the whistleblowing policies, and serious incident reporting policies.
- The publicity surrounding this case; both in terms of the public information exercise, and the coverage of GDC hearings will have raised the awareness of GDC registrants' responsibilities to raise concerns.

6c. Infection Control

Dental practices are allowed to sterilise their own equipment and instruments. (This is no longer the case for General Practices who carry out minor surgical procedures – who are required to use either single use disposable instruments, or have them cleaned and prepared at a Central Sterile Services Department – CSSD).

It is therefore impossible for an external regulator to gain complete assurance that sterilisation processes are fully complied with.

- Practices provide a self-declaration that they comply with the standards
- Sterilisers either have a data tracker, or print a 'receipt' to confirm successful operation of the steriliser cycle.
- These records are routinely checked by CQC at inspections, and by NHS England inspectors / investigators as appropriate.

Summary

This was an unusual case, in that a practitioner was knowingly disregarding acceptable standards of practice, and was aided in this endeavour by his dental nurse. It is impossible to completely mitigate the risk of such a case occurring again. Changes to the regulatory system including more clinically focused inspections, and changes to the protections for whistle-blowers and wider awareness do provide some mitigation. There are some theoretical ways in which greater scrutiny could be applied, but all would require changes to national legislation or contract terms.
Work has taken place to check if there was a correlation between UDA values of contracts and the risk of performance issues; no such correlation was identified.

Dr Ken Deacon
NHS England (North Midlands)

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
13 DECEMBER 2016
SUSTAINABILITY AND TRANSFORMATION PLAN
REPORT OF CORPORATE DIRECTOR FOR STRATEGY AND RESOURCES (CITY COUNCIL)

1. Purpose

1.1 To receive information about the Nottinghamshire Sustainability and Transformation Plan (STP) and consider how the Committee should engage with the future development and delivery of the STP.

2. Action required

2.1 The Committee is asked to:

a) consider the Committee's role in relation to the Nottinghamshire Sustainability and Transformation Plan and how it will engage with its future development and delivery; and

b) decide if the Committee wishes to submit a comment as part of the current feedback exercise relating to the Nottinghamshire Sustainability and Transformation Plan and, if so, the content of that comment.

3. Background information

3.1 Every health and social care system in England has been required to produce a Sustainability and Transformation Plan (STP) showing how local services will evolve and become sustainable over the next five years, delivering the NHS Five Year Forward View. The Plan is required to develop a vision for a sustainable, population focused health and care system that focuses on closing the following gaps:

- Health and wellbeing
- Care and quality
- Finance and efficiency

Locally it has been decided that the STP will also focus on a fourth gap relating to transforming culture.

3.2 The Committee received a briefing on the development of the Nottinghamshire STP in June. (NB: Bassetlaw is an associate to the Nottinghamshire STP but within the South Yorkshire footprint due to the majority of patient flow).

3.3 The first draft of the STP was submitted to NHS England in June 2016 and the second draft was submitted in October 2016.

3.4 The STP was published on 24 November 2016 and a copy is attached. Also attached is a report from David Pearson, STP Lead, updating on the Nottinghamshire STP and a representative of the STP Team will be attending the meeting to provide information on the latest developments and answer questions. This provides an opportunity for the Committee to give initial consideration to the Plan.

3.5 Public feedback and comment on the draft STP is currently being sought until 15 January 2017 and it is understood that there will be further opportunities for people to engage on specific areas of service change with formal consultation if required. The Committee may wish to submit a comment as part of this feedback exercise either at this meeting or at its next meeting in January.

3.6 The Committee also needs to consider its role in relation to the STP going forward and how it wishes to engage with development and delivery of the Plan. The Committee has a statutory role in relation to substantial developments and/or variations in health services but also a wider power to scrutinise the planning, provision or operation in health services in the area.

4. List of attached information

4.1 Nottinghamshire Sustainability and Transformation Plan 2016-2021

4.2 Report from David Pearson, STP Lead, on the Nottingham and Nottinghamshire Sustainability and Transformation Plan

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 Report to and minutes of meeting of the Joint Health Scrutiny Committee held on 14 June 2016

7. Wards affected

7.1 All

8. Contact information

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The Nottingham and Nottinghamshire Sustainability and Transformation Plan

Report for the Joint City and County Health Scrutiny Committee

Introduction

Since the request to attend the Joint City and County Scrutiny Committee the Sustainability and Transformation Plan was published on the 24th November 2016. This plan will continue to be developed, it is not final, it is a reflection of local organisations' current thinking about what needs to be done to improve health and wellbeing, the quality of care and local services, and address the financial challenge.
The published STP is the draft plan submitted to NHS England on 21 October 2016 with some minor updating to reflect the decision by the acute hospital Trusts that they will no longer pursue a full merger but intend to work in a strategic partnership and the removal of Sherwood Forest NHS Foundation Trust from special measures. Three documents were published:

- A summary brief
- A standalone more detailed Executive Summary
- The full plan including the executive summary with appendices

These can be accessed by clicking the link Sustainability and Transformation Plan (STP).

The purpose of this report is to give an outline of the plan, an overview of the next steps including governance and delivery, and how we will engage citizens in the further development of the plan.

Outline of the plan

Local NHS providers, clinical commissioning groups (CCGs), councils, and other health and care services have formed the Nottingham and Nottinghamshire STP footprint - one of 44 in England.

STPs will drive a genuine and sustainable transformation in health and care outcomes over the next five years and help accelerate the implementation of the *NHS Five Year Forward View* locally. As well as strengthening local relationships through joint planning and working, STPs provide partner organisations with a shared understanding of the current challenges, a joint ambition and the steps needed to achieve the sustainability of local health and care services for the future.

The STP for Nottingham and Nottinghamshire addresses how organisations will close the 'three gaps' identified in the *NHS Five Year Forward View* - the future vision for the NHS and social care – which relate to health and wellbeing, care and quality, and finance and efficiency.

The STP identifies five local 'high impact' areas for change:

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

In addition, key supporting areas of work have been highlighted within the plan as crucial to delivery, including; improve housing and environment, strengthen acute services, driving system efficiency and effectiveness, future proof workforce and organisational development and proactive communication and engagement.

The STP partners will continue to work together to develop and deliver these plans - ensuring that health and care services are planned and delivered around the local needs of communities rather than around individual organisations.

Local people will see health and social care services increasingly working as one to improve care planning and patient and service user experiences of care. More services will move out of hospital and into community settings, closer to home, providing better access and value for public money. Improving social care, services for carers and access to primary and community urgent care will relieve pressure on our hospitals, helping people to navigate the system and get the right care, first time with the support and information they need.

Additional support and information will be available to encourage people to adopt healthier lifestyles, prevent disease and help people manage their own health better - improving quality of life and independence into old age. Information sharing and new technology will underpin many of the changes to how health and care services are delivered, from more professionals being able to access records and care plans through to personal devices used to monitor long-term health conditions.

A range of existing transformation programmes have all been integral to the development of the STP in order to ensure best practise locally is driven across the whole area. The core programmes referred to in developing the plan are:

- Mid Nottinghamshire Better Together vanguard
- Principia Partners in Health MCP Vanguard
- Greater Nottingham Urgent and Emergency Care Vanguard
- Nottingham City Enhanced health in care homes vanguard
- Nottingham North and East Primary Care Home vanguard
- East Midlands Radiology Consortium vanguard

The plan has been created having taken into account a wide range of consultation and engagement with citizens, groups and the workforce over the last 2-3 years which have confirmed that local people want:

- Support to stay well and independent
- Quality care with more services in or close to home
- Joined-up services, that will be there for generations

The STP priorities will either be delivered as Nottinghamshire wide initiatives (excluding Bassetlaw which as an associate to our plan and sits within the South Yorkshire STP) in particular where the STP highlighted opportunities for standardisation across the whole STP area or initiatives which are more effective in a larger footprint. The majority of initiatives will be delivered within two delivery units Mid Nottinghamshire and Greater Nottinghamshire (which will include south Nottinghamshire and the City of Nottingham). The delivery units are also exploring how our commissioner and provider landscapes will need to evolve to better meet the needs of our citizens. The landscape will need to be centred on place-based working in natural communities, in collaboration with general practice. A move towards strategic commissioning, with integration of services at provision level, facilitated by a population health management approach and capitated budgets may better enable the required transformation of services.

Next steps

The Programme Executive has agreed the following priorities for the next few months as we move from developing the plan to mobilisation and implementation.

Publication, communications and engagement
Following publication of the draft plan, the STP partner organisations are keen to hear feedback on the draft plan as a general direction of travel for health and care services across Nottingham and Nottinghamshire with an email address provided for feedback before the 15th January 2017. Partner organisations and the STP team are also utilising our existing communications and engagement opportunities to ensure as many stakeholders, public and staff have the opportunity to hear about and feedback on the draft plan.

Our vanguards have provided very good examples of citizen engagement and co-production of our new ways of delivering services and we will build upon this. Specific engagement in relation to the implementation of the plan and formal consultation will be planned to inform decisions about any significant changes to services as the STP is developed and implemented over the next five years. We are currently working to develop our implementation plans and approach which will identify areas that will require formal consultation

Undertaking a further iteration of plan to enable clear delivery and align the STP and organisational plans and contract.
2017/18 is the most challenging year financially and we are working to ensure that responsibilities are clear and there is sufficient capacity in the right place to support delivery of the plans at sufficient pace. As a system we have £314m to save next year. Detailed work is being undertaken to support the mobilisation of the system to further develop and implement the priorities for 17/18. A further challenge is the need to balance the requirements placed on individual organisations with the broader priorities outlined in the STP.

Governance to enable implementation and delivery
As we move from developing the plan to implementation the governance approach to the STP is being reviewed, together with the leadership and organisational development needed to ensure we can lead the cultural shift to deliver more collaborative working as system leaders for health and social care and assure delivery.

David Pearson CBE
STP Lead/Convenor

Nottinghamshire Sustainability and Transformation Plan 2016-21

Footprint name and number: Nottingham and Nottinghamshire (14)
Region: Midlands and East
Nominated lead: David Pearson
Organisations within footprint:

NHS Mansfield and Ashfield CCG	Nottingham Emergency Medical Services
NHS Newark and Sherwood CCG	Healthwatch Nottingham
NHS Nottingham City CCG	Healthwatch Nottinghamshire
NHS Nottingham North and East CCG	Primary care providers
NHS Nottingham West CCG	Local Medical Committee
NHS Rushcliffe CCG	Nottingham City Council (unitary)
Nottingham University Hospitals NHS Trust	Nottinghamshire County Council
Sherwood Forest Hospitals NHS Foundation Trust	Ashfield District Council
Nottinghamshire Healthcare NHS Foundation Trust	Broxtowe Borough Council
Nottingham CityCare Partnership	Gedling Borough Council
Circle Nottingham Limited	Mansfield District Council
East Midlands Ambulance NHS Trust	Newark and Sherwood District Council
Community and voluntary sector partners	Rushcliffe Borough Council
NHS England (for specialised commissioning)	Bassetlaw health and local government as associates

21 Oct 2016

Table of contents

Appendices:

A. Executive summary
B. Project initiation documents for high impact areas, supporting workstreams and enablers
C. How our STP meets national priorities
D. Financial presentation
E. Estates strategy
F. Workforce plan
G. Glossary of terms

Opening statement

Commitment from STP system leaders:

Putting together this STP has been a **collaborative effort** which has been challenging as well as inspiring. The process of developing it has brought us together as leaders of health and social care across Nottinghamshire in a new way, driven by a collective determination to improve services for local people and find innovative ways to continue to deliver the best care. We know that unless we do this, our system will not be sustainable and affordable over the next five years given that funding cannot keep up with rising demand.

We need to make some quite **fundamental changes to be able to deliver care** in more joined-up ways, working across organisational boundaries and thinking less in terms of where care is delivered and more on how it is delivered. As leaders, we take responsibility to lead by example and work together as 'system leaders' to create the conditions for this to happen. This may sound obvious, but it is not straightforward given our statutory responsibilities, the formal accountability we have to Boards and our members, and the way funding flows in the current system.

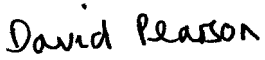
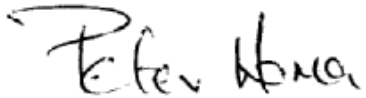
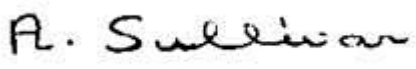
We have some **significant strengths to build on and are proud of what we have achieved so far**, with a number of innovative new ways of providing care and support in Nottinghamshire including five NHS Vanguards, one primary home care pilot, two integrated care pioneer programmes, a fast track for Transforming Care and the recently awarded Nottingham Biomedical Research Centre that brings together Nottinghamshire Healthcare NHS Foundation Trust, the University of Nottingham and Nottingham University Hospitals NHS Trust world class translational research. Learning from each other across the county has been a helpful by-product of the STP process and is something we are committed to continuing.

There are also **some risks of which we are all too aware**. Perhaps the biggest risk is that we are taking on a programme of change which is on a scale and of a complexity which we have never undertaken before. This will place new demands on us in terms of leadership, workforce and organisational development. It will reveal gaps in our capacity and capabilities which we will need to close if we are to be successful in delivering on the aspiration and initiatives described in the STP. First and foremost, we need to make the transition from planning to implementation, which will mean mobilising hundreds if not thousands of our staff to play their part in implementing specific changes which are part of the major initiatives we have agreed upon.

The financial gap our system faces is substantial, and though we have modelled the expected impact of our various initiatives there is **more detailed work to do to refine our estimates of the impact of each initiative**, as well as challenging ourselves to see whether we can bring forward some of the initiatives to deliver benefits earlier. There is also the unresolved question of how we work through situations where the financial gap falls unevenly across the system during the transition process, so that one organisation might be in deficit while others are in a relatively strong position.

There is a saying that ***'a journey of a thousand miles begins with a single step'***, and that seems apt for our situation. We are acutely aware that there is a very long way to go, and that making a strategic plan is much easier than delivering it. At the same time, we have made some important early steps, and done so together, in a way that bodes well for what lies ahead.

We have therefore **signed off this plan as a group of system leaders**, as an articulation of our level of ambition and commitment to work together to do the best we can for our citizens. We recognise that it is a 'work in progress' and gives us a good starting point for contract negotiations, though more detailed work will be needed to align the assumptions required to agree contracts and operational plans. We have some important gaps to close, are aware of those gaps, have discussed them and are equally committed to continuing to work together to refine and strengthen the plan, whilst ensuring we continue to take responsibility at a local level to mobilise for implementation.

STP The Nottingham and Nottinghamshire Sustainability and Transformation Plan	 Peter Herring Chief Executive Sherwood Forest Hospitals NHS Foundation Trust	 Ian Curryer Chief Executive Nottingham City Council	 Bev Smith Chief Executive Mansfield District Council
 David Pearson CBE STP Lead Corporate Director Adult Social Care, Health and Public Protection, Nottinghamshire County Council	 Anthony May Chief Executive Nottinghamshire County Council	 Sam Walters Chief Officer, NHS Nottingham North and East Clinical Commissioning Group	 Dawn Smith Chief Officer NHS Nottingham City Clinical Commissioning Group
 Ruth Hawkins Chief Executive Nottinghamshire Healthcare NHS Foundation Trust	 Dr Peter Homa CBE Chief Executive Nottingham University Hospitals NHS Trust	 Amanda Sullivan Chief Officer NHS Mansfield and Ashfield Clinical Commissioning Group and NHS Newark and Sherwood Clinical Commissioning Group	 Vicky Bailey Chief Officer NHS Rushcliffe Clinical Commissioning Group and NHS Nottingham West Clinical Commissioning Group

Executive summary

We have found the collaborative process of developing our Sustainability and Transformation Plan (STP) both inspiring and challenging. We have used the ongoing engagement and feedback with local citizens through the involvement mechanisms of clinical commissioning groups (CCGs), NHS trusts and local authorities to shape this plan reflecting what is important to people. We have built on the significant improvements to people's health, wellbeing, and care that have been delivered in the recent past, and by seeing the exciting innovations being led by our 'vanguards'. We have been inspired by how much potential there still is to improve our citizens' health and wellbeing, through doing what we already do well more consistently, by developing new ways of for delivering care better and more efficiently, or using technology to support people to manage their own care. We have been inspired to set ourselves ambitious goals and to renew and strengthen our commitment to work together across health, local government, independent sector, and voluntary organisations to deliver these goals.

It is clear that we are facing one of the most difficult periods in health and social care: as our citizens live longer - which should be a cause for celebration - the proportion of their life spent in ill health and their need for health and care support is growing. This is all taking place at a time when our collective resources to support them are increasingly limited and challenges our health and care systems to operate in a better, more sustainable way to support our population, and to do so quickly. This will be achieved not by having each organisation do more in the usual way, but by developing a new model of shared responsibility for health and wellbeing between our citizens and communities and our services, and by developing new models of working together across health and care organisations. We find ourselves challenged as system leaders, to lead together the delivery of a complex change programme at a scale and pace that our system has to date not experienced. This has led us to explore in detail what it takes - in terms of capabilities, resources and mindsets - to deliver, what existing strengths we can build on, and where we will need to learn from others.

Inspired by what we know is possible, we are determined to overcome these challenges and, engaging with the citizens of Nottinghamshire, working with our staff, and acting as one leadership team, build a 21st century health and care system that we can all be proud of. In the rest of this executive summary, we explain the challenges, our approach to overcoming them, and how we will deliver.

What challenges do we face?

Working together and listening to our citizens we have identified the main challenges across all ages and across mental and physical care needs. We know that the foundations of lifelong health and wellbeing are usually established as children and adolescents and it is therefore important to support children and families to make healthier choices.

Health and wellbeing

- The proportion of local people living in ill health is growing, and while people are living longer, an increasing proportion of their lives is spent in ill health. Our healthy life expectancy is lower in Nottinghamshire than many other parts of England. This is due to:
  - An increase in conditions such as diabetes, heart disease and respiratory disease that are often the result of lifestyle choices
  - A result of people living longer, with growing numbers of people with dementia or at risk of experiencing loneliness or social isolation
- We have significant health inequalities, with more than one-quarter of our population living in the most deprived areas of England, and with Nottingham ranked as one of the most deprived city regions in the country. These need to be reduced
- There are big differences in deprivation levels across the city and county affecting older people and children and young people, and a concentration of higher levels of economic deprivation in Nottingham City, Mansfield and Ashfield

Care and quality

Access to care - Nottinghamshire is among the worst performers in the following areas:

- We consistently fail to meet the target for 95% of people arriving at A&E being seen and treated within four hours
- Our ambulance response times are lower than the national average
- Waiting times for treatment for cancer are higher than the national average
- Nottinghamshire has a higher rate than the national average for people with learning disabilities or autism being admitted to hospital
- Young people with mental health needs are receiving care within 10-13 weeks of being referred, against an aspiration of four weeks
- Access times to see a GP vary significantly across Nottinghamshire

Quality of care - we have wide variation within Nottinghamshire in the following areas:

- The numbers of people with long-term conditions aged under-75 who die from preventable conditions is higher than the national average in Nottingham City but not Nottinghamshire, and the number of excess deaths in general for people under-75 is also higher than the national average
- Our providers have good/outstanding regulatory ratings, but Sherwood Forest has a 'requires improvement' rating and is continuing to work to inprove the quality of services it provides.
- Our social care performance includes some of the best in the country, but we are facing sustainability challenges, particularly in the care at home market

Finance and efficiency

- While demand is growing, healthcare services are receiving small budget increases, while social care faces significant decreases
- If we do nothing next year, we are forecasting an overall system gap of £314m for the local authority social care and public health budget.

