NHS
Mansfield and Ashfield
Clinical Commissioning Group

NHS
Newark and Sherwood
Clinical Commissioning Group

Five Year Health and Social Care Strategy

(Incorporating Everyone Counts: Planning for Patients 2014/15-2018/19)

June 2014

Helping to shape future health and social care in Mid Nottinghamshire

better+together

Foreword

We have a bold vision for health and care services for the next five years, based on our population needs and public feedback about current services.

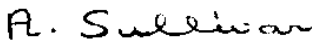
Whole system integration of hospital, community, social and primary care is central to the vision because people tell us that services are currently too fragmented and difficult to navigate. We are moving from a model of predominantly reactive care to one of proactive care, eliminating hospital admissions as a default for people who are not acutely unwell but need help and support. Delays that do not confer added value will be reduced significantly by changing the way that people work in partnership on a day-to-day basis and by removing process barriers to cross-system working. Planned care will be delivered in a more effective and sustainable way, reducing administrative complexity for professionals and patients, whilst reinvigorating working relationships and dialogue between primary and secondary care clinicians.

Put simply, services will change in the following ways:

Mid-Nottinghamshire health and social care roadmap for the next 5-10 years	
Long-term conditions (proactive care)	Scale up and expand integrated health and social care community services (known as the PRISM programme) to make frail and elderly care more proactive and community-based
Urgent care	Provide an integrated urgent care service that that patients receive the right care in the right place from the right professional – integrate GP and A&E / MIU services and develop a care navigation service to ensure people get to the right service in hospital or community settings
Elective care	Review each specialty to ensure that safety and viability standards are met – use existing capacity more effectively
Women and children	Provide rapid medical assessments for children and pregnant women. Ensure that children with complex needs have joined up packages of care and more support in community settings

Our vision and strategy for health and social care services across Mid-Nottinghamshire has been carefully developed over the last eighteen months. A number of organisations came together to undertake a comprehensive baseline analysis of health and social care spend and to develop a blueprint for services. A governance structure and programme team was established under the auspices of the **Better Together Programme**.

Solutions for system transformation and sustainability have been developed by a wide range of clinical and care professionals, with management support. Once the blueprint had been defined, membership of the Better Together Programme Board was extended to include Nottingham University Hospitals. East Midlands Ambulance Service contributed to development of the blueprint and is also now an active member of the Board. The initial baseline and diagnostic phase has been followed by a six month period of deliberative engagement and detailed design. Transformational change interventions have now been defined in detail within detailed service proposals. These documents will form the basis of commissioning outcome specifications. Some initiatives are currently being implemented as part of 2014/15 contract agreements. There is public, provider and political support for the proposed changes. We will continue to work within our local system to commission and implement the changes. We commend the strategy to you.



Judy Jones	Mark Jefford	Amanda Sullivan
Mansfield and Ashfield CCG	Newark and Sherwood CCG	Newark and Sherwood / Mansfield
Clinical Chair	Clinical Chair	and Ashfield CCGs, Chief Officer

1

OUR VISION

We will have joined up, sustainable and high quality services across health and social care. People will remain at home whenever possible, supported by a team of people who are working together to meet their need- shifting the focus from the needs or processes of their organisations. Services will be proactive and fleet of foot. People will be supported to develop the confidence and skills to be as independent as possible.

2

System Objective One

15.1% reduction in A&E attendances

System Objective Two

19.5% reduction in non-elective acute admissions

System Objective Three

30.5% reduction in acute bed days

System Objective Four

25% reduction in admissions to nursing and residential homes

System Objective Five

9.8% reduction in secondary care elective referrals

System Objective Six

20% reduction in paediatric admissions to hospital

4

Delivered through:

- Development of a self-care hub to provide information and knowledge for people with long-term conditions
- Improved access to primary care
- Enhanced community services, based on PRISM model for integrated care teams
- Enhanced intermediate care
- Care and crisis navigation (incorporating a care navigator and crisis response teams)
- Integration of acute and community urgent care services (single front door, linking specialist intermediate care team with single front door, enhanced discharge process)

Delivered through:

- Development of a referral management system to implement best practice across specialties
- Specialty reviews and development of streamlined pathways

Delivered through:

- Development of a short-stay paediatric assessment unit
- Consultant telephone advice for GPs
- Enhanced referral management process
- Implementation of integrated care for complex needs

5

Overseen through the following governance arrangements

- Better Together Programme Board (strategic partnership board for health and social care)
- PMO to oversee work stream delivery
- Expert groups for each intervention areas
- External advice and critical friend
- Governance reporting structure and enabling work streams

3

Measured using the following success criteria

- All organisations within the health economy report a financial surplus in 18/19
- Delivery of the system objectives
- No provider or commissioner under enhanced regulatory scrutiny due to performance or quality concerns
- Best value and high quality services for our population

6

System values and principles

- Work collaboratively in the interests of population health needs, focussing at system not organisational level
- Prevent illness or crises where possible and transfer resources to support this
- Shift care into closer-to-home / better value care settings where appropriate

Section Two | Key lines of enquiry (KLOE)

Segment	Key Line of Enquiry	Organisation response	Supported by:
Submission details	Which organisation(s) are completing this submission?	Mansfield and Ashfield CCG Newark and Sherwood CCG Planning footprint: Population size c.311,000. Substantive catchment for Sherwood Forest Hospitals NHS Foundation Trust	*The plan is aligned with our key providers and Nottinghamshire County Council*
	In case of enquiry, please provide a contact name and contact details	Lucy Dadge Director of Transformation lucy.dadge@mansfieldandashfieldccg.nhs.uk Tel: 01623 673140 Amanda Sullivan Chief Officer Amanda.sullivan@newarkandsherwoodccg.nhs.uk Tel: 01623 673232	
a) System vision	What is the vision for the system in five years' time?	We will have joined up, sustainable and high quality services across health and social care. People will remain at home whenever possible, supported by a team of people who are working together to meet their needs – shifting the focus from the needs or processes of their organisations. Services will be proactive and fleet of foot. People will be supported to develop the confidence and skills to be as independent as possible. Whole system integration of hospital, community, social and primary care is central to our vision because people tell us that services are currently too fragmented and difficult to navigate. We are moving from a model of predominantly reactive care to one of proactive care and self-care, eliminating hospital admissions as a default for people who are not acutely unwell but who need help and support. Delays that do not confer added value will be reduced significantly by changing the way that people work in partnership on a day-to-day basis and by removing process barriers to cross-system working. Planned care will be delivered in a more effective and sustainable way, reducing administrative complexity for professionals and patients and reinvigorating working relationships and dialogue between primary and secondary care clinicians.	*The plan on a page*

