# Better Care Fund planning template – Part 1

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

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

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

## 1) PLAN DETAILS

### a) Summary of Plan

| | |
|---|---|
| Local Authority | **Nottinghamshire County Council** |
| | |
| Clinical Commissioning Groups | **Bassetlaw** |
| | **Mansfield and Ashfield** |
| | **Newark and Sherwood** |
| | **Nottingham North and East** |
| | **Nottingham West** |
| | **Rushcliffe** |
| Boundary Differences | **There is a 2.7% population difference between the Local Authority and CCG boundaries. This small figure is not expected to impact significantly on delivery of this Better Care Fund plan.** |
| | |
| Date agreed at Health and Well-Being Board: | **XX/02/2014** |
| | |
| Date submitted: | **XX/02/2014** |
| | |
| Minimum required value of ITF pooled budget: 2014/15 | **£16,100,000** |
| 2015/16 | **£54,905,000** |
| | |
| Total agreed value of pooled budget: 2014/15 | **£33,971,484** |
| 2015/16 | **£61,664,000** |

## b) Authorisation and signoff

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| **Signed on behalf of the Clinical Commissioning Group** | Bassetlaw |
| **By** | <Name of Signatory> |
| **Position** | <Job Title> |
| **Date** | <date> |

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|---|---|
| **Signed on behalf of the Clinical Commissioning Group** | Mansfield and Ashfield |
| **By** | <Name of Signatory> |
| **Position** | <Job Title> |
| **Date** | <date> |

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|---|---|
| **Signed on behalf of the Clinical Commissioning Group** | Newark and Sherwood |
| **By** | <Name of Signatory> |
| **Position** | <Job Title> |
| **Date** | <date> |

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|---|---|
| **Signed on behalf of the Clinical Commissioning Group** | Nottingham North and East |
| **By** | <Name of Signatory> |
| **Position** | <Job Title> |
| **Date** | <date> |

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|---|---|
| **Signed on behalf of the Clinical Commissioning Group** | Nottingham West |
| **By** | <Name of Signatory> |
| **Position** | <Job Title> |
| **Date** | <date> |

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|---|---|
| **Signed on behalf of the Clinical Commissioning Group** | Rushcliffe |
| **By** | <Name of Signatory> |
| **Position** | <Job Title> |
| **Date** | <date> |

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|---|---|
| **Signed on behalf of the Council** | Nottinghamshire County Council |
| **By** | <Name of Signatory> |
| **Position** | <Job Title> |
| **Date** | <date> |

| | |
|---|---|
| **Signed on behalf of the Health and Wellbeing Board** | Nottinghamshire Health and Wellbeing Board |
| **By Chair of Health and Wellbeing Board** | <Name of Signatory> |
| **Date** | <date> |

**c) Service provider engagement**

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

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

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

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

A county-wide consultation between Health and Social Care has also been concluded, including all providers, regarding budget cuts required by the County Council and the potential impact upon them of any reduction in funding arrangements. Analysis of the results is currently underway, and will be reported in late February. The development of our BCF plan has been fully cognisant of these plans.

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

- The North Nottinghamshire Urgent Care Working Group and Integrated Care Board, engaging clinical and non-clinical members at a senior level
- The HWB Stakeholder Network and Living at Home Programme to engage with providers and patient representatives in North Nottinghamshire, with further events planned as the Strategic Priorities develop
- The Mid-Nottinghamshire 'Better Together' Transformation Programme care design group process, which engaged local clinicians, care professionals, and patients to design a blueprint for future service delivery in a challenging health economy
- A communications forum where communications leads from each organisation involved in the Mid-Nottinghamshire 'Better Together' programme meet on a monthly basis to review the ongoing communications required
- The Greater Nottingham's Vision for Integrated Care (covering South Nottinghamshire), working together with providers to improve quality, outcomes and drive cost efficiencies
- The Strategy and Implementation Group for Nottinghamshire South (SIGNS) with a focus on Frail Elderly – a group of commissioners and providers to set the strategy for frail older people across Greater Nottinghamshire boundaries and oversee its implementation
- The South Nottinghamshire Transformation Board oversees and is accountable for the delivery of the South Nottinghamshire Transformation Programme, with the aim of improving the way care is delivered to citizens, patients, and carers through service redesign and integration
- The Bassetlaw Integrated Care Board has been mobilised as part of BCF implementation in North Nottinghamshire