- By 2021, this would grow to an an overall system gap of £628m for the local authority social care and public health budget
- Closing this gap would require a reduction of 4.5% in spending growth every year against our historic performance of 2%.

How will we address our challenges?

We recognise that the way care is delivered has changed for citizens in the last decade. Many of these changes might not have been expected, such as people safely returning home the same day after having a major operation or soon after giving birth, where previously they would stay in hospital for many days. People with long-term conditions such as diabetes are now able to monitor and manage their health independently at home using technology. In other areas we know that we have not managed to change the system as successfully, with people spending time in hospital when they do not need the specialist care of a specialist but do not have the timely support available to allow them to remain in their own home. Another example is people returning to outpatient clinics when their care could be provided locally.

At a high level, we have to continue to drive change supported by **six main aims** in order to reach our goals and overcome our challenges:

- Organise care around individuals and populations - not organisations - and deliver the right type of care based on people's needs, for example:,
    - Help those who are largely well today (most of the population) stay well through prevention and health education and manage minor issues themselves in so far as it is possible
    - Help those with a complex or advanced long-term condition that needs professional expertise and support to be as enabled as possible to manage their own care, to have an identified system to escalate care quickly in the event of exacerbations, and to have regular monitoring to identify changes in their health and social care needs as early as possible
- Help people remain independent through prevention programmes and offering proactive rather than reactive care, which will also reduce avoidable demand for health and care services
- Support and provide care for people at home and in the community as much as possible – which implies shifting resources into those settings - and ensure that hospital, care home beds, and supported housing are available for people who need them
- Work in multi-disciplinary teams across organisational boundaries to deliver integrated care as simply and effectively as possible
- Minimise inappropriate variations in access, quality, and cost, and deliver care and support as efficiently as possible so that we can maximise the proportion of our budget that we spend on improving health and wellbeing
- Maximise the social value that health and social care can add to our communities

At a more detailed level, our approach will be to **drive change in five high-impact areas**, supported by **continuous improvement** in housing and environment, acute services, and system efficiency and effectiveness, and **enabled** by workforce and organisational development, estates utilisation, and proactive communication and engagement. These are each described below:

Five high-impact areas:

1. Promote wellbeing, prevention, independence and self-care

Our main focus is to prevent illness, disease and frailty to enable our citizens to live healthy and independent lives. We will tackle inequalities in health by targeting our support to those individuals and communities where ill-health and the occurrence of unhealthy lifestyles is greatest. We will measure our success by increases in healthy life expectancy, a reduction in inequalities across population groups, and supporting people to live healthy lifestyles. This will result in:

- An increase in healthy life expectancy of three years by 2020/21 through a reduction in the occurrence and severity of disease. This will be delivered by systematic efforts to support people to improve their health and wellbeing through lifestyle changes, such as reducing smoking and harmful drinking, and improving mental wellbeing, including:
    - Decrease the prevalence of smoking from 24.2% to 18.8% (city) and from 17.1% to 15.2% (county), with separate targets for pregnant women
    - Reduce levels of overweight and obese children aged 10-11 (from 37.9% to 35% in city and 31% to 28% county) and adults (from 62.3% to 59.3% city and from 67.3% to 65.5% county)
    - Reduce rate of alcohol-related admissions from 927.5 to 696.1 (city) and from 653.9 to 585.9 (county) per every 100,000 citizens
    - Reduce organisational staff sickness absence rates
- A reduction in avoidable demand for health and care services by promoting independence and self-care, including through improved information and education and greater use of technology
- Reduction in health inequalities across the STP by reducing the slope index of inequality (mortality from causes considered preventable) from 206.6 to 167.8
- Increase in population levels of physical activity and good diet and nutrition including breastfeeding, and mental wellbeing
    - Reduce levels of physical inactivity to 25.6% (city) and 26% (county)
    - Increase breastfeeding rates from 48.6% to 51.6% (city) and 39.8% to 44.4% (county)

2. Strengthen primary, community, social care and carer services

We aim to ensure that our communities are supported to stay healthier for longer, and that when they are at risk of becoming unwell they are able to swiftly access consistent levels of care that is organised around their needs. Increased levels of access to integrated primary, community, mental health and social care services will help people to live longer, healthier and more independent lives. It will also offer much needed support for carers, reduce the pressure on general practice and reduce the number of people requiring hospital services. This will result in:

- Swifter access to general practice, which will be available 8am-8pm, seven days a week
- Better quality of life for older people and people with long-term conditions
- Reduced numbers of avoidable hospital admissions
- Increased early detection of illnesses, in particular in cancer and dementia
- Reduced instances of waste and patient harm from poor medicines management
- More people dying in accordance with their wishes as a result of better end-of-life planning
- A more multi-skilled and empowered workforce not limited by traditional boundaries
- A net savings of £50m by 2020/21

Through the above, and other objectives, we will reduce the number of emergency admissions in our hospitals (for example, 30% in south Nottinghamshire and 19.5% in mid Nottinghamshire), we will reduce our prescribing costs by 2%, and increase to 40% the number of citizens with diabetes meeting treatment targets. We will be in the top 25% of areas for citizen satisfaction with GP opening hours, those recommending their practice, and those with a same or next day contact. We will be in the top 25% of areas for numbers of older people remaining at home 91 days after discharge from hospital.

3. Simplify and improve urgent and emergency care

We aim to support citizens to access the most appropriate advice or service for their urgent care needs, minimising disruption for citizens and their families. For those with more serious needs, we aim to provide a service that can respond rapidly to meet those needs, whether in the community or hospital, ensuring that patients receive the best possible care and return home as soon as they are well enough. This will result in:

- More people able to self-treat as a result of improved quality of information and support available
- Fewer people arriving at hospital as a result of improved access to urgent care in settings other than A&E, such as general practice or pharmacy
- Timely and safe care for those needing hospital-based urgent and emergency care as a result of swifter access to a senior clinician on arrival at A&E
- People who are admitted to hospital able to return home sooner as a result of more effective processes for discharging patients
- A net savings of £16m by 2020/21

First and foremost, at least 95% of our citizens attending A&E will be seen and treated within four hours. Additionally, we will reduce the total number of emergency admissions by 5% via improved navigation of our citizens and workforce to appropriate services, reduce mental emergency attendances and re-admissions over the next two years by 10%, and we will reduce 200 beds in our acute setting by providing better alternatives for our citizens who are medically fit to leave the hospital but currently do not have enough support in the community or at home.

4. Deliver technology enabled care

We aim to use technology to help citizens stay healthy and manage their own care, and to help clinicians and other staff deliver care more efficiently. This will result in:

- Improved access to information for citizens, including about the availability of services and to all records and relevant self-care information
- Patients and service users no longer required to repeat the same information multiple times to different health and care professionals
- Clinical and care staff able to access and share information to support individuals' health and care needs.
- Availability of new technologies to support independent living, care at home and better self-management of conditions
- Savings of £3m per year by 2020/21 as a result of making better use of technology

5. Ensure consistent, evidence based pathways in planned care

Early diagnosis of illnesses and health conditions can improve outcomes and reduce costs of treatment. This is particularly true of cancer and other long-term conditions. Through early diagnosis we will support citizens to manage their condition and prevent deterioration. Much of this support can be given close to home in a community setting. Where specialist treatment is needed in a hospital or specialist centre, consistent pathways will ensure that patients receive the most appropriate treatment and are supported to return to their place of residence quickly following treatment. This will result in:

- Fewer people diagnosed with cancer or an underlying medical condition through the urgent and emergency care system
- The 18-week referral-to-treatment time for routine planned care will be consistently achieved by ensuring that the right patients are referred for specialist care
- All national standards on waiting times for cancer diagnosis and survival rates will be achieved
- Improved outcomes for people who have hip and knee replacements
- Reduced avoidable admissions for people with musculoskeletal disorders
- Savings of £21m by 2020/21

As a result, we will reduce gastro and cardiology outpatient appointments by 23% by 2018/19, reduce unnecessary ophthalmology referrals ensuring patients have access to the most appropriate service without delay, provide community ophthalmology closer to home allowing hospitals to treat the most serious conditions, and achieve a 9% reduction in musculoskeletal outpatient referrals.

Three areas for continuous improvement:

Improve housing and environment – it is critical that our citizens, particularly those with complex needs, have suitable accommodation that keeps them safe and secure. We will work with our partners to establish clear housing standards and to offer suitable housing while improving engagement of the housing workforce on health issues. We will also use the collaboration made possible by our broader focus to support health and wellbeing by considering, for example, the built environment, leisure and open spaces, as well as co-ordinating the use of regulation to improve health outcomes, such as licensing and air quality.

Strengthen acute services – Nottingham University Hospitals NHS Trust and Sherwood Forest NHS Foundation Trust will work together to manage the pressures and changes that are impacting on acute hospitals. This will assure the ongoing provision of clinically safe, high quality, acute and specialist care for the citizens of Nottingham and Nottinghamshire. Our hospitals will be reshaped in response to the changes brought about as we increasingly provide appropriate care in the community.

Drive system efficiency and effectiveness – ensure the health and care system operates as efficiently and effectively as possible in order to reduce waste and reduce unnecessary variation in the way we deliver care, for example in how regularly older people at risk of falling are assessed, advised and supported, to ensure we spend as much of our money as possible on improving the health and wellbeing of our populations.

Three main enablers:

Future proof workforce and organisational development - we have more than 40,000 highly committed health and care colleagues. Re-designing our workforce is essential for the successful delivery of our plan by working together as a system and with our citizens. Through this we will strengthen the current workforce by introducing new roles, supporting areas where there are shortages, improving integration across sectors and organisations, and embedding approaches to prevention and supporting independence. Our strong relationships between employers, citizens and providers of education will help us to promote local engagement, employment, education and training to support long term sustainability that gives greater flexibility to deliver workforce changes more responsively.

Maximise estates utilisation – working across the system and breaking down organisational barriers to improve how we use our estate to release money tied up in buildings and maintenance. We will also work to ensure our buildings are fit for purpose and in the right locations to support the delivery of our high impact changes. Our estates strategy will deliver £20m saving to help support the financial delivery of our plans.

Proactive communication and engagement - successful delivery of our plan will require us to ensure that local partner boards, councillors, the voluntary sector, staff and citizens understand its purpose and benefits and are fully engaged in making it a reality. It is essential that we harness our staff's energy and commitment to support us in developing and delivering this plan. We want to involve our citizens in designing how we transform our system to enable them to be more independent and to shape the ways in which we deliver health and care services to deliver outcomes that matter to them.

Nottingham and Nottinghamshire STP Plan on a Page

Our Vision: ***Sustainable, joined-up high quality health and social care services that maximise the health and wellbeing of the local population***

System Aims:

- People will be supported to develop the confidence and skills to be as independent as possible, both adults and children
- People will remain at home whenever possible. Hospital, residential and nursing homes will only be for people who appropriately need care there
- Resources will be shifted to preventative, proactive care closer to home
- Organisations will work seamlessly to ensure care is centred around individuals and carers
- Addressing mental and physical health and care needs of population collectively and making best use of the public purse

High Impact Areas:

1. **Promote Wellbeing, Prevention, Independence and Self-Care**: increase healthy life expectancy by 3 years by 2020/21 with a focus on decreasing the prevalence of smoking and reducing levels of obesity in the first 2 years. Enhance health and wellbeing to promote independence and expand levels of self-care
2. **Strengthen primary, community, social care and carer services**: ensure people stay healthier for longer by increasing access and resilience in general practice and improve the quality of life for people with long-term conditions and their carers
3. **Simplify Urgent and emergency care**: deliver the right advice or service at the right time including improving the urgent and emergency care pathway, and redesigning the system to enable reduction of 200 beds in acute hospitals in the first 2 years of this plan
4. **Deliver Technology enabled care**: help citizens stay healthy and manage their own care; help clinicians and other staff deliver more care more efficiently and use new technology to support independent living and care at home
5. **Ensure consistent and evidence based pathways in planned care**: standardise care pathways reducing unwarranted variation, improve the prevention, early diagnosis and recovery in cancer care

Measured through the following success criteria:

- All within the health and care economy achieving financial balance by 2021
- Delivery of the agreed outcomes and targets that reflect our system values and citizen satisfaction: Improve Healthy Life Expectancy by 3 years
- High quality providers through regulatory outcomes

Supporting workstreams and enablers:

1. **Strengthen acute services**: closer collaboration between Nottingham University Hospitals Trust and Sherwood Forest NHS Foundation Trust
2. **Drive system efficiency and effectiveness**: deliver provider Cost Improvement Programmes, additional efficiencies through Carter and reduce variation in top 10 area by value
3. **Improve housing and environment**: provide social and warm housing to reduce emergency department and non-elective attendances
4. **Future proof workforce and organisational development**: redesign our workforce to successfully deliver our transformation plan
5. **Maximise estates utilisation**: improve estate usage to release money and deliver our high impact changes
6. **Proactive communication and engagement**: engage citizens and staff to support us in the successful development and delivery of our plan

Clear delivery governance approach:

- One STP-level delivery architecture responsible for overall programme management, coordinates knowledge sharing and development of consistent standards, ensures capability building and organisation development, and implements footprint-wide initiatives and enablers
- Two delivery units with the vast majority of resources deployed that programme-manage locally implemented schemes, track performance and analytics, and allocates and deploys resources and teams
- Advisory Group, Clinical Reference Group and Delivery Group

Collaboration with Bassetlaw

How will we deliver?

We acknowledge that delivering a programme of this scale at this pace is a major challenge, especially as it has not been done before in our system. We have reflected on and sought expert views on what it will take for us to succeed, and have committed to leading and working together in ways that maximise our chances of success.

We recognise that delivering such an ambitious plan requires us to lead the system in a different way than we have done to date. Our footprint is composed of many organisations with a history of both innovation and successful delivery, and we are proud of that. But we need to shift from acting as organisational leaders trying to make the greatest contribution to health and wellbeing through our organisations, to acting as the leadership team for health and care in Nottingham and Nottinghamshire. This means streamlining our governance arrangements to improve the speed and consistency of decision-making, developing a clear delivery infrastructure to support the changes taking place, and where needed, securing expert support to build the capabilities and capacity of our implementation teams. We have started on this journey and are committed to seeing it through.

At the same time, a core principle agreed by partners in our STP is that we are one health and social care system, with a shared responsibility to manage the whole system finances to meet the populations' needs. In our plan we have set out the finances currently available across local authority and NHS organisations until 2021 and with our citizens we will determine the right mix of services for the population according to need and achieving the best outcomes. We will work together to make the best use of the public purse and ensure that we meet the ambition of our plan at a local level.

We also need to do further detailed planning and engagement in the weeks ahead, in the following areas:

1. We need to rapidly complete more detailed analysis and planning in some areas to confirm costs and the detail in these plans. This needs to take place in time for us to ensure that our operational plans for the next two years are deliverable and developed from a sound basis with the appropriate resources allocated to them

2. We need to continue to complete the good work that has developed a vision and modelling for our future workforce requirements. At its core, this will involve a cultural shift towards much more collaborative working across organisational and professional boundaries, as well as ensuring that we address any projected recruitment and retention challenges

3. As we set about delivering our plans, we need to confirm the measures which will close our financial gap in 2017/18 in order to support the longer term transformation. We therefore need to sequence our work in a way that allows us to make swift progress in year one

4. One of the key risks to our ability to deliver proposed changes is the financial gap that is still forecast for children's and adult social care and public health. We need to find a way to bridge this gap or we risk failing to prevent the required numbers of hospital admissions when people could and should have been better looked after at home

We intend to make swift progress addressing each of these areas between now and the end of 2016.

There is much to do, but equal levels of determination to get there, because we know how much positive difference we can make to deliver a healthier future for citizens, from birth and early years through to adult care, older people's care and end-of-life.

1- Health and Care in Nottingham and Nottinghamshire

The Nottingham and Nottinghamshire Sustainability and Transformation Plan (STP) summarises work undertaken jointly by local health and care organisations to set out the changing nature of local people's health and care needs, and how our local services need to evolve to meet those needs in the future.

People

Our STP is focused on our entire population from birth to the end-of-life. The total population of Nottingham and Nottinghamshire is 1,044,934 (resident population) with a similar age structure to England. The population is predicted to increase by 2.7% to 2020-21. These increases are more apparent in people aged 0-14 years (5.1%), and people aged 65 years and over (4.9%), with greater increases in the 85 years-plus population (16.3%).

The rapid growth of the over-65s population in Nottinghamshire brings challenges to the sustainability of the health and care system, with the average spend being significantly higher than any other age group. This adds considerable cost pressure, particularly around care for long-term conditions (LTC) and dementia. Pressures from LTCs are not limited to the ageing population - with younger people in Nottinghamshire living a large proportion of their life in poor health. There are stark differences in the rates of occurrence of disease between different groups which lead to substantial inequalities in health in our population. Further details on our population, including the impact of the growing numbers of younger people, are available in our Joint Strategic Needs Assessments.[1]

Place

There are some exciting opportunities arising through developments in the local area to attract and retain our workforce. At the heart of the East Midlands, Nottinghamshire is synonymous with the development of health and life sciences. Nottingham is the birthplace of Jesse Boot, and the global Boots brand. It was in Nottingham that Ibuprofen was created and where a Nobel prize was awarded for Sir Peter Mansfield's work on magnetic resonance imaging (MRI). We benefit from a highly regarded and well-established Medical School, a national leader in teaching, learning and development. We have a similarly highly regarded Pharmacy School, and excellent academic links to the pharmaceutical industry. With two thriving universities and a university hospital, we benefit from world-leading research, and with the East Midlands Academic Health Science Network and CLAHRC East Midlands both located in Nottingham we ensure that new developments from research and innovation can be adopted and spread quickly into service improvements for citizens. In MediCity and BioCity, we have burgeoning tech and bioscience sectors. We will therefore harness the skills and resources that our city and county uniquely provides to apply a particular focus to innovation in our STP; systemising and spreading the benefits of the many new technologies, services, products and ways of working that have been developed locally.

[1] https://nottinghaminsight.org.uk/insight/nottinghamhome.aspx

Organisations

Our STP footprint comprises six CCGs, and a unitary and two-tier local government structure with a city council, and a county council with seven district councils. There are two major acute trusts and two transformation partners. There is a large mental health trust (Nottinghamshire Healthcare NHS Foundation Trust) and the local authorities both commission and provide services. There are a myriad of smaller health and care providers across all sectors (including primary care, pharmacy, dental and care sector). There are also two well established Health and Wellbeing Boards – city and county. The two transformation programmes are: *Greater Nottingham Health and Care Partners* (consisting of partners across Nottingham city and south Nottinghamshire) and the *Better Together* alliance in mid-Nottinghamshire.