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		Assistive technology and shared records are being developed to support achievement of the vision. This vision is in keeping with the national policy direction and NHS England planning guidance. We have also developed primary care strategies for each CCG, in line with our NHS England Area Team. These are fully aligned with the Better Together Programme and express the changes that will take place within primary care to support achievement of the overall system vision. Our approach to delivering some of the national NHS planning fundamentals is described below (additional fundamentals are covered in the main body of the plan): <u>Outcomes</u> Our service proposals have been mapped against the NHS Outcomes Framework, in order to ensure that they will have an impact on core outcomes. This was part of the quality assurance process for our plans. We will also ensure parity of esteem for mental health services in a number of ways. First, we have included mental health practitioners within our physical health integrated community teams. This enables psychological aspects of long-term conditions management to become an integral part of care management. Additionally, we are incentivising our mental health provider to increase physical health checks for people with enduring mental illness. Resource allocation will be based on population needs. <u>Patient services</u> Our plans are in line with national strategy regarding urgent and emergency care. We have agreed an approach to designation of facilities with our local acute provider and will work closely with them during 2014/15 as more guidance on designation criteria becomes available.	*CCG Primary Care Strategies*

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		We are working through a process to determine our Commissioner Requested Services and Site Specific Services. We will continue to work closely with Monitor, NHS England, the public and providers in the coming months in light of the challenges we have regarding acute provider sustainability. Final designation of services will be determined following public engagement and in conjunction with stakeholders. We have strong links with the Academic Health Sciences Network (AHSN). The Chief Officer has been invited to represent Nottinghamshire on the East Midlands AHSN Engagement and Scrutiny Committee, alongside the Chief Executive of Nottinghamshire Healthcare Trust. One of our directors has also been very involved in the establishment of the AHSN. We have included the developing role of the AHSN within Governing Body development sessions and also maintain links with our local Collaboration for Leadership in Applied Health Research and Care (CLAHRC). We have had input into proposed research projects to ensure that they are in line with our strategic plans and that they are likely to be applied in practice. We also work closely with local clinicians and member practices to foster innovation from the front line. Our service proposals were generated in this way. The development of our local primary care strategies has also enabled significant involvement of member practices. Both CCGs have Clinical Advisors who are able to lead the development of innovation. Newark and Sherwood CCG is the coordinating commissioner for primary care research management and governance. As such, we work closely with the Mental Health Research Institute, which hosts this function on our behalf. <u>Access</u> Our plans and trajectories comply with the NHS Constitution. We have undertaken further refinement of our activity plans to ensure that referral to treatment times (RTT)	

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		requirements are met for our population. We have introduced an elective referral gateway in Newark and Sherwood and this will be rolled out in Mansfield and Ashfield. The gateway staffs enable detailed conversations with patients about their preferences and help to ensure that appointment times / travel is as convenient as possible. Our development of community services, home-based monitoring and community outreach will help to improve access to services. We will also undertake a review of GP access and action planning to address gaps in 2014/15. <u>Quality</u> We are working closely with the local authority to implement recommendations from the investigation concerning Winterbourne View. Although there are some challenges associated with the development of new types of supportive community provision, we continue to work with providers to expedite patient moves out of hospital settings and are on track to meet national timescales. Our next phase of work will be to review the whole pathway to ensure that people are not admitted to hospital settings inappropriately and that they are able to step down as appropriate to their needs. Newark and Sherwood CCG coordinates this work on behalf of the county CCGs. Since publication of the Francis and Berwick Reports, we have refined our quality monitoring arrangements to include more emphasis on safety culture and patient experience. These reports now drive our quality assessment visits and members of the public are part of the assessment process. In addition to on-going quality monitoring, we now have quarterly reviews on progress with our providers. We will continue to refine this over the coming months. In future, a representative from MIND will join these visits on an annual basis, with a particular focus on vulnerable adults. Compassion is tested as part of this process, mainly through observing practice and talking to patients and carers. We have also ensured that quality contract schedules reflect key findings and that	

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		providers are held to account for their implementation of the recommendations. Sherwood Forest Hospitals was part of the Keogh Reviews and this has given us a structured action plan to improve quality. We continue to monitor progress against the actions that remain partially assured and await the outcome of the recent CQC hospital inspection. In primary care, we have formally extended our process for practices to share quality concerns to the practice nurses. A protected learning time event for the nurses was recently held in relation to Francis and Berwick. We monitor staff satisfaction through national and local survey results. The CCGs have appointed governors for the acute, community and mental health trusts so we are able to gather intelligence from staff governors through that route. Increasingly, our visits to providers provide a rich source of intelligence since these provide an opportunity to speak to members of staff. We will continue to use a self-assessment framework to monitor safeguarding arrangements across the system. This also provides assurance to the local safeguarding boards. Our GPs have annual Prevent and Mental Capacity Act training, through our protected learning time programmes. <u>Seven day services</u> We are approaching this in a number of ways. National requirements within hospitals will be introduced as part of the 2014/15 contract, although we will continue to build on this in future years. In primary care, our plans are incorporated within our strategies. We are able to pump prime developments using our allocation of the Prime Minister's Primary Care Challenge Fund. Initial actions are to integrate GP out-of-hours and urgent care services to improve access. GPs will work within the Minor Injuries Unit at Newark Hospital. Primary Care 24 will also work in a more integrated way with the Emergency Department on the Kings Mill Site. It is likely that sustainable seven day	

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		access in primary care will be delivered through federated working arrangements. We are also increasing capacity within our integrated community teams to ensure that a seven day service can be offered as required. In 2014/15, we will trial different models of provision to determine where capacity is most needed. Our Urgent Care Working Group (System Resilience Group) will be instrumental in determining where additional capacity and capability is required for emergency patient flows. <u>Delivering value</u> Our service plans are designed to achieve best possible quality and value within available resources. Each CCG also has detailed quality, innovation, productivity and prevention (QIPP) plans that will enable local delivery of blueprint schemes in 2014/15 and beyond. Our plans meet CCG business rules on financial planning, including surplus, contingency and non-recurrent expenditure. QIPP schemes all help to deliver a more sustainable local system and are transformational. We are beginning to look more widely across sectors to incorporate more holistic strategies that increase value for money. Our strategic partnerships with our three district councils will be further developed, in order to better understand how housing impacts on health and urgent care demand. The inclusion of the Disabled Facilities Grant in the Better Care Fund provides an opportunity to consider how accommodation could support care outside of an acute hospital setting.	
	How does the vision include the six characteristics of a high quality and sustainable system	We have worked collaboratively over the last year to design a more sustainable system, with high quality embedded within our service transformation schemes. We have established care design groups, with clinicians, care professionals and citizens leading the development of solutions for a sustainable system. Care design groups were established for:	*Details provided within the activity and financial templates which have been*