- South Nottinghamshire's local planning group for the BCF includes a representative of Circle (Independent Sector Provider) as well as the main acute provider NUH

**d) Patient, service user and public engagement**

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

Our vision of integrated care is important, but it is how outcomes are met and experienced by the citizen that really matters. Nottinghamshire's plan for integrated care has therefore been designed with the needs of the citizen at its core. In this vein, we have deliberately implemented all engagement activity at locality level, based on prior experiences on how to best achieve deep and impactful engagement.

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

**South Nottinghamshire**

From September 2013 onwards, the three South Nottinghamshire CCGs and Nottingham City CCG have carried out a large-scale Call to Action engagement exercise to involve patients, the public and partners in how the NHS should respond to meet the challenges of the future. There have been more than 40 events and this significant engagement with a wide range of individuals with different experiences of health and social care has helped inform the debate as to how health and social care services can make bold change. At the end of January, one such exercise engaged over 100 patients.

**Mid-Nottinghamshire**

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

**North Nottinghamshire**

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

Patient representatives across the county have also been engaged in the development of the plan through the HWB Stakeholder Network. Healthwatch are also represented on our Health and Wellbeing Board, as well as the South Nottinghamshire Transformation Board. This Transformation Board is co-chaired by a laymember (who is also a patient). In a similar vein, a member of the Citizen Board advises the Mid-Nottinghamshire Transformation Board.

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

**e) Related documentation**

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

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

# 2) VISION AND SCHEMES

**a) Vision for health and care services**

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

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

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

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

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

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

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

Our services will all look radically different to patients and service users as outcomes will place them at the centre of seamlessly delivered, well co-ordinated Health and Social care services. These outcomes will include a strong drive towards improving alternative

forms of support to self care and an integrated direct payment and health care budget to allow people to experience outcomes which are truly person centred and flexible improve their aspirations to maintain control, choice and independence. This can only be achieved through a resolute focus on patients, services, and resources.

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

**b) Aims and objectives**

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

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

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

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

Our joint objectives are:

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

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

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

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

3. Outcomes
   - Mortality and morbidity rates
   - Case management of Long Term Conditions

- Proportion of people entering Long Term Care
- Patients managed in community bed services
- EOL plans in place/Preferred place of death
- Suitable housing options

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

## 1. Description of planned changes

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

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

The schemes developed across the county to support delivery of the Better Care Fund aims offer the opportunity to address immediate pressures on services and lay foundations for a much more integrated system of health and social care delivered at scale and pace. The schemes have been developed in line with the Nottinghamshire Joint Strategic Needs Assessments, and prioritised through CCG/LA commissioning plans. They are defined across six themes:

**7 Day Service Provision and Access**

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

The success factors are:

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

**Supporting Integration**

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

The success factors are:

- Increase in integrated community support services between health and social care
- Reduction in avoidable admissions
- Reduction in delayed transfers of care
- Increase in service user satisfaction levels
- Reduction in admissions to long term care
- Decrease in use of residential settings for intermediate care and rehabilitation
- More effective use of resources through integration of staff roles

- Increase in development of alternative residential rehabilitation models in the independent sector
- Clear leadership and vision
- Increased care closer to home

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

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

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

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

**Accelerating Discharge**
Services will be redesigned to support ‘transfer to assess’ ensuring timely discharge from acute services to appropriate community or home based services. Health and Social Care will work together to provide good discharge planning and post-discharge support. This includes work around structured discharge planning and early supported discharge to enable people to return home earlier, remain at home in the long-term, and regain their independence.

The success factors are:

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

**Infrastructure, Enablers and Other Developments**

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

The success factors are:

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

Details of the specific schemes being implemented under each theme, along with timescales for delivery, can be found in the attached document 01. In addition to these, CCGs across Nottinghamshire are also working up further schemes to support the BCF outcomes and metrics that are not currently included in the pooled BCF arrangements.