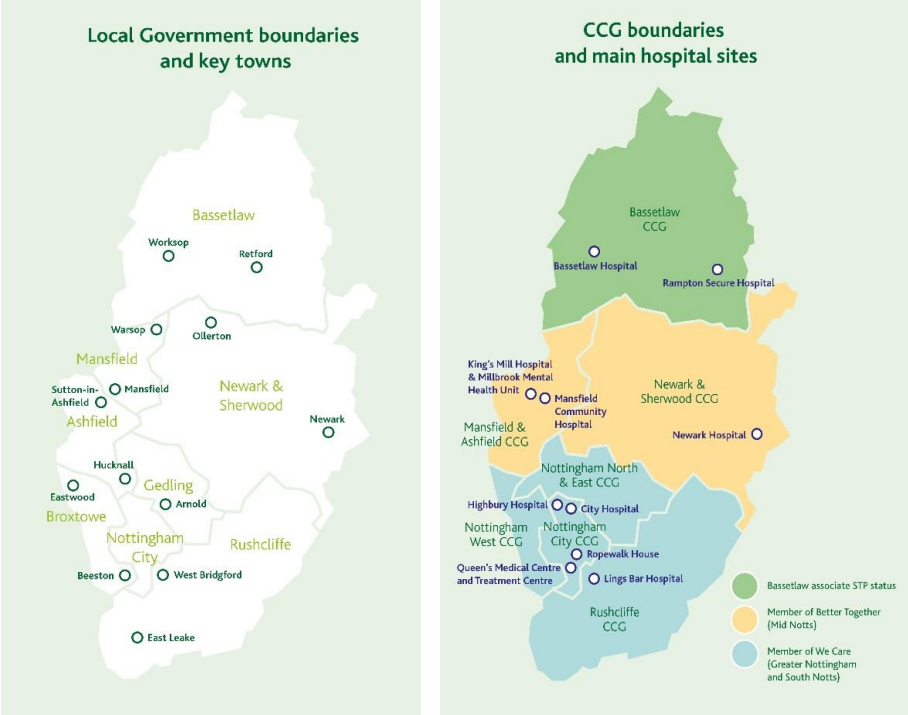


Figure 1: Nottinghamshire local authorities, CCGs and core providers

The statutory sector benefits from working alongside a very engaged and vibrant third sector, independent sector and community interest company providers. Engagement of all these organisations has been key to developing a clear vision that as a system we can coalesce around.

As our STP develops, our commissioner and provider landscape will need to evolve to better meet the needs of our citizens. The landscape will need to be centred on place-based working in natural communities, in collaboration with general practice. It is likely that as population health arrangements arise, the landscape will simplify and the relationship between provider and commissioner will be more coherent. A move towards strategic commissioning, with integration of services at provision level, facilitated by a population health management approach and capitated budgets, will enable transformation of services.

Bassetlaw as an associate to the Nottingham and Nottinghamshire Plan

Bassetlaw forms part of the South Yorkshire and Bassetlaw STP footprint. However, the district of Bassetlaw is part of the Nottinghamshire Health and Wellbeing Board footprint, is coterminous with the boundary of Nottinghamshire County Council, and is provided with mental health and community services by Nottinghamshire Healthcare FT. Bassetlaw is also within the Nottinghamshire Transforming Care Partnership. Acute care is provided to citizens primarily by Doncaster and Bassetlaw Hospitals NHS Foundation Trust.

Health and care transformation – building upon our successes

The spread of our learning and experience will be crucial to our success. Vanguards will continue to set the pace for the rest of the system. We will be leaders in the development of new care models, and share evidence-based learning across Nottingham and Nottinghamshire.

Common aims and objectives across the system

There are a number of high impact areas which taken together will provide large-scale transformation for our citizens. However, we also understand the importance of local ownership – both by our care professionals and our patients/citizens and carers. Considerable energy has gone into communicating and engaging widely with partner organisations and stakeholders to gain support for the STP. Our strategic approach is tailored to the specific needs and challenges of each place. Our aims are ambitious and widely understood:

- People will be supported to develop the confidence and skills to be as independent as possible, both adults and children
- People will remain at home whenever possible. Hospital, residential and nursing homes will only be for people who appropriately need care there
- Resources will be shifted to preventative, proactive care closer to home
- Organisations will work seamlessly to ensure care is centred around individuals and carers
- Addressing mental and physical health and care needs of population collectively and making best use of the public purse

These objectives apply equally to people of all ages and those with mental and physical care needs. It is known that the foundations of lifelong health for our population involve tackling risks to health such as obesity, smoking, substance misuse, and poor sexual and mental health. These are commonly established in childhood and adolescence.[2] Therefore it is essential that preventive activities supporting children and families are prioritised.

[2] Chief Medical Officer of the United Kingdom, *Our Children Deserve Better: Prevention Pays – Annual Report of the Chief Medical Officer 2012*, London, 2012. Retrieved from https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

2- Our gaps, their underlying drivers…

Gaps

Health & Wellbeing

- Low Healthy Life Expectancy (HLE; a measure of physical and mental health and well-being): county LA for men is 62.1; for city LA, 57.8 (versus 63.4 nationally); county LA for women, 62.8; for city LA, 58.4 (versus 64 nationally) (ONS, 2012-14).
- Women in Nottingham can expect 23.2 years (or 30% of their life) in poor health. In Nottinghamshire, the equivalent is 20.2 years of poor health (24% of life). Men in Nottingham can expect 19.3 years (a quarter of their life) in poor health; men in Nottinghamshire can expect 17.4 years in poor health, or 22% of their average lifespan.
- Inequalities in HLE: 22.5 year difference in HLE for women and 22.9 for men between areas with lowest (Nottingham) and highest (Rushcliffe) HLE (ONS, 2012-14).

Care & Quality

Nottinghamshire is a national outlier (among the worst performers) in the following areas:

- People with a learning disability or autism receiving inpatient care: 70 per million, in the worst quartile nationally (NHS England, January 2016)
- A&Etarget: 4 hour target 74.7% (NUH) and 93.7% (Sherwood Forest) versus national average of 90.3% and target of 95% (Trust data, Q1 2016-17)
- Ambulance Red 1 and 2 response times within 8 minutes: below national average of 68% for 5 of 6 CCGs and all 6 CCGs (Trust data, January 2016)
- Cancer <31 day wait from diagnosis to first treatment: all 6 CCGs have worse than national average of 97.5% (NHS England, Q1 2016-17)
- Mental health referral-to-treatment times for under-18s: 10-13 weeks across county against an aspiration of 4 weeks (Trust data, 2014-15)
- Average length of stay for elective and non-elective procedures in elderly: worse than national average for Mansfield & Ashfield CCG in patients over 80 years of age at 4.88 and 7.98 days, respectively (versus 4.61 and 7.42 national averages)

We have wide variation (best-worst) between parts of Nottinghamshire in the following areas:

- GP access: 43-48% of patients in 4 CCGs had same-day access to nurse or GP performing below national average (Public Health England, 2014-15)
- A&E cancer diagnosis rate: Mansfield & Ashfield CCG performs below national average: breast 7% (versus 4%); lung 40% (37%) (Public Health England, 2006-13)
- Cancer <62 day wait from referral to first treatment: Newark and Sherwood CCG, and Nottingham West CCG perform below national average of 82.2% (NHS England, Q1 2016-17)
- LTC under-75 preventable mortality rates: below national average in Nottingham City LA but not County LA, e.g. 73.5 CVD-related deaths and 30.4 respiratory-related deaths per 100,000 in City versus national averages of 49.2 and 17.8 (Public Health England, 2012-14)
- Excess under 75 mortality rate in adults with serious mental illness: 457 deaths per 100,000 in City LA and 370 in County LA versus 358 nationally (Public Health England, 2014-15)

- Care Quality Commission (CQC) ratings: across health providers, the majority have good or outstanding regulatory ratings but Sherwood Forest Hospital Trust has a 'requires improvement' rating and is continuing to work to improve the quality of services it provides.
- Excess medical/surgical admissions: in Nottingham City CCG 38% are excess for those 65 and over whereas only 18% are excess for Rushcliffe CCG (Milliman, 2014-15)

Finance & Efficiency

- Financial gap increasing to £628M by 2021, of which £473M is NHS gap, with £314M gap by 2018
- Avoiding this gap would require a reduction of 4.5% in spending growth every year versus our historic performance of 2%

Underlying drivers

Demographic factors increasing demand / activity:

- Between 2016 and 2021, the population of citizens aged 0-17 is estimated to increase by 5.1% (ONS, 2014 and 2016)
- Increase of 10.9% in the number of people in Nottinghamshire with a learning disability from 2013-14 to 2014-15 (NHS Digital, 2015)
- Population aging and living longer with ill health:
    - over-85s projected to grow by 16.3% from 2015-16 to 2020 (ONS, 2015)
    - 3 CCGs in upper quartile nationally for prevalence of cancer and dementia
- Unhealthy lifestyles impacting on people's health and wellbeing:
    - High adult smoking prevalence and persistence inequalities (city 24.2%, county 17.1%, NHS England 2014)
    - 16.5% maternal smoking delivery (bottom quartile nationally) (NHS England, Q3 2015-16)
    - High levels of alcohol related admissions (related conditions) with the city the worst performing area in the country (city 927, county 653 per 100,000 NHS England 2014-15)
    - 32.7% children aged 10-11 classified as obese or overweight (NHS England, 2014-15)
- Rising citizen expectations around the quality and location of care

Real and/or perceived problems with accessing primary care:

- Avoidable A&E activity growing, with 3 CCGs above national average for ambulatory care-sensitive condition admission rates in 2014 and 2015, versus 2 in 2013 (NHS Digital, 2013-15)
- Primary care workforce: 0.61 per 1,000 population and in the worst quartile with variation across the footprint (NHS England, 2015)

Workforce and community resources unable to keep up with demand

- Rising demand for mental health support
- Social care spending:
    - In Nottinghamshire County LA, there are upcoming elections, which creates some uncertainty. For example, in 2016 the government allowed councils which provide social care to adults to increase council tax by up to 2% (the social care precept, which is ~£6M locally). This is agreed

under the current administration until 2018 but remains a local, politically driven decision, alongside challenges to funding with reductions in central government support
    - Core spending in Nottingham City LA is forecast to decrease by 5.1% between 2015-16 and 2017-18, and by 4% in Nottinghamshire County LA (Department for Communities and Local Government, 2015)

Unwarranted clinical variation in treatment pathways

- If current performance were standardised to top national quartile, there would be savings of ~£5M in outpatient appointments, ~£4M in emergency admissions, and ~£0.6M in surgical thresholds (NHS Better Care, Better Value, Q2 2015-16)

Organisations that are individually successful and pioneering but with little experience working at the footprint level

- Historically successful and innovative individual organisations
- Comparatively little experience working across the footprint, further complicated by some difficult contracting experiences

2- …and our approach to closing them

We recognise that the way care is delivered has changed for citizens in the last decade. Many of these changes would not have been expected. For example, people safely returning home the same day after having a major operation or soon after giving birth, previously they would stay in hospital for many days. People with long term conditions such as diabetes are able to monitor and manage their health independently at home using technology. In other areas we know that we have not managed to change the system as successfully, with people spending time in hospital when do not need the care of a specialist but who could not get the right support or support quickly enough to allow then to remain in their own home or people returning to outpatient clinics when their care could be provided locally.

At a high level, we have to continue to drive change along **six main aims** in order to reach our goals and overcome our challenges:

- Organise care around individuals and populations –not organisations—and deliver the right type of care based on people's needs. E.g.,
    - Help those who are largely well today (most of the population) stay well through prevention and health education to stay well and manage minor issues themselves in so far as it is possible;
    - Help those with complex or advanced long-term conditions that need professional expertise and support to be as enabled as possible to manage their own care, to have an identified system to escalate care quickly in the event of exacerbations, and to have regular monitoring to identify changes in their health and social care needs as early as possible
- Help people remain independent through prevention programmes and offering proactive rather than reactive care, which will also reduce avoidable demand for health and care services
- Support and provide care for people at home and in the community as much as possible –which implies shifting resources into those settings—and ensure that hospital, care home beds, and supported housing are available for people who need them
- Work in multi-disciplinary teams across organisational boundaries to deliver integrated care as simply and effectively as possible
- Minimise inappropriate variations in access, quality, and cost, and deliver care and support as efficiently as possible so that we can maximise the proportion of our budget that we spend on improving health and wellbeing
- Maximise the social value that health and social care can add to our communities

At a more detailed level, our approach will be to **drive change in 5 high-impact areas**, supported by **continuous improvement** in housing and environment, acute services, and system efficiency and effectiveness, and **enabled** by workforce and organisational development, estates utilisation, and proactive communication and engagement.

3- Our priorities and 'plan on a page'

Our Vision: ***Sustainable, joined-up high quality health and social care services that maximise the health and wellbeing of the local population***

System Aims:

- People will be supported to develop the confidence and skills to be as independent as possible, both adults and children
- People will remain at home whenever possible. Hospital, residential and nursing homes will only be for people who appropriately need care there
- Resources will be shifted to preventative, proactive care closer to home
- Organisations will work seamlessly to ensure care is centred around individuals and carers
- Addressing mental and physical health and care needs of population collectively and making best use of the public purse

High Impact Areas:

1. **Promote Wellbeing, Prevention, Independence and Self-Care**: increase healthy life expectancy by 3 years by 2020/21 with a focus on decreasing the prevalence of smoking and reducing levels of obesity in the first 2 years. Enhance health and wellbeing to promote independence and expand levels of self-care
2. **Strengthen primary, community, social care and carer services**: ensure people stay healthier for longer by increasing access and resilience in general practice and improve the quality of life for people with long-term conditions and their carers
3. **Simplify Urgent and emergency care**: deliver the right advice or service at the right time including improving the urgent and emergency care pathway, and redesigning the system to enable reduction of 200 beds in acute hospitals in the first 2 years of this plan
4. **Deliver Technology enabled care**: help citizens stay healthy and manage their own care; help clinicians and other staff deliver more care more efficiently and use new technology to support independent living and care at home
5. **Ensure consistent and evidence based pathways in planned care**: standardise care pathways reducing unwarranted variation, improve the prevention, early diagnosis and recovery in cancer care

Measured through the following success criteria:

- All within the health and care economy achieving financial balance by 2021
- Delivery of the agreed outcomes and targets that reflect our system values and citizen satisfaction: Improve Healthy Life Expectancy by 3 years
- High quality providers through regulatory outcomes

Supporting workstreams and enablers:

1. **Strengthen acute services**: closer collaboration between Nottingham University Hospitals Trust and Sherwood Forest NHS Foundation Trust
2. **Drive system efficiency and effectiveness**: deliver provider Cost Improvement Programmes, additional efficiencies through Carter and reduce variation in top 10 area by value
3. **Improve housing and environment**: provide social and warm housing to reduce emergency department and non-elective attendances
4. **Future proof workforce and organisational development**: redesign our workforce to successfully deliver our transformation plan
5. **Maximise estates utilisation**: improve estate usage to release money and deliver our high impact changes
6. **Proactive communication and engagement**: engage citizens and staff to support us in the successful development and delivery of our plan

Clear delivery governance approach:

- One STP-level delivery architecture responsible for overall programme management, coordinates knowledge sharing and development of consistent standards, ensures capability building and organisation development, and implements footprint-wide initiatives and enablers
- Two delivery units with the vast majority of resources deployed that programme-manage locally implemented schemes, track performance and analytics, and allocates and deploys resources and teams
- Advisory Group, Clinical Reference Group and Delivery Group

Collaboration with Bassetlaw

4- High impact areas

High impact area 1: Promote wellbeing prevention, independence and self-care

Why is this important?

Both the length of life (life expectancy) and the time spent in good health (healthy life expectancy) have increased over time for our population. However, life expectancy is increasing at a faster rate than healthy life expectancy meaning that our population is spending a greater proportion of its total life in poor health. This has implications for both individuals – due to an increased proportion of life spent with illness and disability – and our system - due to associated health and social care costs. There are also major inequalities in the time spent in good health. For example, across the STP, women and men live 22.5 and 22.9 years more in good health in Rushcliffe compared to those living in Nottingham City.

What is our aim?

Our aim is to close the health and wellbeing gap in healthy life expectancy and to move the local system towards sustainability by reducing the requirement for health and social care services. Our main focus is to prevent illness and disease to enable our citizens to live healthy and independent lives. Where ill-health does occur or citizens become frail, our proactive approach to prevention will minimise its severity and we will support individuals to self-care and live independent lives, reducing demand on statutory services across the system. We will tackle inequalities in health by targeting our support to those individuals and communities where ill-health and the occurrence of unhealthy lifestyles are greatest. We will measure our success by increases in healthy life expectancy, a reduction in inequalities across population groups and supporting people to live healthy lifestyles.

What will be different in 2020/21?

- An increase in healthy life expectancy of 3 years by 2020/21 through a reduction in the occurrence and severity of disease. This will be delivered by a systematic up-scaling of efforts to tackle unhealthy lifestyles such as smoking and harmful drinking, and improving mental wellbeing, including supporting our children and young people to make healthy choices
- A reduction in demand for health and care services by promoting independence and self-care as a result of optimising peoples strengths and abilities at an early point as well as providing targeted support and education within communities and resilient services available to assist. This will be achieved by cultural change of staff, citizens and carers, improved community resilience and improving the quality and timeliness of advice and information
- Reduction in health inequalities across the STP by reducing the slope index of inequality (mortality from causes considered preventable) from 206.6 to 167.8
- Reductions in the prevalence of risk factors including smoking, obese/overweight, alcohol consumption at a level which causes harm:
    - Decrease the prevalence of smoking from 24.2% to 18.8% (City) and from 17.1% to 15.2% (County) –in the general population, with separate targets for pregnancy, routine and manual workers
    - Reduce levels of overweight and obesity in children, aged 10-11 (from 37.9 to 35.0 in City and from 31.0 to 28.9 County) and adults (from 62.3% to 59.3% City and 67.3% to 65.5% County)

- Reduce rate of alcohol related admissions to hospital from 927.5 to 696.1 (City) and from 653.9 to 585.9 (County) rate per 100,000 citizens
- Reduce organisational staff sickness absence rates

- Increase in population levels of physical activity and good diet and nutrition including breastfeeding, and mental wellbeing
  - Reduce levels of physical inactivity from 29.1% to 25.6% (city) and from 26.9% to 26.0% (county)
  - Increase breastfeeding rates from 48.6% to 53.1% (city) and from 39.8% to 46.3% (county)
  - Increased uptake of NHS health checks from 50.0% to 55.8% (city) and from 54.8% to 56.6% (county)
  - Reduce the proportion of low birth weight term babies from 3.07% to 2.08% (city) and from 2.89% to 2.12% (county)

What will we achieve in the first two years?

- Deliver tobacco control and alcohol harm reduction activities up-scaled across organisations as two initial areas of focus
- Greater system commitment to the prevention agenda including protection of the current c. £80m City / County investment in Public Health and prevention. Of this investment £13m (16%) is invested directly in activities supporting healthy lifestyles – smoking, alcohol, physical activity, diet and nutrition and obesity - identified as priorities in the STP over the 5 years
- Strengthen system leadership and drive cultural change through all partner organisations to achieve effective prevention and promotion of independence and self-care
- Secure additional recurrent investment in core prevention and healthy lifestyles to delivery systematic and up-scaled activities across the STP (total of £14.5m across the STP lifespan with £350k year 1, £1.35m year 2, £4.25m recurrently yr 3 – 5)
- Improved access to information to promote self-care and independence by establishing a health and social care directories and ensure these are utilised by people across Nottinghamshire

How will we achieve our 5 year vision?