Segment	Key Line of Enquiry	Organisation response	Supported by:
	and transformational service models highlighted in the guidance? Specifically: 1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care 2. Wider primary care, provided at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. A step-change in the productivity of elective care 6. Specialised	• Proactive care (long-term conditions management) • Reactive care (urgent care) • Elective care • Women and children When we embarked on the detailed design phase, the extent of interdependencies between proactive and urgent care became very clear. A new integrated system, combining both of these has been developed and is described in detail in service proposal documents. **1. <u>(A) Citizen inclusion in all aspects of service design and change</u>** Both CCGs have well established engagement mechanisms into our local communities and with our PPGs. We commission a local CVS to facilitate engagement and dialogue with communities. A Mid-Nottinghamshire Citizen's Board has also been established, to provide public input and oversight of proposals as they developed. This is supported by a Communications and Engagement work stream and lead officer. We have commissioned extra capacity from our Commissioning Support Unit to ensure appropriate citizen involvement in our work and to ensure that implementation is informed by public opinion. The work stream is now focussing more on staff engagement to support implementation. A dialogue with the public and stakeholders will be maintained as implementation plans are developed and enacted. It may be necessary to undertake formal consultation as specific plans for service locations develop. We maintain a dialogue with our Health Scrutiny Committee and Health and Wellbeing Board. We submitted our proposals for an NCAT assessment in January. We have undertaken a	*triangulated.* *Detailed proposals:* • *Overarching proposal for system change* • *Proactive and urgent care* • *Elective referral management* • *Elective specialty reviews*

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	services concentrated in centres of excellence (as relevant to the locality)	Gateway 0 Review assurance process and have shared the report with key stakeholders. An action plan has been developed and agreed. We are on track to deliver the action plan ahead of our next Gateway Review, likely to be in the autumn. **(B) Empowering people to be partners in their care** A Self Care Hub will be developed to educate patients about their conditions and give them the knowledge, power and confidence to play a key role in the planning of their own care. The hub will take on responsibility for the co-ordination and delivery of both existing and additional education programmes for patients with Long Term Conditions. The hub will work closely with virtual ward teams, as patients either in intermediate or proactive care are likely to benefit most from self-care. Virtual ward teams include a volunteer coordinator who is able to help mobilise relevant support mechanisms. We are also rolling out an assistive technology programme, whereby patients can use a texting service (Flo) to monitor their condition and to retain more freedom and independence. This is received very favourably by patients and professionals alike and will be scaled up to become an established element of long-term conditions management. **2. Wider primary care provided at scale** Primary care will be integrated with community health and social care teams to enhance proactive care management and crisis management (PRISM scheme, profiling risk, integrated care, self-care). This way of working has already been implemented in Newark and Sherwood CCG and is already showing an impact on admission rates. GP practices risk-stratify patients, using the Devon tool and then have multi-professional team meetings with virtual ward teams. This potentiates the impact of primary and community services through joint working. This way of working is also being rolled out in Mansfield and Ashfield in 2014/15 and will form the foundation for further integration of services.	

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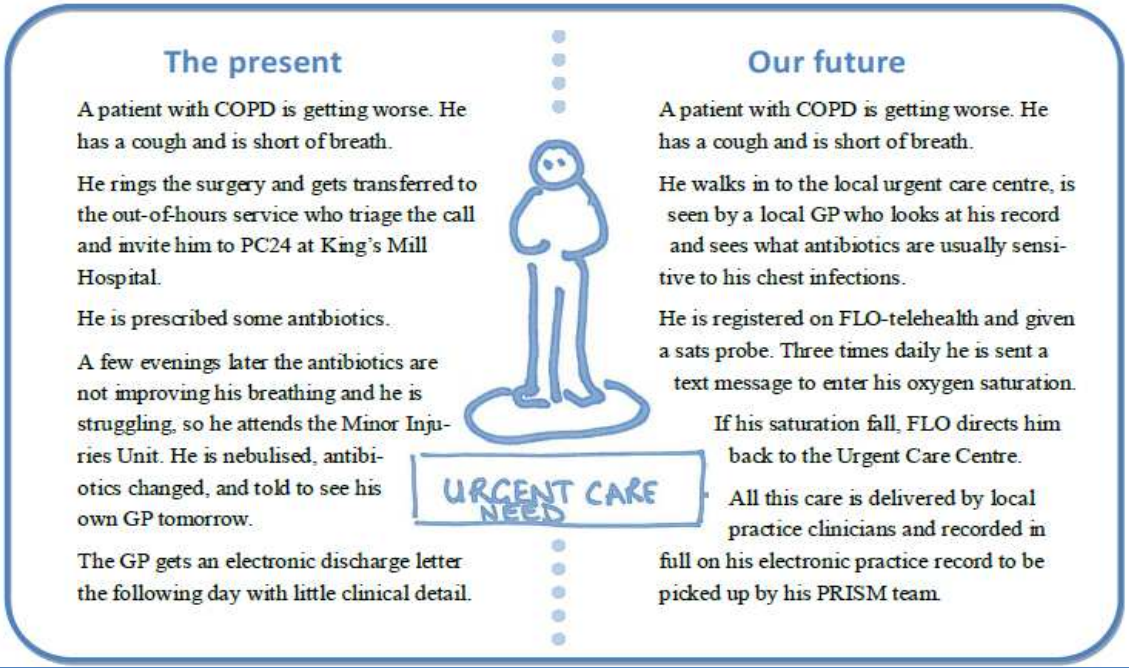
		We have engaged with our population and practices to develop primary care strategies. Priorities include: • Integration of out-of-hours and urgent care services at our ED and MIU, creating an integrated urgent care hub that simplifies access to urgent care; • development of 7-day working hubs for primary care; • review of existing access to primary care across all 46 practices and the development of plans to bridge those gaps; • faster diagnosis and treatment; • more care closer to home; • workforce planning. The combined impact of these changes is reflected in the vignette below:  	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		We recognise the critical role that primary care has in developing services outside of hospital. We will work with partners to develop payment mechanisms for primary care that recognise and reward additional care provided outside of hospital settings. We will also submit an expression of interest to co-commission primary care with our NHS England Area Team. We will explore how shared decision making could be governed and executed in a manner that manages GP conflicts of interest appropriately. **3. <u>Modern model of integrated care</u>** We have adopted a model of integration that makes a person's journey through the system of care is made as simple as possible: "*Care, which imposes the patient's perspective as the organising principle of service delivery and makes redundant old supply-driven models of care provision. Integrated care enables health and social care provision that is flexible, personalised, and seamless." (Lloyd and Wait, 2005)* The system blueprint was developed in a manner that focussed on what our population will need in the next 5-10 years and we designed new services in a provider-agnostic way. Our thinking has not been constrained by current organisational form or payment / contract mechanisms. We believe that form follows function. We defined a set of principles for integration as follows: • Integrated care must focus on those patients for whom current care provision is disjointed and fragmented, mainly complex patients with co-morbidities. • Effective system leadership must exist, to promote changes in clinical behaviour. • The interaction between generalist and specialist clinicians must promote real clinical integration. • There must be integrated information systems that allow the patient's journey to be mapped across a care pathway at any moment in time.	