**2. Implications for the acute sector**

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

Nottinghamshire has the following main acute provider hospitals:
Doncaster and Bassetlaw Hospitals NHS Foundation Trust – DBH; operating from two sites within Bassetlaw.
Sherwood Forest Hospitals NHS Foundation Trust - SFH; operating from two sites in Mid Nottinghamshire
Nottingham University Hospitals NHS Trust – NUH; operating from two sites in Nottingham
Nottingham NHS Treatment Centre (Circle); operating from one site in Nottingham

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

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

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

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

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

Clinicians and care professionals have been fully engaged in the design of the new care system and are committed to making the changes effective. In the unlikely event that the impact of the change is not as great as anticipated, the community services will be further enhanced to bring about the required shift of care from secondary care. A number of pilot

schemes are underway that provide an evidence base for future success, and confidence in delivery is enhanced by these results. Further mitigation, should the positive impacts upon acute activity take longer than envisaged, will include a major focus on organisational development and acceleration of the required workforce change. The Health and Wellbeing Board have also committed to supporting the health and social care system in re-aligning public expectations to support the shift away from the acute system as default towards home/community based care wherever feasible, focussing on proactive care, and self –management as the preferred option.

## 3. Governance

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

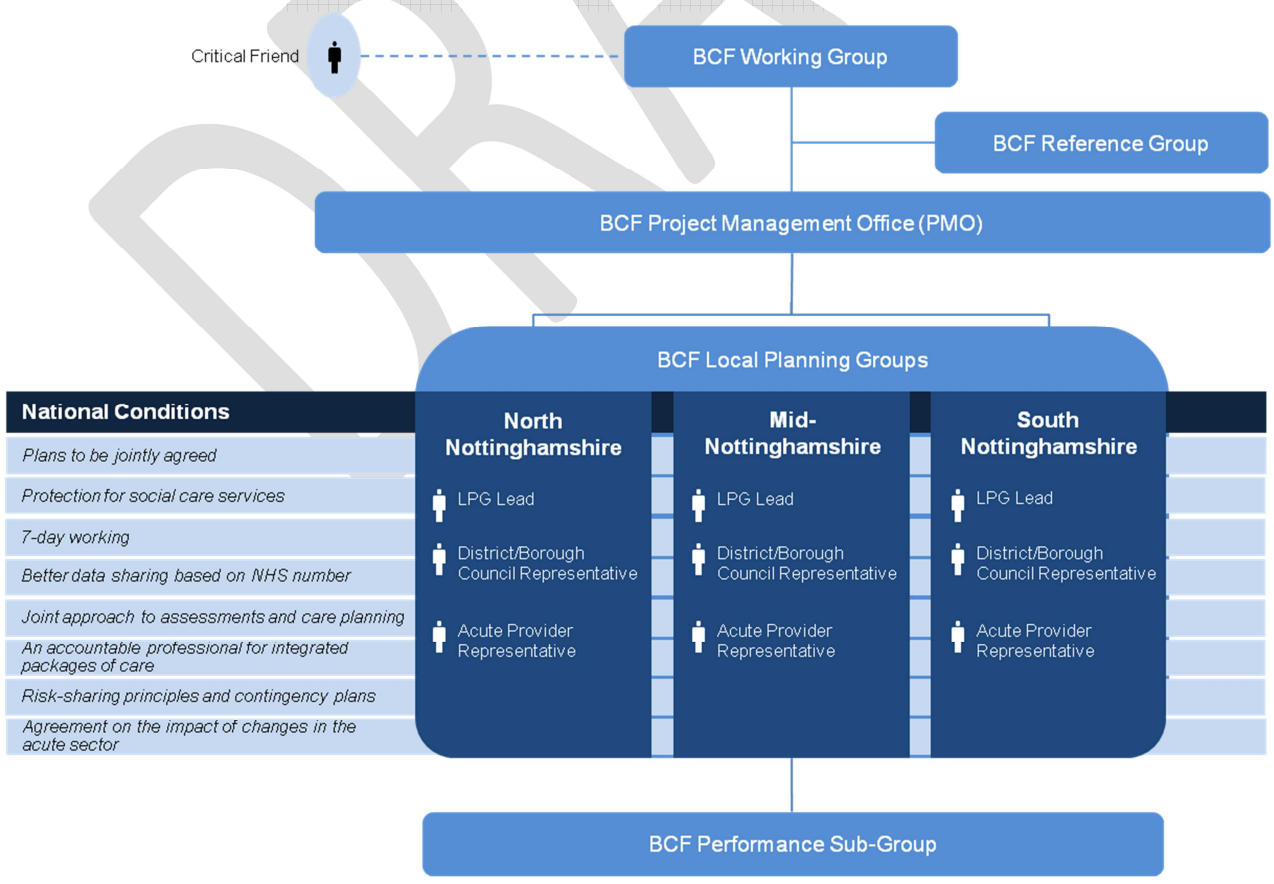
A county-wide BCF Working Group has been mobilised to oversee the development and delivery of a county-wide Nottinghamshire plan for pooled budget(s) under the terms of Better Care Fund. The Working Group is co-chaired by the Chief Executive of Nottinghamshire County Council and a CCG Clinical Chair,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