Strengthen system leadership and drive cultural change through all partner organisations to achieve effective prevention and promotion of independence and self-care

- Develop the commitment of our system leadership and organisations to support the prevention of ill health and disease
- Develop STP partners to be exemplar employers that facilitate health and wellbeing at work (the health and wellbeing of staff employed by health and care providers is improved through meeting the three indicators outlined in the 2016/17 CQUIN and delivery of the Wellbeing at Work programme)
- Deliver a set of key messages and responsibilities that are being communicated across organisations and through staff to promote independence, support people at home and enable self-care, and provide the tools at work that support staff working with people in practise
- Continue the work of STP partners on agreeing a common risk framework to support front-line staff to make decisions on how to support people to continue living at home and make their own decisions about taking positive risks and having control and management of the consequences

Strengthen and deliver the core activities for the prevention of ill health and disease, and increase healthy life expectancy by 3 years

- Develop system wide communications and a health promotion plan to ensure consistent prevention and healthy lifestyle messages across Nottingham and Nottinghamshire, targeted to at-risk groups
- Ensure sufficient capacity within the system to deliver consistent and sustainable healthy lifestyle services and pathways to the STP population including stop smoking, alcohol and weight management services
- Embed prevention and the promotion of healthy lifestyles and mental wellbeing as a core responsibility of all staff employed by STP partners

Enhance health and well-being through new and wider approaches to promote independence, build resilience and expand levels of self-care

- Build strong and resilient communities and people, using a co-produced approach to enable the expansion of the voluntary and community sector to deliver agreed strategic priorities
- Adopt risk stratification processes to ensure that proactive preventative interventions are targeted at people most at risk of losing independence and wellbeing, including vulnerable adults, people with learning disabilities, people with physical disabilities and people with mental health needs (link with Primary, Community, Social care and carers workstream). This includes finding individuals who could potentially be 'at risk' in the future from early indicators and providing targeted support and engagement to prevent crises
- Ensure effective investment in early intervention and prevention services by coordinating across organisational boundaries
- Provide comprehensive advice and information, promote technology based solutions for targeted information on self-care and develop ways for people to access and manage their own information
- Integrate mechanisms for supporting self-care including establishing 15 community based service self-care hubs to provide face to face information, advice and guidance that supports people with long term conditions and social care needs to self-care and remain independent in the longer term.

Overall, in addition to protecting our in current core prevention, healthy lifestyles and Public Health spend, we expect to invest a further £14.5m in core prevention over the next five years and all partner organisations have committed to ring-fencing this investment funding. For this new investment, we expect a return of £23m over the lifespan of the STP (£6.6m per year by year 5) by reducing ill health and therefore the demand for health and social care. This is in addition to the £95m of savings that will be achieved across the lifespan of the STP (£32m per year by year 5) through core prevention which will be realised by continuing the current investment through the Public Health Grants.

High impact area 2: Strengthen primary, community, social care and carer services

Why is this important?
Like other parts of the country, Nottinghamshire is continuing to see a growth in the number of people with long term conditions. Sometimes this is the result of unhealthy lifestyles; for example, the growing number of people expected to develop diabetes and heart disease; in other cases it is the result of an ageing population; for example, the growing numbers of people at risk of developing dementia or experiencing loneliness or social isolation. These factors, including poor mental health, are key drivers of inequalities in healthy life expectancy and life expectancy and there is more that we can do to address this through the provision of more consistent access to high quality primary and community care. In our discussion of these services, we use the term "General Practice" to refer to all primary care excluding prescribing and use the term "community care" to refer to the whole range of services across health and social care which are based in the community.

What is our aim?
Our aim is to build on learning from the three Vanguards in Nottinghamshire and the Integrated Care Pioneers to ensure that our communities are supported to stay healthier for longer, and that when they are at risk of becoming unwell, they are able to swiftly access consistent levels of care that is organised around their needs. By doing this, we will help people to live longer, healthier, more independent lives; support carers; reduce the pressure across primary and community care (e.g. General Practice) and reduce the number of people requiring hospital services and the number of people receiving long-term care services and institutional care.

What will be different in 2020/21?

- Citizens and carers will be supported to maintain independence and manage their own conditions
- Quality of life for people with long term conditions and for older people will be improved through integrated care arrangements across health and social care, and through promotion of independence and self-care
- The workforce will be empowered to work outside traditional boundaries through a holistic approach to assessment, and capacity in the community will be built to address the need
- Improved access to resilient primary and community based care (e.g. access to General Practice 8am-8pm, 7 days a week)
- Significant reductions in unwarranted variation in the quality of care and health outcomes
- 30% reduction in non-elective admissions in Greater Nottingham/South Nottinghamshire and 20% reduction in Mid Nottinghamshire, leading to £27m net savings in year 5, after reprovision costs in the community
- Top 25% for older people remaining at home 91 days after discharge
- 573 per 100,000 care home admissions for over-65s
- 40% of citizens with diabetes meeting treatment targets

What will we achieve in the first two years?

- Improve access to and resilience of primary and community care
- Increase support for healthy lifestyle and secondary prevention for all people, and increase early identification of conditions, including cancer and dementia
- Provide coordinated primary, community, mental health and social care support for people with high and emerging risk through multi-disciplinary team (MDTs)
- Improve self-care and management through information, education and use of technology
- Enhance care to people in care homes through extended primary and community support

How will we achieve our 5-year vision?

Improve access to primary and community care, including mental health services and social care

- Ensure all citizens have access to General Practice 8am-8pm, 7 days a week, designed around the needs of local populations
- Use technology to enable citizens to book General Practice appointments and access advice online or through telephone consultations
- Increase capacity and capability in community services so that people will have swift access to community services, particularly mental health, social care services and homecare to enable reduction of beds in acute care settings (described in High impact area 3: Simplify Urgent and Emergency Care).

Improve primary and community care resilience

- Support General Practice to develop into federations to achieve benefits from operating at scale
- Support the development of the workforce, including through the expansion of their roles (e.g. therapists, community nurses, healthcare assistants and clinical pharmacists)
- Accelerate implementation of the 10 High Impact Actions to relieve pressure on GPs and increase the proportion of their time that they are able to spend with patients
- Upgrade and make more efficient our use of primary care and other NHS and local authority owned estate – including considering where co-locating services would make it easier to deliver swifter access to diagnostics and more integrated care

Reduce unwarranted variation in quality of care

- Increase early identification of chronic and episodic conditions, in particular in cancer and dementia, through empowering the workforce to identify and respond to early signs of disease and isolation

- Identify and reduce unwarranted variation in the quality of primary, community and social care, including by reducing variation in the management of people with chronic conditions
- Standardise and monitor clinical thresholds for referrals from General Practice into secondary care to make sure that people consistently receive the right care for their needs (links to High impact area 5: Ensure consistent and evidenced based pathways in planned care)
- Enhance medicines management to improve patient safety and avoid waste through achieving prescribing standards and ensuring medicines are prescribed and managed in safe and cost effective manner, targeted medicine reviews to check that people are taking the right drugs and engaging the public in waste management
- Increase the quality of end of life care planning so that more people die in the place of their choosing and fewer die in hospital
- Ensure we meet new access and waiting time standards for mental health services, including access to psychological therapies and treatment for psychosis

Increase the care and quality of life for people with long term conditions and for older people

- Increase support for healthy lifestyles and draw on a broad range of data from health and social care to better identify people at risk of developing long-term conditions
- Provide coordinated primary, community, social care and mental health support for people with high and rising risk through multi-disciplinary teams, operating across local integrated care team footprints
- Improve self-care and management through information, greater use of assistive technology, support to carers, social prescribing and staff working to empower citizens
- Build on the lessons from care home Vanguards to deliver enhanced primary and community care to people in care homes, including through use of technology and ensuring each care home is supported by a single general practice
- Implement and expand access to Integrated Personal Commissioning (IPC) budget. We intend to become an early adopter in the NHS England IPC programme.

Overall, this high impact area will produce net savings of £50m by year 5, mainly by avoiding unnecessary admissions and reducing the average length of stay.

High impact area 3: Simplify urgent and emergency care

Why is this important?
We know that today too many citizens in Nottinghamshire with both mental and physical urgent care needs end up visiting accident and emergency departments (A&E) as a result of not being aware of or not being able to access appropriate advice or services closer to home. In addition, waiting times to be seen in A&E are sometimes unacceptably long, and once admitted people spend longer in hospital than they need to before returning home due to the complexity of the transfer of care process.

What is our aim?
Our aim is to support citizens to access the most appropriate advice or service for their urgent care needs, minimising disruption for citizens and their families. For those with more serious needs, we aim to provide a service that can respond rapidly to meet those needs, whether in a community or acute hospital setting, ensuring that people receive the best possible care and return home as soon as they are well enough.

There are two systems based around two A&Es, in Mansfield and Nottingham. In designing this future service, we are combining the best of the two urgent care systems, sharing lessons and examples of good practice in both directions. Significant gains have already been made in Mid Nottinghamshire in bringing together multi-disciplinary and multi-organisation teams to develop services, which has led to significant reduction in bed numbers (more than 100) through the mindset of discharge to assess. Greater Nottingham/South Nottinghamshire has benefitted from expert diagnostic work from the Emergency Care Improvement Programme (ECIP) and it is a priority for the whole STP to address remaining challenges.

What will be different in 2020/21?
- Improved quality of information available to people with urgent care needs
- Improved access to urgent care beyond A&E through a shared front door
- Timely and safe care for those who require hospital based urgent and emergency care
- 6% reduction in A&E attendances

What will we achieve in the first two years?
- System redesign to enable reduction of 200 beds in acute hospitals over two years in NUH and 20 beds in SFH that are currently occupied by patients who are medically fit-for-discharge
- Develop system leadership to enable a shared understanding of problems and coherence of actions
- Improve capability to discharge from A&E and hospital settings
- Operate single front door at A&E with streaming to primary care and ambulatory care pathways, including redirecting ambulance to primary / urgent care centre

- Establish clinical hub for patient navigation, linking to 111, OOH, signposting and booking into local services, increase 'hear and treat' and 'see and treat'
- Through the implementation of the Urgent and Emergency Care (UEC) Vanguard in Greater Nottingham/South Nottinghamshire, we will capture net savings of £2.6m in year 1 and £3.5m in year 2

How will we achieve our 5-year vision?

Improve quality of information available to people with urgent care needs

- Increase citizens' awareness of how and when to best deal with their urgent care needs, by providing them with education and tools to support self-assessment and self-care, and by encouraging them to use an enhanced 111 service able to provide them with the right advice about how to respond to their urgent care needs (e.g. self-care, pharmacy, GP or urgent care centre)
- Improve the current 111 service by establishing a clinical hub that will operate across the whole of Nottinghamshire, offering a booking service for local urgent care services, and able to provide greater clinical input to decision making, including for people requiring mental health services
- Building on the existing 'Call for Care' and mental health triage services, further develop a community based professional navigation service to staff across the system who need clinical input into their decision making, or who require advice about the availability of physical, mental health or social care services.

Improve access to urgent care beyond A&E

- Operate a 'single front door' at A&E, able to direct citizens to co-located primary care, ambulatory care or urgent care services, including those who arrive by ambulance
- Integrate crisis response support with community services in order to provide a 24/7 rapid response service that is able to support people with urgent mental or physical needs at home or in community settings and prevent avoidable hospital admissions.

Make sure there is timely and safe care for those who require hospital based urgent and emergency care

- Ensure that staff providing urgent and emergency care (particularly in A&E) have access to patient's records and care plans in order to ensure patients receive the most appropriate care for their needs
- Ensure access to a senior opinion before patients are admitted to hospital via A&E in order to ensure that a hospital admission is required
- Make sure there is access to relevant specialist opinion or assessment and diagnosis e.g. for patients admitted with mental health needs or frailty syndromes

- Improve patient flow in A&E and through the hospital by implementing the SAFER patient flow bundle and establishing protocols for specialty wards to receive patients directly following referrals from GPs or emergency departments

Put in place more effective processes for discharging people from hospital

- Establish a facilitated engagement and design process, based on patient cohorts (e.g. frailty) by forming a cross organisational team of clinicians to work together for the best care for each cohort of patients. The goal is to assess and standardise procedures to optimise flow from admission to discharge
- Building on recent successes in Mid Nottinghamshire and advice from ECIP, commence discharge planning by multi-disciplinary teams as soon as patients are in a stable condition after being admitted to hospital and ensure that people are discharged back home or for a period of short-term assessment and diagnosis or further recovery in community beds as soon as they are medically fit
- Enhance and scale up schemes to provide specialist intermediate care in citizens' homes to reduce re-admission by providing home based support or rapid access to community based assessments

Overall, this high impact area will produce net savings of £16m by year 5, combining the ongoing benefits from UEC Vanguard and the system redesign to provide greater support in the community releasing 200 beds in acute hospitals in the first 2 years

High impact area 4: Deliver technology enabled care

Why is this important?

We recognise the importance of utilising technology to best effect in order to maximise the potential of technology-enabled practice and care and assistive technology. Working together will ensure consistency across the system and improve the effectiveness of key pathways as identified in our High impact areas. We will maximise the use of telecare, telehealth and assistive technology to promote independence, self-care and to support positive risk management allowing people to live independently. We will ensure that information and advice to enable prevention, self-care and wellbeing is available. We are leaders in the deployment of technology to support self-care and have had particular success in deployment of FLO telehealth technology to reduce the impact of long-term conditions and using technology to sustain independence for people living with dementia.

What is our aim?

Our aims are to be bold and maximise the value potential of information technology (IT) and Digital in care delivery, and use technology to help citizens to stay healthy and manage their own care, and to help providers deliver care more productively.

What will be different in 2020/21?

- Ensure all records are in digital form and are shared across all settings of the Care Community Portal
- Enable online appointment booking and self-referrals to be electronic
- Enable citizen access to all care records and relevant self-care information
- Achieve savings of £3m per year by 2020/21. These savings are additional to those captured in the other high impact areas.
- Increased usage of assistive technology by 20% each year

What will we achieve in the first 2 years?

- Share information for direct and indirect care (secondary) purposes to support the ambitions of the STP in other workstreams
- Develop new, more efficient ways of working across health care through improved infrastructure
- Support self-care and healthy living using technology, including the provision of information to support healthy lifestyles and citizens living with health conditions using web and mobile application technologies, in particular, to provide access to vital information
- Measure successful adoption and change management aspects to ensure that Nottinghamshire providers of care are making the most of the opportunities that digital enablement can bring to improve diagnosis, monitoring and management
- Implement priorities outlined in the Local Digital Roadmap

How will we achieve our 5 year vision?

Share information in a way that makes citizen data available at the right place at the right time

- Convert all records to digital versions with sharing across the system with digital as the default method of tracking citizen information, for example, all secondary care reporting will be digital (paperless) by 2020
- Input all citizen records from all settings of care into a shared Care Community Portal (Portal)that can be viewed by clinicians involved in direct care , including data provided by local systems , and provide the option for direct input by users (i.e. clinicians)
- Share data across all settings of care and update live with data from the Medical Interoperability Gateway (MIG) (below) which allows secondary care providers to view primary care citizen information and will be integrated with the Portal
- Increase the number of users able to access MIG to cover all secondary and mental health providers
- Collect data from across the system into one repository to give system-wide outcomes and performance tracking with citizen-identifiable data available only to GPs, but anonymised data available more widely for performance tracking, and combined with a desktop analytic tool (EhealthScope2) that allows users (e.g. case managers) to stratify citizens by risk and hence identify those that require early intervention
- Implement Phase 2 of the GP repository for clinical care (GPRCC) to increase the amount of data from across the system collected in one place to give system-wide outcomes, performance tracking and risk stratification

Improve infrastructure and communication tools

- Provide necessary tools for remote access and mobile enablement of the workforce, including improved Wi-Fi access across the system for all sites and one Community of Interest Network
- Improve inter-organisational communications by moving the whole system to a new mail system, allowing secure email and live chat between all care and support staff from each setting of care and later supplement with video. Transfers of care will be supported by secure, automated message exchange between all provider organisations using national standards

Improve access to information for citizens

- Enable all citizens to access own data from every setting in one place through the Community Portal tool with the option to share their data with third sector and carers. Data availability will be supplemented with targeted education/marketing programmes to drive citizen usage, coaching them on how to access, interpret and act on the information available to them

- Enable citizen access to self-care information and navigation via the expansion of self-care information sites with a focus on priority interventions (links with High Impact Areas on Primary, community, social care and carer services, and Urgent and emergency care) including a review of sites already available in Nottinghamshire and nationally

Improve overall digital maturity

- Perform Digital maturity assessment testing annually and publish the results
- Set up workforce to identify variation in usage and weak areas including the roll-out of change management toolkits and frameworks to train staff and maximise impact of new technology
- Develop system-wide toolkit including: process mapping, communication tools, training courses and early support tools

Continually search for new technologies and implement to support independent living, care at home and better self-management of conditions

- Increase the use of telehealth, including telecare and telemedicine. One prominent example in the footprint is Flo (text messaging) and MyGP24/7
- Continue developing COVIRT: a "COPD virtual ward".
- Implement the use of new technologies; for example, wearable technology to allow for better self-care and empower patients to live independently. This is one of the key aspects of this High Impact Area and one that we are highly committed to further develop as part of the implementation phase

Overall, this high impact area will require an investment of £19.25m (year 1), £34.25m (Year 2) and £27.25m (year 3) and will produce recurring savings of £1m (year 2) and £3m (year 3). These savings are additional to those enabled in the other High Impact Areas

High impact area 5: Ensure consistent and evidenced based pathways in planned care

Why is this important?
Early diagnosis of illnesses and health conditions can improve outcomes and reduce costs of treatment. This is particularly true of cancer and other long term conditions. Through early diagnosis we can support patients to manage their condition and prevent deterioration by making lifestyle changes or providing early interventions. Much of this support can be given close to home in a community setting. Where specialist treatment is needed at an acute hospital or specialist centre, consistent evidence pathways can also ensure that outcomes are good and patients are supported to return to their place of residence quickly following treatment. Demand on planned and cancer services is high, placing pressure on specialties and causing delays to diagnosis and treatment (e.g. Newark and Sherwood CCG and Nottingham West CCG perform below national average against the cancer waiting time target of a maximum 62 day wait from referral to first treatment.)

What is our aim?
We aim to provide planned care with minimum avoidable variations in timeliness, quality and cost, ensuring early diagnosis, information and support to patients and developing new models of elective care, with increased activity in the community rather than secondary care setting. We aim to improve the utilisation of our specialist services by focusing on complex care, with a reduction in duplicated activity and follow-ups that do not add clinical value.

What will be different in 2020/21?

- Citizens will be given more advice and support to manage their condition
- More specialist advice and diagnostics services will be available to GPs and in the community to reduce unnecessary referral to hospitals and specialist centres
- Fewer citizens will be diagnosed with cancer or an underlying medical condition through the Urgent and Emergency care system (e.g. in A&E)
- The target times for referral to treatment times for routine planned care will be consistently achieved by ensuring that the right patients access the specialist at the right time with evidence based pathways
- All national standards on Cancer waiting times diagnosis and survival rates will be achieved
- Improved support for people recovering from Cancer
- Improved patient outcomes for knee and hip replacement (e.g. PROMS EQ-5D)
- Reduced excess admissions for citizens with musculoskeletal (MSK) problems
- Reduced unwarranted variation to improve patient outcomes, create transparency and reduce costs
- Reduced number of inappropriate secondary care referrals - reduction of 10,901 (9.8%) referrals by 2019
- Reduce numbers of citizens in inpatient beds to no more than 36 by March 2019
- Achieve access standards for early intervention psychosis service and IAPT
- Referrals to treatment for mental health conditions in under-18s within four weeks

- Net savings of £21m realised by 2020/21

What will we achieve in the first 2 years?

- Increase in cancers diagnosed a stage 1 or 2 ensuring better outcomes investing £2.25m to improve access and recovery with a net saving of £1.7m by 2018/19
- Implement NICE guidance and improve access to diagnostics for GPs to improve early diagnosis of cancer. Additionally, deliver the additional actions referenced in the "STP aide-mémoire for Cancer"
- Standardise elective care pathways for gastro, cardiology, ophthalmology, reducing unnecessary referrals, ensuring earlier diagnosis leading to a net saving of £654k by 2018/19.
- Develop a new integrated multidisciplinary model for MSK, improving experience, aligning pathways and reducing duplication and waste costs leading to a net saving of £5.65m saving by 2018/19
- Reduce unnecessary attendances and provide alternative ways of providing follow up care in local GP surgeries or the community where clinically appropriate saving £7.3m by 2018/19
- All in all, we expect net savings of £18.5m by 2018/19

How will we achieve our 5 year vision?