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		• Financial and non-financial incentives must be aligned to provide the conditions to ensure that care delivery is of high quality and cost-effective. The approach and principles have been built into all of our transformation schemes and are reflected each intervention. It is noteworthy that a key element of integration will be the way in which health and social care come together to jointly commission new ways of working. A core principle is to achieve best outcomes and best value within existing resources. We recognise that this will mean increased co-design of services to meet people's social and health needs in a joined up way. **4. <u>Access to the highest quality urgent and emergency care</u>** We have designed an integrated system for urgent and proactive care, based upon national policy direction and public feedback about current services. We are planning for tomorrow, but also have robust mechanisms in place to operationally and tactically manage current pressures. Our Urgent Care Working Group is coterminous with our strategic planning footprint. We have also incorporated winter planning within our urgent care networks. We are now developing a System Resilience Group in line with national guidance. It will drive urgent and elective care performance overall. Some Better Together initiatives have been agreed in provider contracts for 2014/15, in order to lay foundations for the reformed system. The impact of these is closely monitored through a joint monitoring group, alongside current performance. Each scheme has been designed to help improve Emergency Department performance, but full impact will be cumulative, as additional parts of the system outside of hospital become fully functional. We have mapped our service provision against a number of recent national publications and policies. The new model is built on three main considerations: safety, patient experience and flow and efficiency. All elements of the service have been assessed in terms of current provision and future requirements have been modelled.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		Self-care and primary care developments have already been described. Additional interventions are as follows: **i) Enhanced Community Services** <u>Proactive care</u> Proactive care is currently being delivered within the PRISM model in Newark and Sherwood. It is based upon the concept of providing preventative treatment to patients deemed to be at high risk of future admission. These patients are identified via a risk stratification process (the Devon Tool) and then a course of action is determined following a case review by the wider multi-disciplinary team. This proposal scales the system across Mansfield and Ashfield. <u>Enhanced Intermediate Care</u> The new intermediate care model will focus on increasing the number of patients treated at home rather than in a bedded facility. The capacity and capability of home based intermediate care will be significantly increased to enable this. Patients who currently need to be treated in hospital will be able to be treated at home. Patients receiving the most intense level of care can expect to receive up to four visits per day and have access to night sitting and telehealth services. **ii) Care and crisis navigation** <u>Care Navigator</u> Care Navigation is essential within the design to enable the component parts in the system to achieve more than the sum of their individual parts. The Care Navigator will be a seven day service that health and social care professionals can call when a patient presents with an urgent care need. The Care Navigator will help to identify and arrange community alternatives to hospital admission or support a discharge from hospital or care home. GPs will be encouraged to use the service for all unplanned hospital	

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		admissions with the exception of patients with clear life threatening conditions and children. <u>Crisis Response Team</u> The crisis response service will operate 24/7 and provide intense and focused health and social care (including personal care) to assist people through a worsening crisis to remain living in their own home and maintain independent living skills. The crisis response staff will be unqualified but trained staff who will work closely with community teams who will provide clinical back up. The key elements are a rapid response to the individual's home, a thorough assessment and an integrated care package allowing for short term results and a long term solution. **iii) Integrating acute and community services** <u>Specialist Intermediate Care Service</u> Specialist Intermediate Care Teams (SICT) will provide a multi-disciplinary health and social care service, whose aim is to bridge the current gap between the acute and community services. Linking these services together will facilitate effective admissions avoidance, reduce delays in discharge and enable more effective patient flows through the system. <u>Single Front Door</u> At King's Mill there are currently separate doors for A&E and Primary Care 24 (PC24). This will be changed so that all patients enter through a single front door and book in at one front desk. This will remove patient confusion around whether their medical needs are best met by primary or secondary care. Nurses, ENPs and ANPs supported by a GP will undertake clinical triage to identify the level of patient need and a 'see and treat' model will be in place so that where possible a patient's needs can be met during this initial contact.	

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		<u>Discharge function</u> The Specialist Intermediate Care Team will liaise with Single Front Door staff to identify patients who are being admitted and are likely to required community based services upon discharge. From the moment these patients are admitted this team will take responsibility for overseeing, coordinating and supporting timely discharge. They will achieve this by working closely with community based services to ensure that they are ready to receive the patient as soon as their need to be in hospital has expired. **iv) Communicating effectively with the public** A social marketing approach will be implemented alongside existing communication channels to educate specific parts of the population around how to choose the most appropriate health service for their need and deliver sustainable behavioural change. It will work with discreet segments of the population to understand their current use of urgent care services and remove barriers to access where necessary. When aggregated together, these interventions create a strategically different model of care, with a greater proportion of care provided out of acute hospital settings, with care professionals working across organisational and professional boundaries to deliver radically improved outcomes for citizens and patients. The inter-relationship between services and a schematic of the new system is shown below:	

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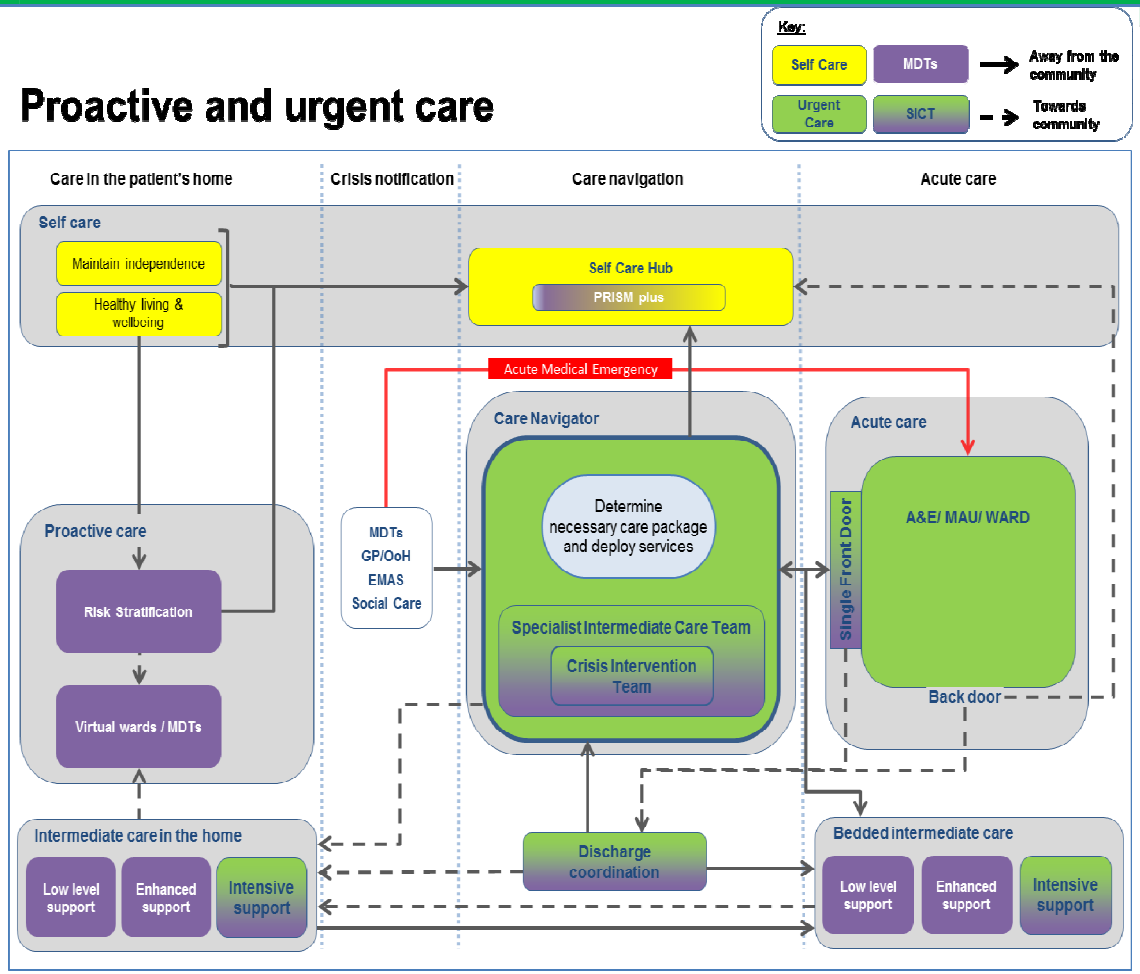