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

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

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

Our county-wide BCF governance structure is shown below:



# 3) NATIONAL CONDITIONS

**a) Protecting social care services**

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

In Nottinghamshire, eligibility is set at Critical and Substantial.

The Care Bill, which is currently in Parliament, includes national eligibility criteria. The criteria are yet to be finalised but the intention is to set the criteria at a level which will be consistent with Critical and Substantial. Therefore, the criteria are not the substantive issue; rather the challenge is to deliver services which meet the needs of existing and future service users, given the known increases in the number of older and younger adults with increasingly complex needs arising from disability and long term conditions.

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

In the context of the Better Care Fund, our priorities for protecting social care services are:

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

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

**b) 7 day services to support discharge**

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

Nottinghamshire is committed to providing seven day services within its local planning groups, and within the Joint Health and Wellbeing Strategy. Our Health and Wellbeing Strategy is based on three key principles:

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

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

Nottinghamshire currently has a number of seven day services already in place, such as Rapid Response Teams and Intermediate Care Teams, and a number of new services outlined in the BCF plan, such as a 24/7 acute care liaison service, where gaps in provision have been identified. The continuation, and/or expansion of existing services is crucial to delivering the change required. To ensure a consistent approach, a working group has been established to base line activity already taking place within Nottinghamshire, and provide evidence based advice and evaluation of other initiatives and the potential development opportunities. Evaluation findings of local initiatives will be shared amongst Nottinghamshire's planning groups. Local planning groups will be reviewing the findings, and refining plans for their areas as appropriate over the duration of the BCF period.

We are currently undertaking a county-wide exercise to better understand how 7-day services are being rolled out, and our implementation progress. The outputs of this exercise will allow us to map the requirements for meeting this national condition, and timescales for delivery.

**c) Data sharing**

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

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| The NHS Number is currently in use in all NHS organisations and used within them as the primary unique and unambiguous identifier for communication with other providers of healthcare services. Expectations are that during 2014/15 formal agreement and arrangements for this will be put in place and that interim arrangements can be established through the use of portal technologies. |

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

| |
|---|
| The Nottinghamshire Health & Social Care community has established a collaborative programme called Connected Nottinghamshire that will facilitate developments in IM&T and record sharing. The programme will also establish a shared identifier, and at the a recent IT summit event the NHS number was identified as the best way to do this. Expectations are that during 2014/15 formal agreement and arrangements for this will be put in place. It is likely is that some LA systems will not be able to take the NHS Number in the short to medium but through identity management systems (utilised through the use of portal technologies) an interim arrangement can be put in place. |

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

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

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

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

**d) Joint assessment and accountable lead professional**

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

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

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

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

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

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

It is likely that lead accountability for oversight and ownership of the patient's care plan will still sit with a member of the community team in partnership with the GP, who retains formal medical accountability.

# 4) RISKS

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

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

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

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

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

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