Standardise elective care pathways to achieve better value by reducing unwarranted clinical variation (in line with Monitor report "Helping NHS providers improve productivity in elective care")

- **Improve primary and community care referral process**
  - Streamline and standardise diagnostics in the primary care setting before referral to planned care to include explicit referral thresholds
  - Create individual clinician dashboards to detect and manage emerging variation in referrals practice
- **Improve elective specialist care services**
  - Stratify patients by risk and assign lower-risk patients to less complex, possibly more customised pathways
  - Extend the responsibility of nurses and other staff to undertake routine tasks usually performed by doctors
  - Standardise procedures for planned care surgeries including pre-assessment on day of deciding to operate, secondary prevention, planned discharge (complex care) and admission on day of surgery
  - Optimise scheduling including e-rostering of surgical theatres to increase throughput
  - Proactively manage infections and scenarios for readmission
  - Implement standardised ward care and enhanced recovery procedures to reduce length of stay

Develop new models of follow-up care to improve patient experience and reduce unnecessary attendances at hospital

- Embed an approach of risk stratification for follow up care in all specialties through greater integration between primary and secondary care to deliver optimum outcomes for patients
- Support the delivery, review and follow-up of care using new technology and information sharing building on local initiatives and national and international best practice such as the Medical Interoperability Gateway (MIG) to deliver a modern system of care
- Develop and enhance the opportunity provided by the Advice and Guidance service to provide rapid access to specialist advice to support the management of care close to home
- Introduce nurse/allied health professional-led, virtual follow-up or no follow-up for routine patients and alignment of follow up intensity to patient risk profile wherever appropriate

Implement the requirements of the Five Year Forward Vies for Cancer assuring the delivery of the constituent cancer waiting times

- Work with other workstreams to increase prevention messaging and support across the systems (in line with High impact area 1: Promote wellbeing prevention, independence and self-care)
- Diagnose more cancers earlier, through improved screening models, GP access to diagnostics (more diagnostic capacity – especially imaging and endoscopy) and theroll out of the Qcancer risk tool embedded in GP systems
- Improve cancer treatments and care by introducing high-quality modern therapeutic services (e.g. personalised treatment informed by molecular diagnostics), tumour site pathways redesign, access to diagnostics in acute hospitals and commissioning the recovery package

Develop innovative new models to transform the management and delivery of planned care

- Design and develop a new integrated model of MSK care designed by clinicians and citizens
- Develop patient care navigation system and patient decision aids for direct access to physiotherapy or cognitive behavioural therapy. e.g. to support patients with self-assessment and self-care
- Deliver new models of planned care in the community that provide services closer to home which have clear pathways should referral to secondary care become necessary

All in all, through the implementation of the above, we expect net savings of £21.5m by 2020/21

5 – Supporting workstreams

Supporting workstream 1: Improve housing and environment

Why is this important?
For the full benefit of health and quality of life, it is critical that our citizens, particularly those who have a high level of need , have suitable accommodation that keeps them safe and secure. We will therefore work collaboratively to establish clear housing standards and offer suitable housing while improving engagement of the housing workforce on health issues. We will also use strategic planning policy more effectively to support health and wellbeing by considering for example, the built environment, leisure and open space provision, as well as co-ordinating the use of regulation to improve health outcomes, such as licensing and air quality. This theme is a key enabler to support our STP high impact areas.

What is our aim?
We aim to maximise the potential improvements in health and wellbeing by addressing the wider determinants of health such as housing standards and environmental factors.

What will be different in 2020/21?
- Improved standards and quality in private sector housing to meet the needs of citizens both now and in the future
- People supported to live independently in adapted and appropriate housing to reduce demand for health and care services
- Options for healthy takeaway food to allow citizens to have more control over their health
- A planning system that takes full account of future health needs through the provision of green and open spaces to encourage participation in physical activity, quality adaptable housing and employment opportunities
- Improved air quality in key hotspot areas in a way that has an impact on citizen health with an impact on reductions in mortality attributable to particulate air pollution from 6 (City) and 5.8 (County) to 4.7
- Reduction in excess winter deaths index (3 years, all ages) to 14.5 (city) and 12.9 (county)
- Reduce fuel poverty to 12.2 (city) and 8 (county)
- Reduce fraction of mortality attributable to particulate air pollution to 4.7
- Achieve savings of £2.4m per year by 2020/21

What will we achieve in the first 2 years?
- Develop and implement a common hospital discharge scheme across the STP footprint that supports citizens with housing needs to access safe and supported housing in a timely manner
- Build on the Nottinghamshire 'Warm Homes on Prescription' scheme by identifying and targeting high-risk individuals, providing home energy assessments as well as advice, information and support

How will we achieve our 5 year vision?

Support people to live independently at home

- Provide timely, safe and supported home environments for people who are medically fit to leave hospital through a common discharge scheme
- Deliver a common approach to home adaptations that create suitable and safe environments for people to live
- Work with key partners to identify and implement a common referral pathway that supports people who would benefit from Assistive Technology in their home

Improve private sector housing standards

- Develop a Nottinghamshire 'Health and Housing Profile' that will allow better targeting of interventions towards those with long-term health conditions and who live in the poorest housing conditions
- Implement a programme to remove the most serious hazards from the home environment through a combination of advice, support for repairs and enforcement
- Expand the Nottinghamshire 'Warm Homes on Prescription' scheme, which will improve the thermal efficiency of homes inhabited by people with health conditions that are made worse by the cold
- Support health professionals by establishing a single point of access for housing-related referrals, which will facilitate the delivery of timely and appropriate housing advice and assistance

Provide healthy takeaway options

- Ensure fast-food takeaways implement healthier methods of cooking and offer healthier food options on their menu by increasing the number of premises participating in the Healthier Option Takeaway (HOT) Campaign

Integrate health into planning and development

- Implement the 'Spatial Planning for the Health and Wellbeing of Nottinghamshire and Nottingham' Framework including embedding the Health Impact Assessment model within Local Planning Development and working on the development of supplementary planning guidance to ensure that large developments are subject to a Health Impact Assessment at the planning stage

Reduce health impact of air pollution (anthropogenic particles and nitrogen dioxide).

- Develop and implement an Air Quality Strategy for Nottinghamshire that will drive positive action to reduce the impact and cost of air pollution on the population's health
- Develop and deliver a communications and engagement strategy to encourage positive behavioural change in a range of diverse groups with varying priorities and differing health/economic consequences from air pollution
- Prepare for proposed Nottingham Clean Air Zone (planned implementation in 2019), which will identify a range of actions to reduce emissions of nitrogen dioxide and particulates from road transport and other sources

Overall, these initiatives will require an investment of £1.3m (year 1), £1.4m (Year 2) and £1.4m (year 3) and will produce recurrent savings of £3.8m (year 1 onwards). These are additional to the ones accounted in other high impact areas.

Supporting workstream 2: Strengthen acute services

Why is this important?

In the Nottinghamshire health and social care system, hospital services are operating under severe pressure, particularly as a result of the demand for urgent and emergency care at hospitals. The system has an explicit intention to reduce this demand by investing in prevention, primary and community services. Hospital services will be re-shaped to meet future demand.

Nottinghamshire is a centre for the provision of tertiary (specialised) hospital services and the location of a Biomedical Research Centre (from 2017). The combination of substantial service re-design, supported by research and innovation will help us to close the care and quality gaps described earlier.

What is our aim?

To increase the effectiveness of prevention, primary and community services and thereby allow hospital services to be reshaped in response to the new level and character of demand. Increased consistency of clinical practice in hospitals, and other efficiency improvements, will enable further reduction in the size and cost of our acute hospital services.

What will be different in 2020/21?

- Our acute hospital resource will be smaller, and fewer patients will be attending hospitals for acute general care. The hospital estate still in use will be that of the highest quality.
- Patients will be admitted to and remain in secondary or tertiary hospital care only for as long as they need it.
- A greater proportion of care delivered by current secondary and tertiary clinicians will be delivered outside hospital facilities.
- Pathways of care will avoid unnecessary duplication of assessment and inputs.
- A higher proportion of patients will be offered the opportunity to participate in research.
- Greater involvement by secondary and tertiary providers in encouraging self-care, prevention and well-being, including in mental health and resilience in patients, citizens and staff.
- New models of care, and new paradigms for care across organisational boundaries supported by new financial and risk-sharing models.

What will be different in the short term (2 years)?

1. Necessary hospital services that are not clinically or financially sustainable in their current location or delivery model will have been developed and/or moved to achieve safe sustainability;
2. Reduced numbers of patients attending and being admitted to acute hospitals;
3. Made progress on reducing unwarranted variation in the way in which hospital services of all types are accessed and delivered;
4. A number of collaborations on clinical and non-clinical support services in conjunction with other STP partners to deliver cost reductions.

What will we do first?

- (NUH and SFH) Boards and CCGs will confirm their proposals about the scope of acute services.
- Support commissioned specialised services

- Improve information sharing between partners
- Develop business plans to maximise impact of technology on closing the health outcomes gap and for improving safety and experience, including in hospital (electronic prescribing), and technology-assisted living at home or in care homes.
- Expand research (both publically funded and commercial), and encourage and embed innovation.

How will we achieve our five year vision?

Acute Services

- **Consolidation of acute services:**

SFH and NUH both acknowledge that they must make an important and joined-up contribution to the new models for urgent and non-urgent care outlined in this STP, driven by improved care quality and the need for clinical and financial sustainability. This will require integration of some services (already largely identified), close co-operation and joint working in some, and more independent services in others. We will define a strategic partnership in line with and supported by this STP to enable us to deliver this pattern of safe and sustainable services across Nottingham and Nottinghamshire.

Specialised services and research

- **Specialised Services**

Nottinghamshire has a strong history of providing Specialised Services in both acute and mental health services (e.g. stroke, renal, neurosciences, cancer services & trauma services in the acute settings and Tier 4 CAMHS, gender dysphoria and high, medium and low secure services within the mental health setting). We will bring equity and excellence to the provision of specialised care and treatment, aligned with the priorities of NHS England. In selected specialties where NUH or NHCT has a particularly strong national or regional presence, the Trusts intend to expand market share and generate a limited additional revenue stream that will aim to make a net contribution to the STP economy.

Acute specialised services, though based largely at NUH (hub) will be provided locally (spoke) to as great an extent as is consistent with safety, outcomes and affordability. For some specialised services, partnerships will be required with organisations outside the STP footprint and with non-NHS organisations (eg St Andrews for the forensic pathway in mental health service provision).

Research

Nottinghamshire has a strong history of providing leading edge research and innovation (R&I), and they remain central to our ambition to deliver patient and economic benefit. Innovative, research-intensive organisations deliver better clinical outcomes for patients. Our ambition is to become a national leader in clinical research and innovation which is rapidly translated into patient care. Our ambition is also to become an outstanding clinical partner to academia, industry and local government and make Nottinghamshire a centre of excellence in research and innovation in which NUH and NHCT (and indeed all partner organisations) develop and support cutting edge research and innovation. Increasingly both publicly funded and commercial research activities will have a positive financial impact on the STP footprint.

Our focus on R&I means that we are at the forefront of innovation improving efficiency and effectiveness of medical care and attracting clinicians who wish to work in such an environment. The success of the footprint's research endeavour will help improve recruitment and retention issues (and thereby reduce premium pay costs) across its organisations. NUH, in collaboration with a range of partners, was awarded £23.6million over 5 years in September 2016 to establish a Biomedical Research Centre (in 2017). This will drive innovation and internationally competitive research in therapeutic areas which are highly relevant to the health of our patients and public: gastrointestinal and liver disease, hearing loss and tinnitus, respiratory and musculoskeletal disease and mental health and technology.

Supporting workstream 3: Drive System Efficiency and Effectiveness

Why is this important?
We want to ensure that the system resources are used to improve health and wellbeing in the most efficient and effective way.

What is our aim?

Ensure the health and care system operates efficiently and effectively in order to reduce waste and unnecessary variation in the way we deliver care to ensure we spend as much as our money as possible on improving the health and wellbeing of our citizens.

What will be different in 2020/21?

In order to meet this objective, we will:

- Reduce the running costs of our organisations by working more efficiently
- Capture additional efficiency opportunities by collaborating across organisations
- Make sure that we invest in programmes and procedures that have the best possible impact on improving citizens' health and wellbeing
- Eliminate differences in how we deliver care where those differences are not good for patients or service users
- Accelerate digital transformation (see High impact area 4: Deliver technology enabled care)

What will we achieve in the first 2 years?

- Deliver individual organisational efficiencies
- Progress Back Office Programme releasing £9.6m recurring savings
- Develop and agree EMPATH Pathology Full Business Case
- Deliver a focused joint local authority (County and City) programme to identify additional savings opportunities

How will we achieve our vision?

Reduce the running costs of our organisations by working more efficiently

- All NHS provider organisations will deliver at least 2% efficiency savings each year by running their organisations more efficiently
- All NHS commissioning organisations will reduce their running costs by between 0.5-1% each year (separate from demand management initiatives)
- Local authorities will deliver 5.8-9.5% efficiency savings
- We will deliver a estates rationalisation programme (see Estates submission), leading to £27.2m savings by 2020/21

Capture additional efficiency opportunities by collaborating across organisations

- **Consolidation of back office functions**

All NHS providers in Nottinghamshire are collaborating with each other to establish a partnership or shared service arrangement to provide financial transaction, payroll and procurement services to each other, which deliver leading practice at competitive market cost.

- **Capturing additional efficiency opportunities by collaborating across organisations**

All NHS STP organisations have participated in submitting 2015/16 activity and financial returns for the corporate areas. These returns and supporting information are being shared between counterparties to allow performance benchmarking and to understand drivers behind differences in unit costs and output measures, with a view to informing where synergies can be achieved by integrating functions. This information will be used to establish a planned trajectory for service development and cost reduction as part of the formation of the Nottinghamshire back office shared service.

With regard to local authorities Nottinghamshire County Council is currently undertaking a review of corporate services, the outcomes of this review will be incorporated into the future model of corporate services consolidation. Nottingham City Council utilise a mixed model of service delivery for corporate services including outsourcing of elements of finance, HR and payroll and collaboration on Procurement and Estates and Facilities.

There have also been expressions of interest shown in the work that has been progressed from University of Leicester, Nottingham Citycare Partnership, NHCT, EMAS. These are now being explored.

- **Pathology**

Pathology services are currently operated under a single management structure (EMPATH) supported by a Memorandum of Understanding between NUH and University Hospitals Leicester (UHL). Both Trust Boards approved the Strategic Outline Case for Building World Class Pathology Services in December 2015.

Work undertaken since then has concluded that there is significant opportunity for consolidation into a central laboratory of all GP activity and routine and specialist blood sciences, microbiology and molecular diagnostic activity with a turnaround time greater than 4 hours.

Providing access to the latest equipment and IT in purpose built accommodation will allow pathology services to significantly improve the range and quality of their services to GPs, hospital consultants and other customers. It is also noted, an off-site hub would release 4000 square metres of space on Trust premises to support reconfiguration of each Trust's estate.

The net annualised financial benefits are will be assessed as part of the business case process. The draft Outline Business Case quantified potential savings in the region of £10 million per annum (split equally between savings from consolidation and the savings from improved procurement & supply chain). These savings are represented within the NUH and UHL Organisational efficiency forecasts. Further savings may be achieved if further health care systems joined this Joint Venture.

It is envisaged that the central laboratory, logistics, managed equipment service and Pathology IT will all be financed through revenue solutions. The only CAPEX costs would relate to reconfiguration of local estate following contraction of the laboratory footprint after consolidation of services to an off-site laboratory. A consolidated operating model would take a minimum of 3 years to be fully implemented.

Make sure that we invest in programmes and procedures that have the best possible impact on improving people's health and wellbeing

- Right Care opportunities - these have been looked at in detail and drove to planned care savings
- Launch "Essential project" – an initiative to engage the system in identifying practices that add limited or no value.
    - Identify and reduce specific practices which add low value (e.g. practices that lead to over-diagnoses, over-treatment, etc).
    - Inspired by the "do not do" (UK), "Choosing wisely" (Canada) and "Essencial" (Catalonia, Spain). Focus is on selecting one recommendation every two months. Recommendations are suggested by multi-disciplinary teams and the STP Executive Board decides every month which ones to implement and expand into the system

Eliminate differences in how we deliver care where those differences are not good for patients or service users

- We have commenced work to identify top 10 areas of unwarranted variation by value and work intensively on eliminating variation in those areas
- Expected value to be captured is £45m by 2020/21
- At the same time, we will develop and update on an ongoing basis a system-wide patient outcomes platform that spans all providers of care for all patients within select cohorts
- This will be used to inform the development of the "Nottinghamshire Observatory of Health and Care Outcomes", formed by three teams:
    - Data Analytics and Reporting Team: Time series reports of outcomes by patient cohort / pathway / cycle of care and provider. Data shared specifically for service improvement rather than performance management
    - Best Practice Identification Team: Benchmark locally, nationally and internationally to relentlessly identify best-practices and assess the root-causes behind. Best-practices also include service innovations and how enablers are used (e.g. IT to change the interaction between providers). This becomes a Library of Best-practice ("Observatory of Best practices")
    - Coaching and Implementation Team: Working with teams across commissioners and providers to implement interventions that reduce unwarranted variation
- In addition, across the system, we will:
    - Undertake a detailed review of current spending by non-clinical area of cost and every month, propose at least 3 measures to the STP Executive Board where a significant cost reduction can be made (at least £100k). We are working on assessing the recurrent impact of this initiative and therefore, we have left it outside our financial calculations as conservative measure.

6- Enablers for our priorities

Enabler 1: Future proof workforce and organisational development

Why is this important?

Redesigning our workforce is essential for the successful delivery of our STP priorities. We will strengthen our collective workforce data and use it to inform our shared decision making in creating the right workforce to meet local population needs in the most effective and efficient way. By working together as a system and with our citizens we will strengthen the current workforce by the introduction of new roles, support for areas where there are shortages, improve integration across sectors and organisations, embed approaches to prevention and supporting independence and enable change through system wide organisational development and sharing resources. We have learned a lot already from innovations within the system including our many Vanguards; we will share the best practice across the system and build on this for the future. Our strong relationships between employers, citizens and providers of education will help us to promote local engagement, employment, education and training to support long term sustainability that gives greater flexibility to deliver workforce changes more responsively.

What is our aim?

Our aim is to deliver an integrated strategy for the whole workforce to support the sustainable delivery of the Nottinghamshire STP, working through the new Local Workforce Action Board building networks with the capacity and capability to lead workforce change.

What will be different in 2020/21?

- A sustainable, affordable workforce with the right skills, knowledge and capacity working in partnership to deliver new models of care designed around the needs of our citizens
- A workforce with the confidence and capability to work in partnership with others and lead and deliver service improvement and change
- A workforce with positive attitudes and behaviours to deliver and sustain transformed services

What will we achieve in the first two years?

- Improved supply of professional staff at all levels through collaborative HR leading to reduced reliance on agency staff
- Greater resilience, capacity and capability in general practice teams including prescribing pharmacists, advanced practitioners and new support roles working in partnership with multi-disciplinary teams
- Consistent population based, integrated, multi-disciplinary teams across the county delivering our urgent & proactive care ambitions
- Sustainable medical workforce in primary and secondary care working to the top of their licence, supported by the introduction of new roles and new ways of working in the wider team e.g physician associates, nurse associates, rotational posts, maximising the benefits of the long term partnership between NUH and SFH and collaborative working across the CCGs to implement the GP Forward View
- A step change in prevention and wellbeing skills at system level across the whole workforce including the formal and informal workforce
- A move away from OD at organisational level to a system-wide approach to embedding leadership and OD at all levels to deliver change

- Improved supply of professional staff at all levels through collaborative HR leading to reduced reliance on agency staff

How will we achieve our 5 year vision?