Cumulative impact of changes of the integrated proactive and urgent care system:

A&E attendances	-15.1%
A&E admissions	-19.5%

Segment	Key Line of Enquiry	Organisation response	Supported by:
		5. <u>Step-change in the productivity of elective care</u> We have developed plans to achieve greater efficiency in two main ways: • Development of a referral management system that will systematise best practice in referrals and reinvigorate clinical relationships across primary and secondary care. • Specialty reviews to develop more effective pathways for each area (tranche 1 complete, tranche 2 and Newark Hospital surgical review currently underway). The new referral management system will have the following features: • **Peer to Peer review –** within each GP practice, a peer review of referrals as deemed necessary by each GP. Helps to reduce inappropriate referrals early on. • **Standard referral template and guidelines –** specialty-specific guidelines, easily available on the computer to provide a point of reference before a GP refers a patient. Plus, a pre-populated, standard referral template to aid both GPs and acute clinicians. • **Clinical partnership** o **a.Gateway administration** – processing and checking function ensure quick and correct referrals are made. A key stage in providing shared decision-making for patients who are contacted and given choice on their treatment provider. The Gateway provider will use a comprehensive Directory of Services, updated regularly by service providers, with support from CCGs. o **b.Consultant triage –** review of all referrals (at first) by a specialist consultant to help reduce the numbers of inappropriate referrals coming into outpatient clinics • **Two-way training and development –** a core element, back and forth sessions and dialogue between clinicians to share best practice and learn to improve the referral pathway.	

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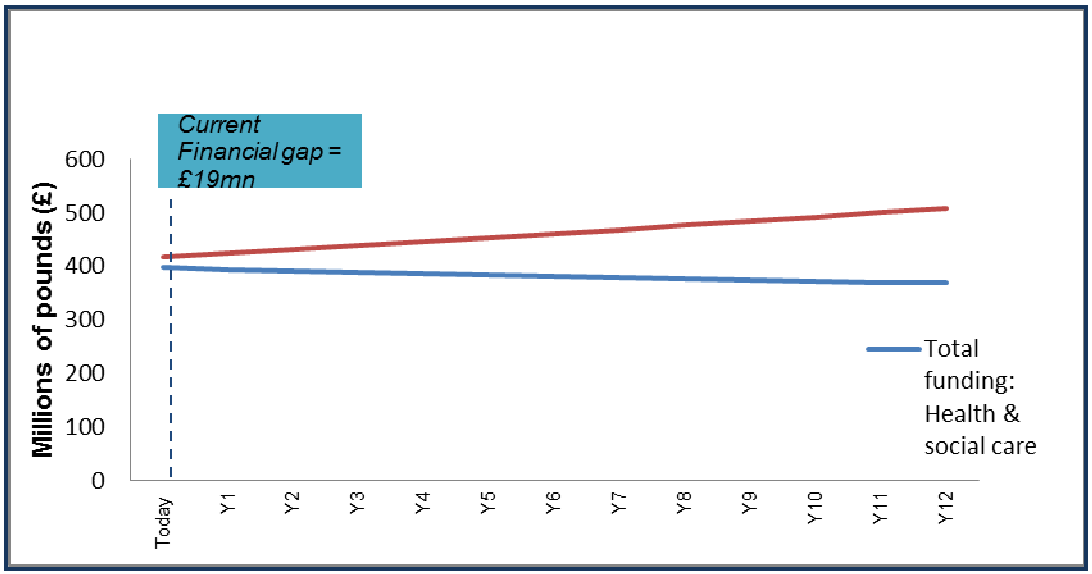
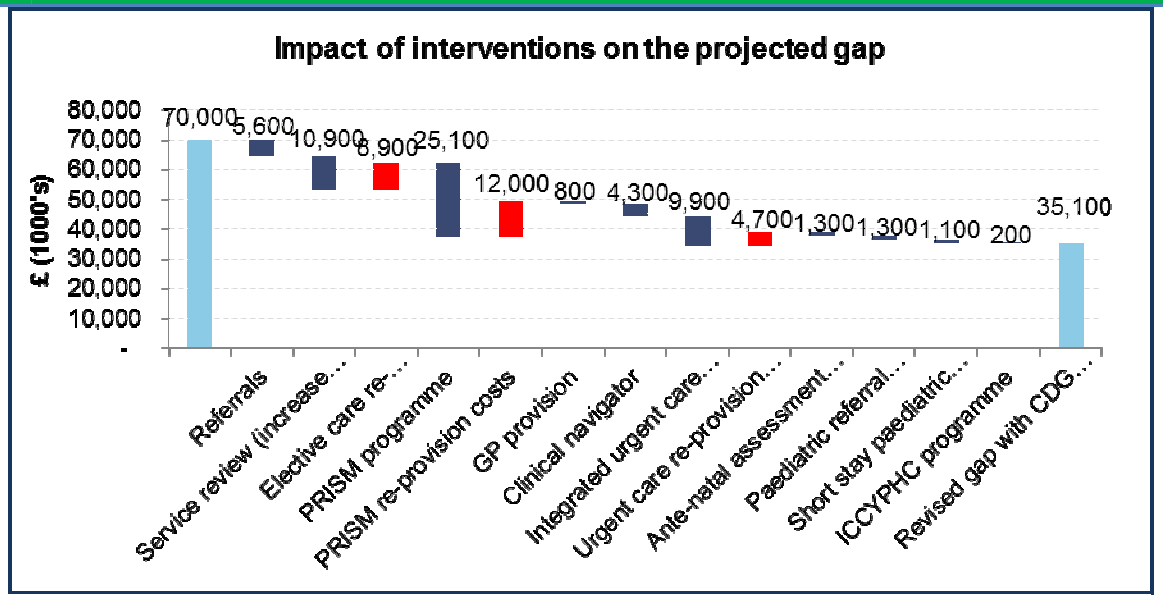
		Specialty reviews have been conducted for tranche 1 specialties. A methodology was developed to consider a number of quality and financial indicators (shown in detail in the service proposals). Key interventions are shown below:	

Specialty	Intervention
Rheumatology	DMARD monitoring in primary care
Orthopaedics	Seven day discharge
Gynaecology	Community delivery
	Gynaecology Ambulatory Unit
	One stop clinics
ENT	One stop clinics
Urology	Community clinics
	One stop clinics
	Green Light Laser
Cardiology	Direct access
Pain Management	None
Podiatric Surgery	None
Respiratory	None
Geriatric	None
Ophthalmology	Stable wet AMD
	Nurse-led injections
	Resource investment
	One stop cataract clinics

Tranche 2 specialty reviews are underway and these will be completed by April 2014.

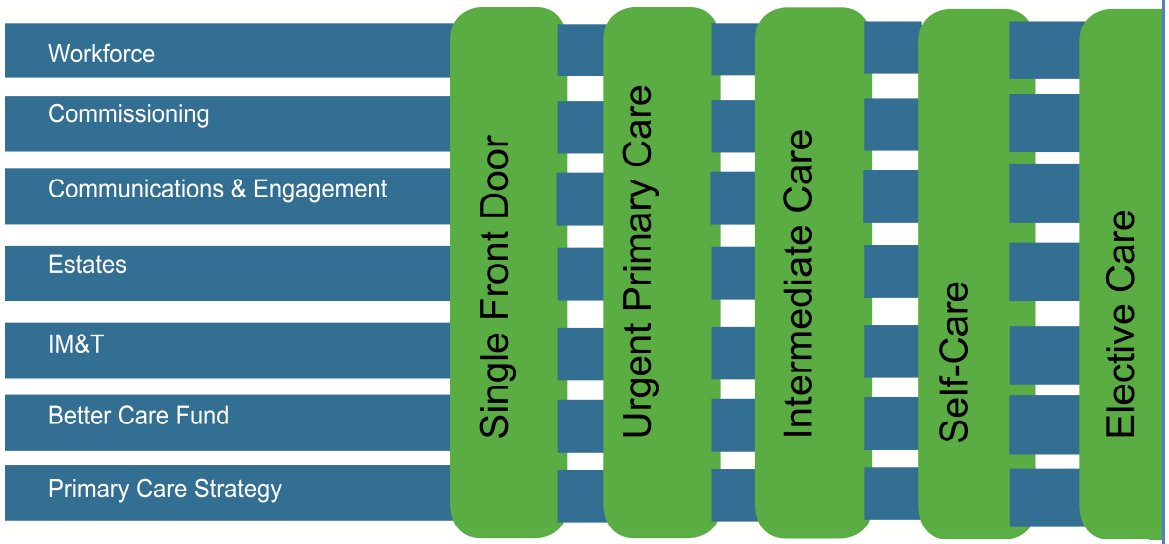
Segment	Key Line of Enquiry	Organisation response	Supported by:
		6. <u>Specialised services concentrated in centres of excellence</u> The CCGs have already implemented changes that resulted in the concentration of services in main centres. These include the re-designation of Newark Hospital Accident and Emergency to a Minor Injuries Unit and Urgent Care Centre. Vascular surgery has also moved to Nottingham University Hospitals, which is a large teaching trust. We will use the tranche 2 elective specialty review to consider specialties that appear to have low volumes or problems with quality and sustainability. Most complex surgery has now ceased at Newark Hospital and a review is currently underway to determine the future of joint replacement surgery. Partnership working with Nottingham University Hospitals is developing, so that clinical networks can be developed to support quality and sustainability. Joint working has been established within the stroke team and consultants work across both sites. Additional horizontal integration and joint working on areas such as procurement will be developed in 2014.	
	How does the five year vision address the following aims: a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven	**A. <u>Delivering a sustainable NHS for future generations</u>** CCG and adult social care costs of provision have been mapped, in order to provide a baseline for sustainability planning. Currently, all organisations are in balance except for Sherwood Forest Hospitals NHS Foundation Trust, which has required Public Dividend Capital to support liquidity in 2013/14 and 2014/15. The trust is in special measures and has a regulatory requirement to produce an improvement plan that shows financial sustainability in 5 years. Our County Council is also facing significant budget challenges, so our plans have taken into account the impact of social care spend and services as well as health. Assuming that there is no available subsidy for excess PFI costs within the acute trust,	*Mid-Nottinghamshire Blueprint for a Safe and Sustainable Health and Social Care Economy for Mid-Nottinghamshire* *Review of*

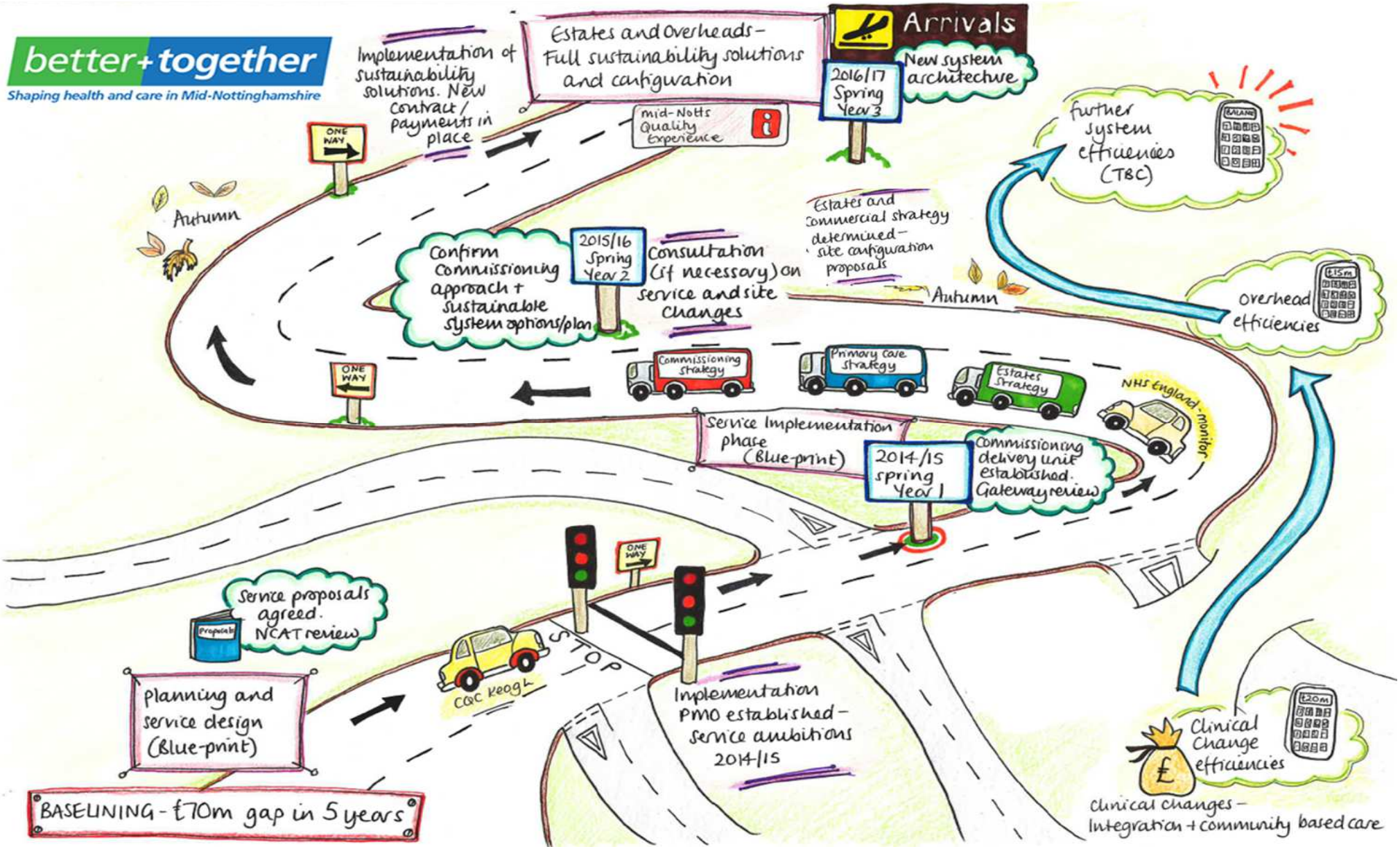
Segment	Key Line of Enquiry	Organisation response	Supported by:
	ambitions c) Reducing health inequalities?	our financial gap as a health and social care system will be approximately £70 million within 5 years. This assumes that no changes are made to the way we provide services and that population growth is in line with forecasts.  The transformation interventions that are identified in the blueprint are estimated to deliver £35 million of recurrent savings to the cost of provision within 5 years (assuming full cost release as activity changes). Detailed proposals describe how the benefits of the clinical changes will be achieved over the next 2-5 years.	*Mortality across Mid-Nottinghamshire Clinical Commissioning Groups, 2007-2012* *Improving quality and efficiency: alignment of plans across organisations, Briefing for Mid-Nottinghamshire Integrated Care Programme Board, January 2014*