Develop a Nottinghamshire HR Collaborative to enable the delivery of new models of care

- Develop collaborative recruitment strategies to reduce the use of agency staff
- Develop policies and procedures to enable flexible employment and deployment of the workforce

Develop and deliver the Nottinghamshire organisational development plan to support system effectiveness

- Deliver a 'mind-set shift' with greater emphasis on the development of system capacity, capability and behaviours, new models of partnership working and shared decision making at all levels from system leadership to the front line and the public
- Build on existing good practice and engagement in scoping the opportunities for collaborative working and implementing high impact change

Develop a population/place-based approach to workforce re-design through a system wise approach to systems dynamic modelling tools and techniques

- Co-produce a range of costed future workforce options through a scenario-based approach integrating demographic, activity, transformation and financial assumptions
- Develop and deliver a transition and implementation plan to build capacity and capability across the whole system: citizens, carers, community & voluntary sector and the employed workforce from home care, primary care and secondary care

Embed a systematic approach to prevention and lifestyle behaviour change by rolling out prevention and early intervention skills across workforce

- Ensure all interactions have a prevention and whole-health mind-set by embedding prevention skills and tools across the workforce.
- Ensure that all staff have the skills and confidence to discuss lifestyle issues, provide brief interventions or signpost people to appropriate support

Address capacity and capability in primary care to deliver the General Practice Forward View, Pharmacy Forward View and the ambitions of the STP

- Develop recruitment & retention strategies for example, portfolio working, incentives, rotational opportunities, collaborative campaigns, sharing specialist staff
- Review impact of wellbeing initiatives targeting general practice and roll out in a sustainable model (supported appraisals, coaching and mentorship)

Initial Workforce Modelling Outputs

- The modelling work to date in Urgent and Proactive Care has generated a potential optimum future skill mix based on agreed activity and financial assumptions including significant increase in self-care. Further work is ongoing to refine and test both the assumptions and the outputs of the modelling work and to build capacity and capability across the system in understanding the approach and how to use it.
- Initial outcomes have indicated:
    - An increase in senior decision makers earlier in the pathway in urgent care
    - A growth in the primary care workforce of 24% with reductions elsewhere
    - Overall increase in advanced skills levels with potential reduction in core professionally registered levels
    - An indication that the paybill can be reduced by 12m over five years due to the change in skillmix and activity implications – investment to achieve the change has not yet been quantified

Enabler 2: Maximise estate utilisation – To be read in conjunction with Appendix E: on Estates strategy

Why is this important?
Our workforce and citizens should work and attend premises that are "fit for purpose" to deliver and receive the right care and the system should make sure that the current and new infrastructure is used as efficiently as possible. For example, today our unoccupied estate in SFHT and NUH is two to three times higher than the Carter metric and the non-clinical space is also higher than it should be. We are committed to changing this to give better care to our citizens, better premises to our workforce and achieve more efficient use of our estate.

What is our aim?
We aim to have a sustainable estate infrastructure that will enable our High Impact Areas and Supporting Work Stream projects to be delivered as set out within this STP, with a focus on two key aspects: (1) Efficient use of estates; (2) Estates that are "fit for purpose" to support service change
Our Estates Strategy will deliver a total of £43.5m of which £28.8m will be a recurrent saving by 2020/21 and is additional to the organisational efficiencies that we have identified. We have three main Provider Trust performance targets to achieve: (Acute – NUH/SFH, Community/Mental Health – NHCT).

What will be different in 2020/21?
- The utilisation of health and social care estate will be maximised and excess buildings will be disposed of
- All Estate, Technology and Transformational Funding (ETTF) projects will be delivered
- We will be on target to deliver the 10 year Estate Transformation Strategy of the acute provider, which includes the aim of reducing secondary care capacity
- Implement the One Public Estate (OPE) initiative at whole Nottinghamshire level, which governed by an agreed system wide (Health and Public Sector Partners) governance structure

What will we achieve in the first two years?
- Complete detailed design of required estate in the community to enable **High impact area 2: Strengthen primary, community, social care and carer services**
- Start to implement the 10 year Acute Transformational Plan, stage by stage, to deliver the reconfiguration model of the acute estate that will see an increase in primary, community, social care and carer services to support the reduction of estate/services of the acute providers in accordance with the FYFV
- Increase utilisation of high-quality public finance initiative and 'Lift' estate in conjunction with the acute merger objectives that will start to see a reduction at City Hospital and increased use of the SFH and and the Queens's Medical Centre sites.
- Implement existing OPE/Health projects and apply for final OPE funding scheduled for April 2017

- Reduce non-core administrative estate lease agreements outside of the NHS/Public sector asset base where lease breaks are scheduled for 2017/18 – in collaboration with Supporting workstream 3: Drive System Efficiency and Effectiveness, leading to £0.8m of recurrent savings
- Agree the governance structure for programme delivery of the estate that will report to the STP Executive Board
- Agree a delivery programme for the STP estates workstream(including a proposed programme of Healthcare/One Public Estate projects)
- Introduce high quality and meaningful system wide estate data onto the STP estate desktop software SHAPE (Strategic, Health, Asset, Planning and Evaluation) tool that will aid delivery
- Continue looking for potential efficiencies. This is one of the main areas we will look at as to identify concrete initiative to fill the stretch target for 2017/18

How will we achieve our 5 year vision?

Over the next 5 years, we will move to a future scenario aligned with the Carter Review (see table below)

	Current	**Planned**
Estate Running Costs **£m/2**	Acute: £163.2m (£326m/2) NHFT £24.5m (£166.15m/2)	Acute: £138m (275m/2) NHFT £22.5m (£152.58m/2)
Non-Clinical Space (%) **(Carter Metric max 35%)**	Acute: 35%+ NHFT 31%	System <31%
Unoccupied Floor Space (%), (Carter Metric Max 2.5%)	Acute: 6.02% NHFT 4%	System <2.0%

The savings of £43.5m over the next 10 years will be delivered by a combination of 8 main initiatives with further savings/capital monies being targeted (Note: + Cash Saving)

Initiatives	Strategic Objective	System Benefits	Delivery Years	Additional to organisational efficiencies
Acute Reconfiguration	• NUH reconfiguration to maximise activity at QMC and significantly downsize city hospital will deliver over a 10 year period a circa 15-20% reduction in the NUH estate with estates revenue savings circa £15m. The East Midlands Trauma Centre is the catalyst for change which will be housed at QMC – Hot site • The acute reconfiguration work will also reduce outpatients departments in the acute & bed space to align with the shift of activity into the community	+£15m	10 years (2027)	Yes
Shared Service Collaboration between NUH & SFH eg CSSD/ADU re-provision (pt. of the acute reconfiguration)	• Realise further 30,000sq.m reduction in floor area circa £9m. Reduction in backlog from demolition and disposal of buildings £1.9m at City and £12.8m at Kings Mill.	+£9m pa +14.7m backlog reduction	2017 to 2021	Yes
KMH, Newark – Estates Rationalisation, improved utilisation of high quality PFI and Lift estate (incl. CSSD, ADU re-provision	• SFH - Maximise utilisation of the long term core estate, Lift and PFI Estate – Mansfield Community Hospital, Newark (57% underutilised) , Ashfield Wellbeing Centre (65% underutilised), Kingsmill Hospital (Acute PFI- New build), Byron House and Highbury Hospital – Reducing voids of 811.37sq.m which is currently a cost of £509,000 pa & long term NHSPS lease estate	+£0.8K to £1m & reduce voids and costs to CCG's	2017 to 2021	Yes
Align Primary/Community estate to service	• Increased service delivery in primary, community estate (7 day access, diagnostics) – ascertain key estate hotspots for primary care and the development of proactive/clinical hubs with new care	Practice mergers, increased co-location and	2017 to 2021	Yes

strategies/population growth	teams co-located into core estate. Link strategies with both ETTF NHSE capital injection and Section 106/CiL – GP Forward view • Integrated primary, community, social care and mental health multidisciplinary teams (MDTs) working in formal network arrangements within a local clusters of practices to facilitate estate utilisation and 7 day working, maximisation of technological enablers and remote work will enable a reduction in non-priority estate through co-location	alliance benefits of co-locating key workforce will reduce Community Estate by a planned £2m by 2021		
Urgent Care - Build and maintain Primary Care capability	• Urgent Care - Build and maintain Primary Care capability by co-location of GPs within A&E department at Kingsmill & QMC to continue with the successful 'single front door access' scheme established through the Better Together Programme	Evidence to date has proven a reduction of beds	2017 to 2019	Yes
Consequence of merged Trusts – Demolition and disposals Links above RE: backlog	• Further opportunities to reduce the footprint of estate through system wide disposals approx. £6.3m+ Incl. redundant Primary Care/Community Estate	+£6.3m	2017 to 2021	Yes
Corporate Services – Administrative office estate reduction	• Respond to the Carter review and corporate services consolidation to support a potential reduction in floor area of administrative estate by 2,500 sqm. – 3,500 sqm. or between 70% and 100% of total floor area. Potential to reduce running costs by £1.3m – £1.5m, with required capital expenditure. Known schemes include the retraction from rented accommodation as Trust HQ within the Mid Notts footprint £0.8 to 1.0m	+£0.8 to £1m	2017/18	Yes
Planning, infrastructure levy	• Working with the Health and Wellbeing Board, an engagement process is ongoing to help Local Authority Planners familiarise themselves with each Local Estates Forum to ensure that housing/business growth is captured through capital monies to support ongoing health infrastructure development – One example -	+£1.7m confirmed to date	2017/18	Yes

	Mid-Notts CCG for Newark South have agreed £1.7m over 5 phases with developers for existing infrastructure upgrades			

Enabler 3: Proactive communication and engagement

Why is this important?
Successful delivery of our STP will require us to ensure that local partner boards, councillors, the voluntary sector, staff and citizens understand its purpose and benefits and are fully engaged in making it a reality. Over 43,000 staff are employed in our health and social care system and it is essential that we harness their energy and commitment to support us in developing and delivering this plan. Our citizens need to be involved in designing how we transform our system to enable them to be more independent and self-care, and to shape the ways in which we deliver health and care services to deliver outcomes that matter for them..

What is our aim?
Our aim is to provide STP communications and engagement across the footprint including:

- *Publicity* - raising initial awareness of the draft STP
- *Purpose* - explaining and gaining understanding about what it is and what it is not
- *Participation* - encouraging involvement in the process (from citizens, staff, partner organisations, politicians, media and others)
- *Progression* – ensuring that the dialogue and feedback obtained helps shapes the plan and implementation.

What will be different in 2020/21?
Transformation of our health and care system will have been enabled by the active engagement and participation of citizens and staff, and effective communication and engagement with key stakeholders and leaders.

What will we achieve in the first two years?

- The case for transformation of our health and care system and our proposals to carry out this transformation will be communicated to the public and all key stakeholders through a proactive and effective communications and engagement programme
- Citizens, staff and key stakeholders will be actively engaged in supporting or co-designing the transformation described in the STP following an agreed system-wide approach
- Communication and engagement leads from partner organisations will be working together through a newly formed joint city and county STP communications and engagement group
- Core communication materials will support communication about our plans, including a public-facing summary, a web area (hosted by Nottinghamshire County Council), core slides and further newsletters

How will we engage clinicians, staff and the public?

- The STP Clinical Reference Group will support current channels of clinical engagement in partner organisations, in workstreams, and across the system through the establishment of a virtual clinical and social care leaders forum for wider communication and engagement. Engagement activity will include email, meetings, working groups and occasional larger clinical events
- An STP communication and engagement leads group has been established to determine the approach and methods for communication and engagement with staff, the public and other key stakeholders, building on work to date. Channels are likely to include face-to-face (events and meetings), print (public-facing summary and other documents), digital (website and social media) and media relations
- Key priorities for engagement are to communicate the citizen and clinical case for change to the public and all our stakeholders, and to agree how we will foster and develop further engagement with citizens, staff and the public

Strategic communications and engagement – our offer to the public

From the outset we have taken a strategic view to our communications and engagement activity. Our approach has been to engage as widely as possible during the initial scoping period while acknowledging our activities must conform to a planned national process and dialogue. A draft communications and engagement strategy is being put together for consideration by local communications and engagement leads. This is by necessity an iterative process as we can only communicate key messages and to target audiences when we know more of the detail of the content that is to be discussed. As the plan becomes more advanced, we will be able to broaden discussions with all audiences. Our offer will be based on not only setting out the challenges (the triple aim) facing local health and social care but the benefits of doing things differently. By moving services closer to home, by providing services in the right place, by placing GPs at the front door of A&E, by developing seven-day primary care, by improving planned care, by helping people to help themselves to improve self-care and become more independent, we can improve people's quality of lives and their life expectancy.

Engagement to date with local authorities, patients, staff and key stakeholders

Engaging with a range of stakeholders across the health and care economy has been critical to the success of developing our STP in Nottinghamshire. This engagement will continue as we further develop and implement the plan. Plans have been developed in partnership across the STP footprint, with commissioners and providers working jointly. Our engagement process has so far included all partners from the health and care economy and additionally, district and borough councils, the independent sector, and voluntary organisations.

Our STP is built upon the firm foundations of months and years of engagement with local citizens through the involvement mechanisms of CCGs, trusts and the local authorities. The two transformation programmes in Mid Nottinghamshire and Greater Nottingham / South Nottinghamshire have been developed in dialogue with their local populations, as have the vanguards with engagement being intrinsic to their planning and implementation. These transformation programmes and vanguards are feeding in to the STP with our new five-year plan having the challenge of spreading best practice from these initiatives.

In addition, since we began drafting the STP we have been listening to the views of interested groups and individuals. In the build-up to the initial June submission we held two major stakeholder events with staff from health and social care organisations, representatives from the voluntary sector, and representatives from independent Healthwatch. We have hosted several meetings for members of the city and county Health and Wellbeing Boards and non-executive directors of CCGs and Trusts, and held conversations and engaged in correspondence with local MPs.

To widen understanding and participation we have produced three dedicated STP newsletters to date which have been shared with stakeholders. They will be published on a dedicated STP web area being designed and developed by Nottinghamshire County Council. We will publish a public-facing summary to help further the dialogue with citizens.

We have been proactive on the media front and met as many media requests as possible. These have included providing interviews to BBC Radio 4 You & Yours programme, BBC News, Nottingham Post, Mansfield Chad and Pulse magazine. We have taken part in national debates such as the recent NHS Expo where David Pearson joined a panel of experts lined up by the Health Service Journal.

In other engagement activities we have seen CCG boards consider the draft STP, and an initial meeting of CCG, trust and local authority communications and engagement leads take place in order to support them to brief their own organisations about plans and responsibilities. As we move into October and beyond we want to carry out more engagement activities with more audiences, sharing our initial thoughts and gaining vital insights from citizens about what is required and how any plans would best work in their local communities.

Engagement to date with the clinical community including GPs

Clinical engagement is central to the success of this STP and our proposals are grounded in the clinical community. Clinicians have provided their input into this draft STP through regular and ongoing participation in STP meetings, at the major stakeholder events held and through a dedicated STP clinical reference group which includes representation from GPs, consultants, community clinicians and social care. A video of clinicians discussing local plans and their aspirations for the STP is available on our STP Vimeo site.

7- How we will work together to deliver this plan

The STP process has been helpful in bringing together the entire Nottinghamshire health and care system in a new way to jointly develop a strategic plan which will close our 'triple gap' over the next five years. We recognise that we are now at the point of needing to make the transition from planning to implementation, which is a different type of work which will place new and different demands upon us. We will need to self-organise to implement a programme of change which goes beyond anything we have taken on or achieved before.

As we do that, we are clear that our purpose is to bring about transformational change in the way care is delivered so that we provide consistent, high quality care in the most cost effective way for the people of Nottinghamshire. This will best be done by continuing a process characterised by strong co-production and engagement with citizens, clinicians and the wider workforce.

The delivery of sustainable and transformed health and care services will depend on our ability to change practice, integrate relevant commissioning and service arrangements. It will require the collective commitment of over 40,000 people working in health and care in Nottinghamshire. All organisations will need to promote, facilitate and deliver treatment and care at home first, through new care models. The changes will require support from political representatives and the support of citizens and patients in sharing responsibility for the health and wellbeing of 1.1 million citizens.

We also recognise that most citizens and patients live in their communities where primary care delivers 90% of the activity of the health service that patients receive through their family doctor services and pharmacists, and the same is true for the social and voluntary care services. An important theme within the STP is that GP practices and community services are increasingly working together and collaborating for their patients to ensure they can offer a more developed and integrated set of services closer to home.

The two systems within the STP footprint – Greater Nottingham/South Nottinghamshire and Mid Nottinghamshire – are testing different business models through the Vanguard programme for managing and improving population health. It makes sense to continue with those for now, with a shared commitment to share knowledge and learning across the STP and potentially to align on one model over the longer-term

Therefore, we intend that the majority of the initiatives described in the STP will be implemented at the local system level, with accountability for delivery, allocation of resources and tracking of impact being at that level. At the level of the STP footprint, there is an important coordination role to play, ensuring consistency of standards across the county and that the overall impact of the STP can be tracked and aggregated against a consistent set of metrics, as well as implementing Nottinghamshire-wide initiatives. In practice, the leadership teams of the two local systems come together as the overall STP leadership team where they will take collective responsible for the delivery of the whole STP, holding each other to account.

The changes we plan to bring about are profound and on a very large scale, and although we have some important strengths to build on, such as strong clinical engagement in service change, we acknowledge as a system that we have a sizeable 'fourth gap' which we need to close, which is one of mindsets and capabilities. As a leadership group, we have made a start in addressing this through a series of workshops where we have sought to understand the root

causes which have made it difficult for us to collaborate effectively across organisational boundaries in the past, to overcome misaligned incentives and to strengthen relationships and build trust to overcome barriers to cross-system working.

We recognise that there remains work to do in describing how we will work together to deliver the STP, and that it is about much more than governance structures and programme management; behaviours and ways of working need to change too, across our entire workforce. For now we want to share our early thinking in this area, with the caveat that we see this as an iterative process – not least because it is not yet clear how the STP process will develop nationally.

Governance and Leadership

The evidence from previous attempts at developing integrated and accountable delivery systems both in the UK health and care systems and abroad is that they have generally failed to live up to their promise because insufficient attention was given to execution and implementation. Implementing the STP will similarly not realise its potential unless we put in place new skills and capabilities in leadership and governance (as well as managerial and financial systems) to support new care models.

A governance structure has evolved to deliver the STP, and as we make the transition from planning to implementation there is an open question on how this should develop. As a system we have undertaken to continue to review and refine these arrangements with a view to signing off an MOU that sets out the agreed arrangements by late November.

Delivery Architecture

As well as governance, there are a number of other key functions which will be crucial for successful implementation and which we collectively think of as the 'delivery architecture' (i.e., the infrastructure and capabilities) we need to have in place to deliver the STP.

As described above, our intention is to manage and oversee the implementation of the bulk of our STP within our two local systems; Greater Nottingham/South Nottinghamshire in the south of the county and Mid Nottinghamshire to the north. Our working assumption at this stage is therefore that the **STP-level delivery architecture should be as light as possible** to fulfil the essential functions of oversight and assurance, and where value-adding, a coordination role where there is a need for consistency across the STP footprint, and avoiding duplication of activity or reporting. In practice, this might translate into the following functions;

- **Agreeing the overall programme management approach** so that there is a consistency of language, approach and metrics in tracking and reporting progress to facilitate learning within Nottinghamshire and reporting the aggregated position to central bodies. This is also important given that some providers span both local systems.