Segment	Key Line of Enquiry	Organisation response	Supported by:
		 This impact has been analysed by provider sector, so that the impact on acute, community and primary care services can be determined. Financial implications over the next five years have been shared with our main providers, in order to help them plan for the future. For instance, additional community staffs are currently being recruited to support the roll out of PRISM in Mansfield and Ashfield. A risk assessment has been conducted in relation to each of the interventions and incorporated into the proposals. Sensitivity analyses have also been undertaken. System-wide risks and opportunities regarding areas such as workforce and estates are described in more detail in the overarching case. Clinical assumptions have been validated through detailed design work, but there is still further work to do with regards overhead costs, such as use of estates. The proposals have also been reviewed by the National Clinical Advisory Service	*NCAT Report*

Segment	Key Line of Enquiry	Organisation response	Supported by:
		(NCAT). The proposals were supported, with the following conclusion: *'...the present plans largely follow the directions of travel of NHS England policy to provide more services within the community and home. There is a strong emphasis on proactive care and integrated care. This can be strongly commended. Cost benefit realisations may be over emphasised but there is still the potential here to do some really ground-breaking work on breaking down care barriers, interdisciplinary and professional working. When the time comes capacity planning, workforce development and operational plans will be required.* *The ICTP programme (former name for Better Together Programme) can be commended. Whilst concerns and caveats are expressed as above, it is predicted that there should be no clinical concerns or governance issues resulting from the new reconfigured service. NCAT can support the current proposals.'* The Programme Board is actively developing plans for the second £35 million that is required for full system sustainability. Additional savings opportunities that have not been incorporated within this analysis are: • Provider cost improvement programmes; • opportunities for horizontal integration outside of the Mid-Nottinghamshire area; • development of an estates and commercial strategy; • further back office efficiencies through service integration and streamlining of teams; • opportunities to generate income through re-use of estate on PFI sites; • potential PFI subsidy (not confirmed); • different payment mechanisms, such as outcomes based capitation and realignment of financial incentives across the system to achieve transformation goals; • opportunities for rationalisation of specialty provision.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		Commissioner and provider efficiency schemes for 2014/15 have been shared across health and social care and mapped to ensure alignment with the blueprint. Programme risks and mitigating actions have been identified across the system. Commissioners and providers are also currently learning from international models of integration to understand incremental benefits from system change and further opportunities for efficiencies. We are aware that there are significant challenges to overall system sustainability, particularly in view of the financial challenges within Sherwood Forest Hospitals. We will continue to work proactively with partners, NHS England and Monitor to ensure that robust transitional plans are developed. Workforce planning and development will play a vital role in system sustainability and transformation. During the first two years of the strategy, rotational opportunities and appointments will be made so that people begin to work across a broader range of settings. Learning Beyond Registration allocations will prioritise integrated working and ways of working that will support achievement of the vision. We will also focus on GP recruitment and retention. A GP taskforce is being established through Health Education East Midlands to develop strategies for this. We do not under-estimate the considerable level of complexity and commitment that this programme of transformational change entails. Planning guidance states that bold and ambitious plans are required in order to achieve sustainable services within the current climate. Our plans are bold, but they are also built on the best available evidence and clinical insights. The clinical case has been validated through detailed design work over six months, but we know that plans will continue to be refined and adapted in the coming months and years. We have developed Programme infrastructures that will deliver service transformation.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		Work streams are shown below:  We are also mindful of the considerable operational pressures that providers already face. Our plan will ameliorate the impact of growing demand on acute services over time. During the transition phase, we will need adequate resource to deliver the required level of change, whilst maintaining a grip on performance and standards of care. The CCGs are structured in a manner that enables transformation for tomorrow as well as management of today. We have resourced a Programme Team, but will keep capacity and capability requirements under review. Now that we have defined the type of care we want to buy, we are considering how best to commission this. Existing contract and payment mechanisms are unlikely to incentivise service integration and care outside of hospital. We have established a Commissioning Delivery Unit with legal and procurement expertise to enable us to commission integrated services and supply chains. We have a roadmap for system change, showing our overall Programme approach:	


better+together
Shaping health and care in Mid-Nottinghamshire
Implementation of sustainability solutions. New contract / payments in place
Estates and Overheads – Full sustainability solutions and configuration
Arrivals
New system architecture
2016/17 Spring Year 3
mid-Notts Quality Experience
ONE WAY
Autumn
Confirm Commissioning approach + Sustainable system options/plan
2015/16 Spring Year 2
Consultation (if necessary) on service and site changes
Estates and commercial strategy determined – site configuration proposals
Autumn
further system efficiencies (TBC)
£15m
overhead efficiencies
Commissioning Strategy
Primary Care Strategy
Estates Strategy
NHS England - monitor
Service Implementation phase (Blue-print)
2014/15 spring Year 1
Commissioning delivery unit established. Gateway review
ONE WAY
Service proposals agreed. NCAT review
Proposals
STOP
CQC Keogh
Planning and service design (Blue-print)
Implementation PMO established – service ambitions 2014/15
£20m
Clinical Change efficiencies
£
Clinical changes – Integration + community based care
BASELINING - £70m gap in 5 years