- **Analytics and performance tracking** are important functions associated with good programme management, both for ongoing reporting and for ad hoc analyses which might be needed (e.g., to estimate the system benefits of proposed changes). It might therefore make sense to provide some resource at STP level, at least initially, to ensure a 'common currency' and methodology to evaluate equivalent changes and understand and measure variation across the footprint.

- **Co-ordinate knowledge sharing and the development of consistent standards.** As we look to reduce unwarranted variation in how we deliver services, we have aligned on the aspiration to "standardise where possible, but localise where necessary". To facilitate this, we see a potentially important role in sharing knowledge and good practice and standards across Nottinghamshire which could be overseen at STP level. For example, where we find that the existing incentives and funding flows do not align with changes we want to make in how services are delivered (e.g., shift of care to primary care or admission avoidance which benefit the system but may reduce provider income), it may make sense to invest time and effort to jointly solve these at the level of the whole STP footprint rather than develop local solutions in parallel.

- **Leadership, capability building and organisational development** will be important as we look to build capacity within the system to deliver the STP. This will need to be developed and adapted within the delivery units , but there may well be an additional need in developing and designating system leadership, looking collectively at the organisational complexity in commissioning and also between providers, inventing new governance arrangements for the common resource, and new models of cross organisational care and Where we need external support or want to work with local partners (e.g., Nottingham University, East Midlands Leadership Academy) there may be obvious benefits in speaking with one voice in specifying and procuring the support we need.

- **Implementation support for initiatives and enablers which need to be consistent across the whole STP footprint,** such as some aspects of planned care, prevention, workforce and organisational development, estates and communications and engagement. This may be because there is a clear need for common standards or a consistent approach, or there may be a natural synergy or economy of scale.

At local system level, we would see the following delivery architecture and the vast majority of the resources being deployed;

- **Programme management of all locally implemented schemes**, following a common methodology and reporting tools agreed at STP level and as described above to allow for aggregated progress reporting and to facilitate learning.

- **Allocation and deployment of resources and teams**, with responsibility for recruiting and mobilising the resources and teams needed to deliver the changes described in the STP. This is best done locally given that for the most part these staff currently work in organisations within that local system, will have been involved in developing these initiatives and therefore have a natural sense of ownership for them.

- **Implementation support for most initiatives** which are tailored to the local context. For example, local Vanguards, improvements to the local urgent and emergency care pathway, strengthening primary care and reducing unwarranted variation.
- **Analytics and performance tracking** will also be available at local level to track the delivery. We will ensure we efficiently use our resources by leveraging the same methodology for reporting for the whole STP footprint. Tactically, the Delivery Units will track delivery of those initiatives implemented within their respective Delivery Units and then aggregated up at a foot-print level, where aggregated performance will be tracked and system leaders will hold each other to account.

The way these functions are distributed needs to be worked through, but this represents our starting point. There is a strongly held view within the STP that given our starting point, implementation is best managed locally, with the primary mechanisms for accountability and performance management being at that level. That said there is also recognition that regulatory assurance of delivery of the STP must be explicit, visible and credible at the level of the overall STP, which means that *some* functions and infrastructure are needed centrally.

Proposed transformation partnership in Greater Nottingham/South Nottinghamshire

In the case of Greater Nottingham/South Nottinghamshire, the system has confirmed its intention to create a new Integrated Accountable Care System (ACS) as the vehicle through which the organisational model will be transformed, as well as the delivery of the patient-facing clinical delivery system. The first step in developing the ACS focused on the completion of a detailed actuarial analysis to understand where user activity and costs are in the system with the identification of the opportunities to move to person and population centred care (i.e. reshaping the care system, with a specific focus on tailoring services to the user groups with the biggest value opportunity) to fundamentally improve quality and reduce system costs.

This analysis confirmed a very significant opportunity in terms of reducing the amount of potentially preventable care and associated cost undertaken within the acute sector. The opportunity identified is far greater than other benchmarks (e.g. NHS Right Care). For community care, social care and mental health provision, the analysis confirmed it was difficult to draw meaningful conclusions regarding their effectiveness based on the data quality and completeness. This in itself was a key conclusion and we understand that this is relatively consistent with the starting point of most fragmented systems that have successfully transformed into a high-performing system.

The second stage of the process of development of the ACS is focused on a period of detailed design work. This design phase is being supported by international organisations that have successfully brought about well managed integrated health and care systems in the United States and Spain providing a unique opportunity to understand, in practical terms, the requirements of delivering an integrated ACS, including what it would take of each of our component parts, from organisations who have actually achieved this ambition.

By November 2016, this design work will confirm the care system needed to achieve a high performing, integrated system, delivering the value opportunity confirmed in the actuarial analysis i.e. the services required, the obligations of each partner, together with the solutions the ACS would need to put in place

in respect to the resource and capacity gaps. The proposed solution will include the characteristics of an integrated ACS and the optimal contractual framework for this system. The solution will incorporate the innovative service changes and new models of collaboration being progressed through our Vanguards and Integration Pioneers as appropriate.

The design phase is specifically focused on an assessment against an integrated accountable care framework – which confirms the indirect enablers and integration functions needed - and is being progressed through six design work-streams, namely Patient Pathways, Population Health, Social Care, IM&T, Provider Payment Models, and ACS Governance and Contract Design.

At the end of the design phase, Greater Nottingham/South Nottinghamshire will present its STP delivery plan in the form of a Value Proposition which will outline proposed next steps. The emerging delivery plan is ambitious with the need for ongoing leadership and partner organization commitment. An Associate of the NHS Leadership Academy is supporting us on the culture, mindsets and behaviours needed for the next stage of the transformation journey.

***Better Together*, in Mid Nottinghamshire**

We are committed to delivering outcome focused, population based services to the people of Mid Nottinghamshire through a capitated budgeting model, with joint commissioning of health and social care services wherever possible.

Our integration journey is iterative. The Better Together Programme has introduced a number of changes to services through collaborative working across organisations and sectors. However, partners all agree that we need to become more joined up if we are to make services more integrated for our citizens. Initially, the CCGs tried to achieve this by asking providers to come together to work under the umbrella of one overall contract. The approach used is a recognised procurement route, known as the 'most capable provider' process. As part of that process, we tested the collective provider capability to deliver integrated services in May 2015 (known as the Capability Assessment).

This assessment showed that, whilst there was a general willingness to work together to improve services, large scale sharing of risk and reward was felt to be too risky in a single step. Providers wanted a more defined means of working together; one that separated joint risks of pathway provision that they could influence and control from other potential risks (such as pre-existing provider deficits).

As a result of this, providers, local government and commissioners entered into an Alliance in April 2016. .

The Alliance is a group of partners who collectively determine how services will be delivered and are collectively responsible for improving health outcomes. In 2016/17, the Alliance is covering the following areas:

- Development of whole-system plans for sustainable services until 2020/21, aligned with the STP footprint

- Development and shadow testing of new payment mechanisms (capitation, based on outcomes)
- Working together to achieve some defined service changes under an Alliance contract. Individual contracts with providers will also exist alongside this

The key features of the Alliance in 2016/17 are shown below.

The Alliance brings transformation partners together more formally, with shared objectives and governance. This puts us in a very favourable position to develop our system sustainability and transformation plan (STP). This is important as the system faces significant financial challenge. We have been working together to address this and we have a strong analytical base that underpins our new care model, both in activity and financial terms. We also have an outcomes framework that has been developed with local communities.

The alliance arrangements, alongside a system-wide approach to service improvement and the introduction of capitated payments, are key enablers for the delivery of our new care models.

8- How our plan bridges our financial gap

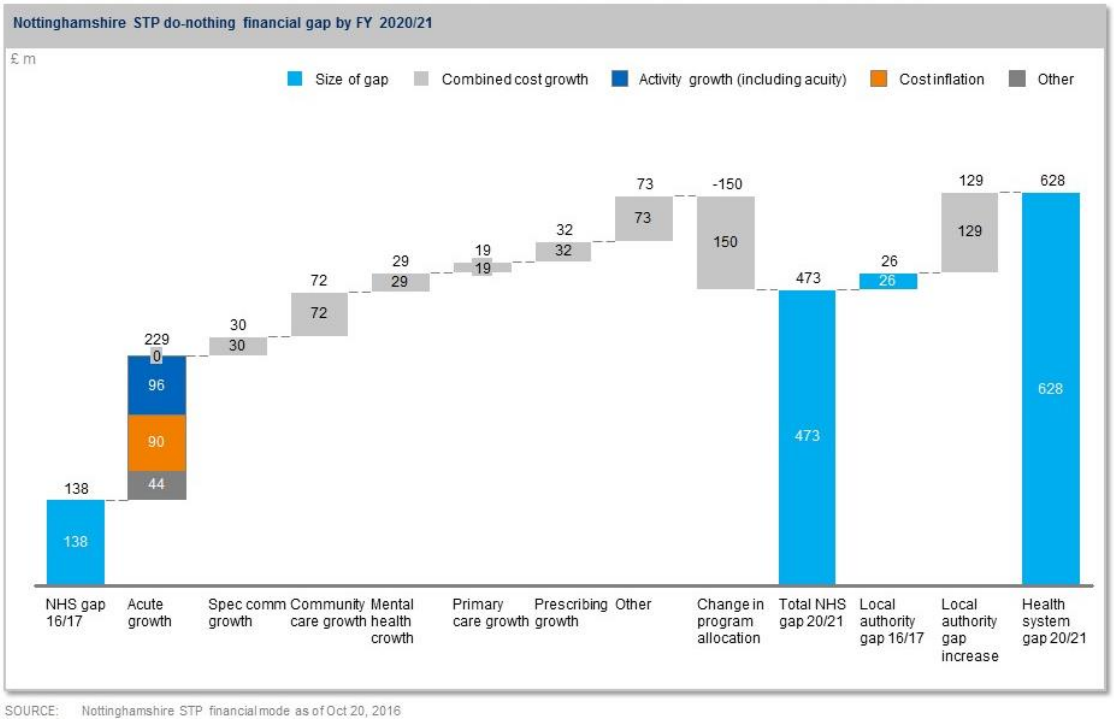
Why is this important?

Nottinghamshire currently faces a health system gap of £146m (FY 16/17), this includes a £120m NHS gap and a £26m Local Authority gap. In a 'do-nothing' scenario this gap is expected to rise to £628m by FY 20/21, this includes a £473m NHS gap and a £155m Local Authority gap.

Within the NHS this gap is caused by rising activity and cost of healthcare (£485m) outstripping the growth in allocation to NHS (£150m). Rapid cost growth in the acute sector (£229m) is responsible for half the increase of the financial gap.

A £628m gap is financially unsustainable and requires us to make significant efficiency savings and transformation changes to our model of care within Nottinghamshire, as well as, continue empowering our citizens to self-care independently.

Figure showing size of 20/21 do nothing gap:



What is our aim?

To meet this financial challenge while continuing to improve the quality of care for the people of Nottinghamshire will require two key actions. Firstly, delivering annual organisation internal efficiency savings and secondly, transformational changes to the way we deliver care to reduce activity or shift it to a lower cost setting of care.

What will be different in 2020/21?

Providers will need to improve their operational efficiency enabling them to treat the same patient for a lower cost. Improvements to provider efficiency will mainly come from each organisations own internal efficiency savings (£313m by 20/21; 2%+ per year). In addition, £187m of system wide initiatives, and £20m of required additional support in relation to the PFI at Sherwood Forest Hospital.

Operational efficiency will not be enough to close the gap alone and therefore transformational change to the model of care will be required. Seven sets of initiatives will focus on transforming the model enabling removal of ~£200m worth of cost by 2020/21. These initiatives will aim to both reduce the demand for healthcare and shift activity into lower cost settings of care within the community and closer to people's homes.

The sets of initiatives aimed at transforming the the way we delivery care are estimated to save up to £187m. The financial impact of each initiative is summarised below and more detail on the actions themselves is provided in sections 4, 5 and 6, as well as, the PIDs in the appendix. For detailed assumptions, please refer to the Finance Presentation attached with this submission.

The values listed here are an average of high and low savings scenarios. However, they still represent a big challenge, pushing a level of integration and demand management not yet seen in the NHS (there are international examples listed in this document) and as a result there is a high level of risk involved in the delivery of these savings.

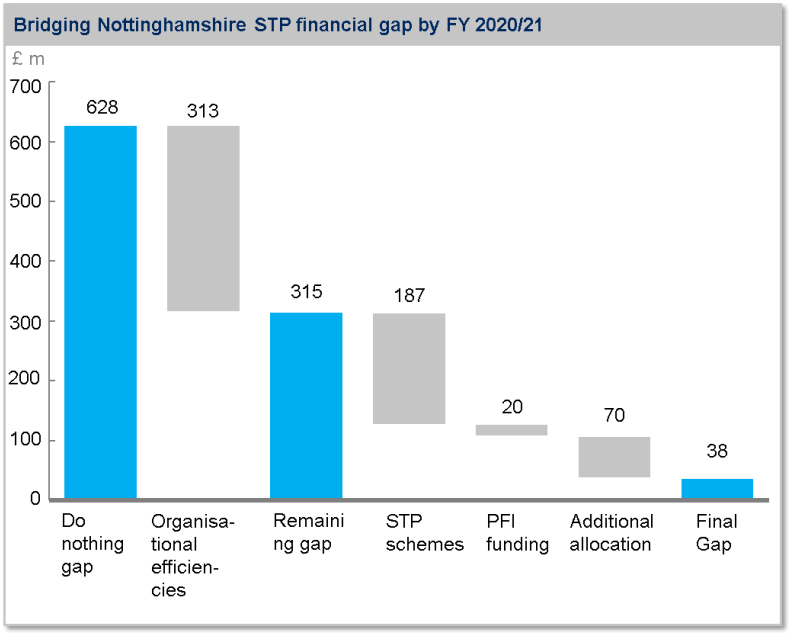
Initiative	Assumptions	Impact by 2020/21
Strengthen primary, community, social care and carer services	▪ Transforming healthcare delivery in Greater Nottingham / South Nottinghamshire - 20-40% reduction in non-elective admissions - 1-3% reduction in prescribing costs ▪ Better care programme in Mid Notts - 15.1% reduction in A&E Attendances - 19.5% reduction in NEL acute admissions (spells) - 30.5% reduction in NEL acute bed days - Excess Bed Days - 25% reduction in admissions to nursing and residential homes - 9.8% reduction in secondary care elective referrals (excluding 2ww)	Gross: £72m Reinvestment: £22m Net: £50m
Simplify urgent and emergency care - Acute bed reduction (200 over 2 years)	▪ System redesign to enable reduction of 200 beds in acute hospitals over the next 2 years and provision of care in alternative settings that are more appropriate for our citizens	Gross: £15m Reinvestment: £7m Net: £8m

Initiative	Assumptions	Impact by 2020/21
	▪ Care will be reprovisioned to short term residential/community beds, short term assessment beds, standard residential beds and also supported at home living	
Simplify urgent and emergency care - A new model of urgent care	▪ Based on UEC Vanguard Value Proposition	Gross: £11m Reinvestment: £3m Net: £8m
Ensure consistent, evidence based pathways in planned care	▪ 5% saving on MSK Outpatient & Elective ▪ First to follow up ratio to be at quartile ▪ Increase referrals and diagnostics which reduces complex cancer care	Gross: £35m Reinvestment: £14m Net: £21m
Reduction in system variation	▪ Based on estimated saving potential by the Actuarial Analysis (net of reprovision) undertaken in April 2016 in South Nottinghamshire ▪ The value of the above initiatives have been subtracted to avoid double-counting	Gross: n/a Reinvestment: n/a Net: £45m
Maximise estates utilisation	▪ Based on 75% of the value identified by carter review	Gross: n/a Reinvestment: n/a Net: £20m
Promote wellbeing, prevention, independence and self-care	▪ Assumptions outlined on Prevention section in STP, as well as, STP PIDs for this workstream	Gross: £34m Reinvestment: £3m Net: £31m
Improve housing and environment	▪ Based on assumptions for Social Housing and Warm Housing PIDs ▪ Adjusted down significantly to avoid double-counting	Gross: £3.8m Reinvestment: £1.4m Net: £2.4m
Deliver technology enabled care	▪ Only savings not accounted above have been considered. These relate mainly to the LDR (e.g. reducing repeated diagnostics)	Gross: n/a Reinvestment: n/a Net: £3m

If savings can be achieved both in terms of provider efficiency requirements and the redesign of the model of care they will unlock additional sustainability and transformation fund allocation worth £70m. These additional funds plus the savings initiatives should reduce the financial gap to £38m. This is enough to return the NHS to a surplus of £65m by 20/21, but there remains a £103m local authority gap linked to the health system. This local authority gap will require additional actions to close for us as one integrated system. If the gap is not closed there is significant risk that investment needed to support the new model of care will instead be needed to support existing social care services and the demand management activities of the new model of care will not be adequately supported.

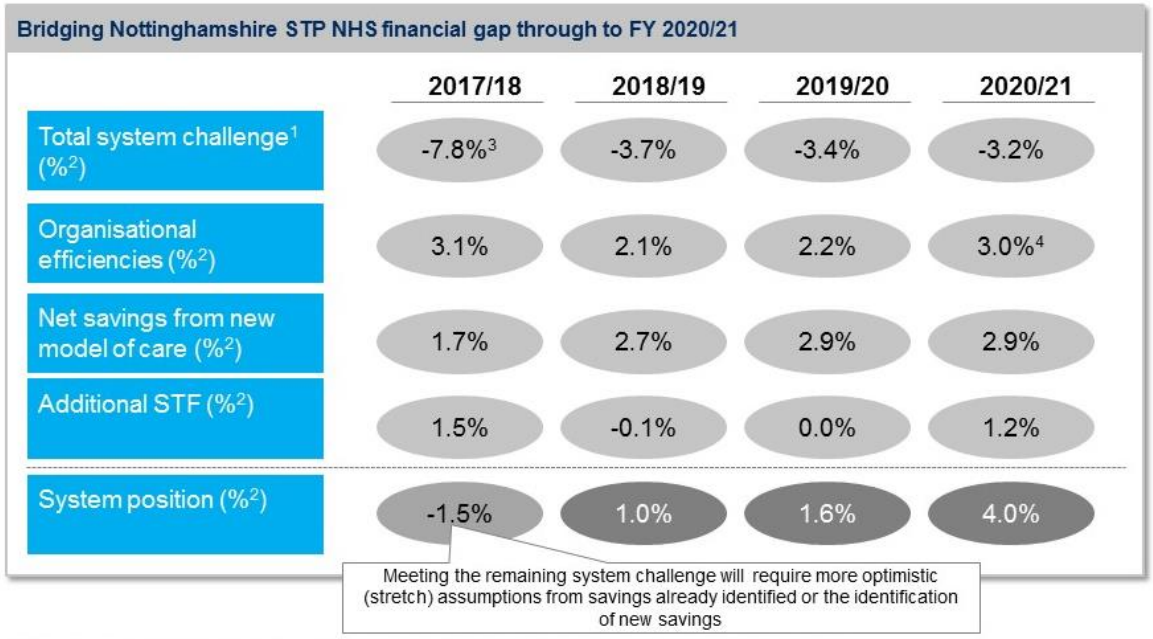
Additionally, as stated above, a core principle agreed by partners in our STP is that we are one health and social care system, with a shared responsibility to manage the whole system finances to meet the populations needs. In our plan we have set out the finances currently available across local authority and NHS organisations until 2021 and with our citizens we will determine the right mix of services for the population according to need and achieving the best outcomes. We will work together to make the best use of the public purse and ensure that we meet the ambition of our plan at a local level

Bridging the 20/21 financial gap



How will these initiatives be implemented over the five year period?

Savings from provider efficiency are expected to approximate 2-3% per year through to 20/21. However, due to the scale of the transformation required savings from the new model of care are expected to only start ramping up from 17/18. This will mean a greater challenge on the providers within the short to medium term to make all efficiency savings possible.

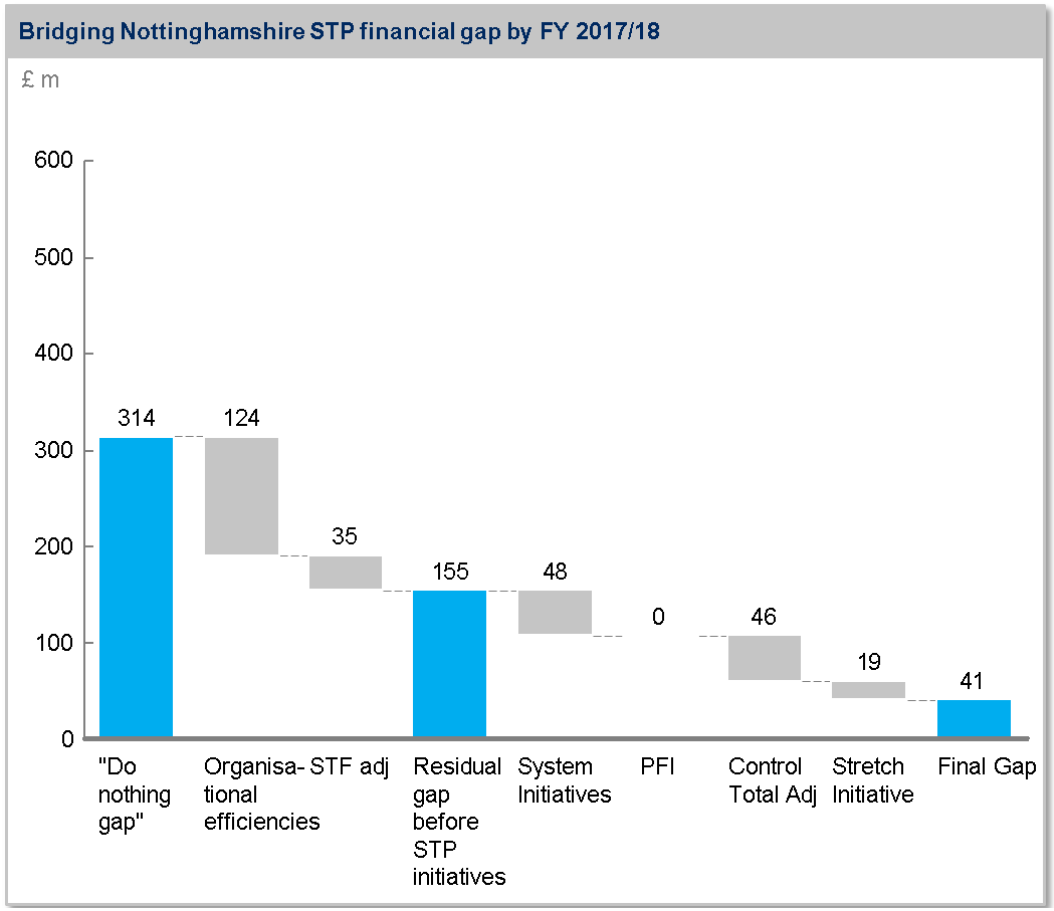


1: Challenge is defined as percentage saving required to meet control totals in 17/18 and 18/19 and to break even in 19/10 and 20/21
2: Percentage of NHS only and is over provider cost base
3: Accounts for pre-existing 16/17 gap in challenge
4: Includes £20m saving on maximizing estates utilisation
SOURCE: Nottinghamshire STP financial mode as of Oct 21, 2016

Due to the slower ramp up of demand savings and the deficit the system is already carrying, the financial gap of £314m will be particularly challenging to close in 17/18. If we deliver our organisational efficiencies and transformational plans the 17/18 remaining gap is expected to total £40m. This is composed by an NHS gap of £11m (expected vanguard and mental health funding) and Local Authorities gap of £29m. Reaching this position will require an additional £19m of 'stretch' savings currently being identified to bring new savings such as estates, back office consolidation, refined value of initiatives after further

detailed modelling, revised opportunity after Phase 2 of work is completed in South Nottinghamshire, etc. To support this, the STP would need additional transition funding of £26m in 2017/18 and £19m in 2018/19 to be invested to outside of acute hospital to support the reprovision of finance for the new model of care (plus, the above stated £11m for Vanguard and mental health funding).

Bridging the 17/18 financial gap



9 – Risks and mitigating actions

Set against this positive picture of local and national engagement in developing and implementing new care models, there are some key risks to delivering transformational change.

	Risk	Mitigation actions	Risk Rating
1. Financial	1.1 Insufficient non-recurrent or Transformation funding available for the enabling/implementation costs during first three years of implementation	▪ Identify preliminary transitional funding requirements and refine over the next three to six months ▪ Develop a robust plan to provide confidence to the regulators in our commitment and ability to deliver ▪ Explore approach with a partner to support delivery of Accountable Care System	MEDIUM
	1.2 Misalignment between regulators makes it difficult for organisations to share risk and operate in a way that supports system objectives	▪ Early engagement of regulators, including to explore options for contractual approach to managing system risk ▪ Explore with other systems how they have developed system flexibilities	HIGH
	1.4 New services and models are implemented but planned savings are not delivered	▪ Ensure detailed plans to take out costs as well as invest ▪ Tighten leadership, governance and delivery infrastructure to give ourselves the best chance of successful delivery	MEDIUM
	1.5 Failure to secure adequate capital Primary care Estates, Technology Enabled care to deliver the scale of change required	▪ Continue to refine funding requirements over the coming weeks ▪ Work hard to identify additional estates savings that can be delivered early	MEDIUM
	1.6 Failure to close Local Authority gaps means services are reduced, resulting in significantly increased levels of demand for acute hospital services and risks of Local Authorities being unable to meet statutory requirements	▪ Resources will follow activity so e.g. shift to community based care (incl social care) will be funded by acute hospital bed reductions ▪ Potential impacts on the system of LA gaps will be discussed at Programme Executive to continue looking for solutions	HIGH

	Risk	Mitigation actions	Risk Rating
2.Operational	2.1 While the 5 year plan is achievable, the scale and pace of change to close gap in 17/18 and 18/19 is unprecedented an	▪ Put a strong programme governance and reporting in place that identifies key milestones and actions/ways of working required to deliver ▪ Launch and sustain supporting delivery units ▪ Launch and sustain a capability building programme among programme office and project leaders ▪ Ensure the above is appropriately funded and resourced	MEDIUM
	2.2 STP delivery footprints (Mid and South Notts) move away from agreed principles and standards during implementation and implementation of STP benefits are not consistently achieved for our citizens.	▪ Clear agreements in relation to roles and responsibilities of Delivery footprints ▪ STP programme governance monitors implementation and delivery and escalates issue to STP Programme Board	MEDIUM
	2.2 Quality of care of providers across all sectors is adversely affected due to the changes proposed	▪ Ensure that clinical leaders are fully engaged with work programmes and ensure that all proposals are subjected to rigorous quality impact assessment ▪ Continue ongoing leadership engagement with transformation boards	LOW
	2.3 We are unable to maintain quality and capacity in the social care market due to financial and workforce challenges	▪ Ensure sufficient investment in the market	MEDIUM
	2.4 Short-term pressures both at organisation and system-level conflict with the strategic direction set in this document	▪ Maintain open and trust-based relationship with the regulator ▪ Maintain strategic alignment and co-ordination across the system through enhanced system governance arrangements	HIGH
	2.5 Current PIDs are insufficiently detailed to assure plan and partners to enable successful translation to two year operational plan and contract	▪ Rapid development of plans in next 6-8 weeks ▪ Agree approach to managing system risk during 17/18 and 18/19	MEDIUM
	2.6 STP programme governance adds to the workload of the delivery and implementation teams and there is	▪ Agree approach to governance with delivery footprints to minimise duplication and misalignment ▪ Discuss with regulators	LOW

	Risk	Mitigation actions	Risk Rating
	duplication with system regulators and other reporting lines		
2. Operational	2.7 Continued uncertainty about the merger of NUH and SFT leading to risks and changes to the process and sustainability	▪ Continue with effective collaboration pending decision	MEDIUM
3. Workforce	3.1 Shortage of care professionals to deliver the added capability and capacity in the community	▪ Continue intensive support from Local Workforce Action Board and on-going leadership and support from Health Education East Midlands ▪ New models ensure the right care is provided in community settings allowing specialists to focus on complex care	MEDIUM
4. Engagement with clinicians, citizens	4.1 Insufficient clinical engagement and buy-in to detailed implementation plan due to scale of clinical involvement required	▪ The establishment of Executive Clinical Reference in clinical engagement, continue developing plans bottom-up and create wider opportunities for participation of clinicians	LOW
	4.2 Failure to ensure effective consultation and engagement to enable implementation at the required pace.	▪ Ensure ongoing engagement and involvement in the development of plans, playing back how feedback has been taken into account ▪ Work through existing channels of citizen engagement to ensure that benefits of proposed changes are clearly understood	LOW
5. Political	5.1 Insufficient political engagement and support	▪ Engaging during design and implementation with local and central politicians ▪ Leverage Health and Wellbeing Boards as start point	MEDIUM
	5.2 Legal and policy constraints slow down the process (for example, competition authority, procurement laws)	▪ Detailed planning undertaken ▪ Open dialogue with regulators	MEDIUM

10 - Questions we are still working to answer and requests to NHS England and our regulators

Open issue	*Options that have been considered*	*Approach to resolving issue*	*Planned timeframe*	*Requested support to NHSE*
1. A large proportion of our STP initiatives are fully costed (e.g. UEC Vanguard or Better Together Programme). However, some other initiatives require further work to allow successful delivery of the contracting and operational planning processes	A. Continue detailed modelling and planning work after submission	▪ Over the next 8 weeks, we will build on the PIDs to turn these into more granular, bottom-up, fully costed initiatives underpinned by robust implementation plans ▪ For those HIA that we will implement at each delivery unit (e.g. Primary, Community, Social care and carers), these plans and bottom-up costing will be developed at a Delivery Unit level. Those implemented at footprint level (e.g. Prevention, Estates), will follow a similar process but undertaken centrally ▪ We will use the same programme management methodology across the footprint ▪ This will allow us to support the contracting and operational planning processes by the 23rd of December	8 weeks	-
2. Evaluate option to secure a transformation partner for Greater Nottingham/South Nottinghamshire	A. Option to secure transformation partner B. Do not secure transformation partner	▪ In Greater Nottingham/ South Nottinghamshire (Delivery Unit), over the next 8 weeks, we will put together the findings of the Phase 2 of work undertaken by international organisations that have successfully brought about well managed integrated health and care systems in the United States and Spain, with the 3 local Vanguard value propositions and this submitted STP. We will also assess the different options for delivery ▪ We will then update this document accordingly to reflect the preferred option, as well as, any other implications for this plan that are relevant (e.g. updated sizing of STP initiatives)	8 weeks	Agreement has been reached with NHSE that we will update this STP document after completing of Phase 2 of work
3. Address LA gap particularly in years 1 and 2 to ensure the	A. LA finds internal efficiencies to	▪ A core principle agreed by partners in our STP is that we are one health and social care system, with a shared	10 weeks (final	

system benefits from STP transformational initiatives can be delivered and that social care system is sustainable	deliver the required savings without impacting performance B. NHS funding/ surplus funds LA gaps C. LA gap is covered with additional national funding D. LA reduces its expense and it impacts negatively the performance of the health and social care system	responsibility to manage the whole system finances to meet the populations needs. In our plan we have set out the finances currently available across local authority and NHS organisations until 2021 and with our citizens we will determine the right mix of services for the population according to need and achieving the best outcomes. We will work together to make the best use of the public purse and ensure that we meet the ambition of our plan at a local level ▪ We will work out the exact details on finances over the next 10 weeks in parallel and as a result of issues 1 and 2 outlined above	decision after completing issue 1)	
4. Detailed transitional funding requested and specific requests to NHSE	A. Request the required transitional funding to NHS E	▪ As part of the process described to resolve issue 1, we will also calculate concrete transitional funding ▪ The current transitional funding requested in this draft document is an estimate based on all the work done, but is likely to be refined	8 weeks	Provide feed-back on the high-level estimate requested
5. 5. Workforce Strategy provides a vision and preliminary costing at a system level. Organisational plans will reflect system priorities and gaps in planning will be addressed.	A. Continue detailed modelling and planning for workforce after this submission	▪ Over the next 16 weeks, current organisational plans will be reflective of Notts STP workforce strategy. - First 8 weeks: we will iterate between the workforce strategy and operational plans and contract requirements ▪ 6 months to fully develop system wide including primary care and community voluntary sector	16 weeks	-

		▪ Continue to review organisational plans annually ▪ Over this period of time, we will continue to engage with our staff		
6. Building on section 7 of this STP, we need to consider evolving towards a more effective and quick decision making process	A. Discuss internally as Exec Board how to continue to increase the pace of decision-making	▪ Over the next 5 weeks, the Executive Board will continue to discussions (already started) to further reach more effective and quick decision making consistent with our delivery requirements ▪ Any further conclusions, plus all the conclusions presented in section 7, will form part of the MOU that will be signed by late November 2016	5 weeks	-
7. Finalise the exact delivery structure, and resourcing to deliver this STP and refine how much, and what type of external support will be needed to ensure successful delivery	A. Discuss as an Exec a proposal of detailed resourcing at each delivery unit, building on the agreement stated in section 7	▪ Over the next 5 weeks, the Executive Board will resolve the details of the delivery structure within each delivery Unit and overall footprint, as well as, resources required (internally and externally). This will determine whether existing capacity and capabilities need to be enhanced ▪ This will build on all the work done and agreement reached in section 7 of this document	5 weeks	Support in commissioning required support if deemed necessary
8. Alignment of regulators and ALBs on the STP goals and how they performance manage individual organisations	A. Align with the regulator how to best manage individual organisations incentives with overall, long-term goals	▪ We see this STP as a journey and not an end-point ▪ We are aware that there will be situations, both in the short term and long term, in which we will need support from our regulators in finding the right balance between short and long term pressures and objectives	Ongoing	Our request is to have open and honest discussions with our regulators to ensure this balance is achieved

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

13 December 2016

Agenda Item: 7

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents.

3. The work programme for 2016-17 is attached as an appendix for information.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the content of the work programme for 2016-17 and dates for future meetings.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Joint Health Scrutiny Committee 2016/17 Work Programme

12 July 2016	• **Transforming care for people with learning disabilities and/or autism spectrum disorders in Nottingham and Nottinghamshire – outcomes of consultation and progress against key deliverables** To consider the consultation process and findings and if/how proposals are changing to reflect those findings; and progress against the key deliverables to be completed by June 2016 (Nottingham City CCG lead) • **The Willows Medical Centre, Carlton** To review action taken by Nottingham North and East Clinical Commissioning Group to ensure that all patients in the Carlton area have access to good quality GP services during the temporary closure of The Willows Medical Centre; and in the future. (Nottingham North and East CCG) • **Work Programme** To consider the 2016/17 Work Programme
13 September 2016	• **Environment, Waste and Cleanliness at Nottingham University Hospitals** To review progress in improving the environment, waste management and cleanliness at Nottingham University Hospitals sites (Nottingham University Hospitals) • **Defence and National Rehabilitation Centre (Stanford Hall)** To examine the development of services for trauma rehabilitation (Nottingham University Hospitals)

	• **Future of Congenital Heart Disease Services** To consider NHS England's recent announcement about the future of congenital heart disease services, including changes to the commissioning of services at the East Midlands Congenital Heart Centre at Glenfield Hospital, Leicester. • **Work Programme** To consider the 2016/17 Work Programme
11 October 2016	• **Nottingham University Hospitals and Sherwood Forest Hospitals Trust Merger – Progress Update** (Nottingham University Hospitals) • **Community Child and Adolescent Mental Health Services (CAMHS)** **(**Nottinghamshire Healthcare Trust/ commissioners/ local authority public health) • **Rampton Hospital/Psychologically Informed Planned Environments (PIPES)** To receive information on the operation of PIPES in prisons (NHS England) • **The Willows Medical Centre, Carlton** To consider changes to services following the resignation from Dr Nyatsuro in relation to his GP practice contract (Nottingham North and East CCG) • **Work Programme** To consider the 2016/17 Work Programme

8 November 2016	• **East Midlands Clinical Senate and Strategic Clinical Networks** To receive the EMCSSCN Annual Report and updates on other recent developments (EMCSSCN) • **NUH Emergency Department Targets** To receive briefing on Accident and Emergency performance (NUH) • **NUH Planning for Winter Pressures** To receive briefing on NUH's plans to cope with winter pressures 2016/17 (and also whole system briefing from commissioners and social care partners). (NUH) • **Work Programme** To consider the 2016/17 Work Programme
13 December 2016	• **Environment, Waste and Cleanliness at Nottingham University Hospitals** To review progress in improving the environment, waste management and cleanliness at Nottingham University Hospitals sites (NUH) • **Daybrook Dental Practice Report Findings** An update further to the conclusion of recent proceedings (NHS England) • **Sustainability and Transformation Plan** To receive information about the STP, including an outline of the Plan, governance and plans for delivery, plans

	for consultation and engagement; and information about any anticipated substantial developments or changes to services. (STP Team) • **Work Programme** To consider the 2016/17 Work Programme
10 January 2017	• **Uptake of child immunisation programmes** To consider the latest performance in uptake and how uptake rates are being improved (NHS England/ Local Authority Public Health) • **Winter Pressures - EMAS** Evidence gathering as part of an ongoing review of winter planning (EMAS) • **Work Programme** To consider the 2016/17 Work Programme
7 February 2017	• **GP service capacity in Carlton area** (TBC or March) To take a strategic overview of GP capacity and any pressures on service provision in the Carlton area and, where appropriate, work taking place to ensure access to good quality GP services for all residents in the area (Nottingham North and East CCG/ Nottingham City CCG) • **Work Programme** To consider the 2016/17 Work Programme

14 March 2017	• **Work Programme** To consider the 2016/17 Work Programme
18 April 2017	• **Urgent Care Resilience** To review progress in developing resilience within the urgent care system, including the delivery of services during winter 2016/17 and how effectively winter pressures were dealt with. (Nottingham City CCG/ NUH) • **Work Programme** To consider the 2016/17 Work Programme

To schedule:

- Progress against JHSC recommendation that "that the City and County Councils work with their partners, for example Marketing Nottingham and Nottinghamshire to support Health Education East Midlands to promote the East Midlands as a place for health professionals and students to train and work"
- Integrated Community Children and Young People's Healthcare Programme – review of implementation and outcomes from service changes
- Procurement of Patient Transport Service, including development of service specification - awaiting confirmation of procurement timings
- Evaluation of Urgent and Emergency Care Vanguard (primary care at the 'front door')
- Integrated Urgent Care
- Strategic Health Plans for the South of the County
- Evaluation of GP Access pilots

Study Groups:

- Quality Accounts

Visits:

- Nottingham University Hospitals sites

Other meetings:

- NUH (Peter Homa)
- NHCT (Ruth Hawkins)
- EMAS (Greg Cox) (informal meeting with East Midlands Health Scrutiny Chairs to consider EMAS response to CQC inspection)

Items for 2017/18 Work Programme:

May/ June

- Nottinghamshire Healthcare Trust Transformational Plans for Children and Young People – CAMHS and Perinatal Mental Health Services update (to include workforce issues, development of Education Centre and financial position)

NHS 111 (align with publication of NHS 111 Annual Report)

Visit to new CAMHS and Perinatal Services Site (spring 2018)