Segment	Key Line of Enquiry	Organisation response	Supported by:
		B. Improving health outcomes for the seven ambitions **(i) Securing additional years of life for people with treatable mental and physical health conditions** The CCGs commissioned a very comprehensive review of mortality in 2013, in order to better inform commissioning decisions. Both CCG rates of potential years of life lost are in the second highest quintiles for England and there are significant health challenges within these communities. Total deaths across Mid-Nottinghamshire remained virtually unchanged from 2007-2012, at just under 3,000 per year. Deaths have fallen in people under 85 years, but have risen for the over 85s. This indicates longer life expectancy. Fluctuations for different years mirror those seen across the country. Significant progress has been made in a number of areas during the period of the review: • Deaths from heart attacks have reduced by 33%. • Deaths from hospital acquired infections have reduced dramatically. • The re-classification of Newark A&E department has changed the pattern of care but has not had a detrimental impact on mortality for the population of Newark - overall mortality reduced by 6%. Analysis of Category A (blue light) ambulance travel times show no correlation with mortality rates. • Sherwood Forest Hospital deaths have reduced in 2013, so that the trust is no longer an outlier for mortality. The review revealed a number of areas for development and these form the basis of our mortality improvement actions:	

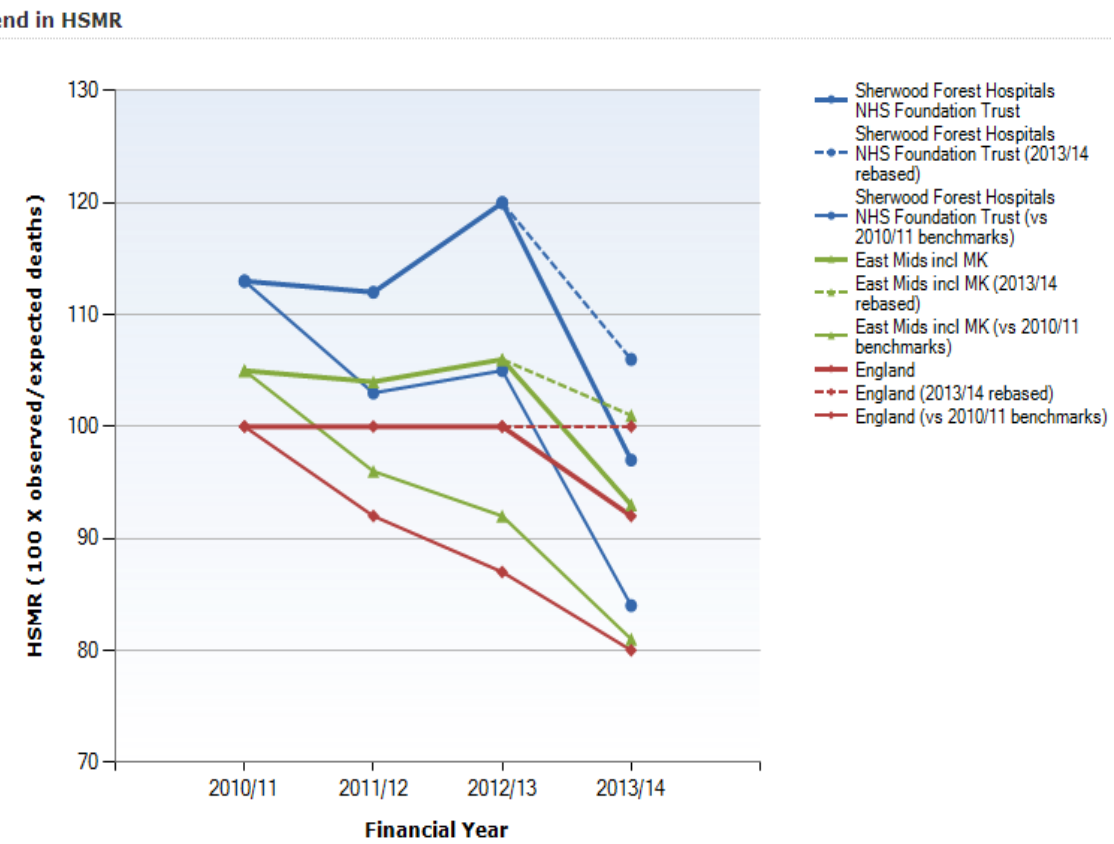
Segment	Key Line of Enquiry	Organisation response	Supported by:
		• Develop better alternatives for people at end of life (a summit was held in late January and an action plan has been developed in light of this). • Investigate cancer care across the whole chain of care from screening and early detection to end of life care, to see where improvements need to be made. Different types of services will be commissioned where required and we have partnered with MacMillan to help us with this work. • Work with local GP practices to understand variations in mortality patterns in different areas and to develop improvement plans. • Conduct reviews of individual cases to gain more insight in to the causes of higher deaths for Sunday hospital admissions and the association between increased ward moves and higher mortality. • Work with the public health department at Nottinghamshire County Council and District Councils to help prevent diseases developing or becoming worse (particularly for smoking, obesity and alcohol). We now have detailed information about mortality at practice level and are working with our practices to understand the implications of the findings in more detail. The NHS Commissioning for Value insight pack also highlighted diabetes as an area for improvement. We have reviewed our model of care and will be developing primary / community care provision to reduce the complications of diabetes. Gastrointestinal disease will also be an area of focus, particularly in relation to alcohol-related harm. **(ii) Improving the health related quality of life for people with one or more long-term condition** This will primarily be achieved through our PRISM programme of integrated care and	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		self-care (described above in relation to primary care and integrated care). The PRISM service has evaluated extremely positively in Newark and Sherwood. There are a few specific benefits to health related quality of life that have emerged: • People feel much more supported because they know that there is a multi-professional team working together to support them • Carers are more involved in decision making • Integration of mental health workers and volunteers into the PRISM team enhances access to IAPT, dementia diagnosis and other support mechanisms The PRISM programme incorporates people with dementia and early identification of this condition. The Devon risk stratification tool will be used systematically in all practices by June 2014, so this will enable more effective identification of vulnerable people. Multidisciplinary team assessments and proactive care management enable better coordination of care for people with dementia and their carers. We will also work closely with our providers to ensure that national CQUIN requirements for dementia are achieved, using the FAIR (find, assess, identify and refer) framework. We have also introduced a CQUIN scheme that incentivises partnership working between mental health professionals and GPs, in the interests of improving physical health. The CCGs have conducted an external review of IAPT uptake and an improvement plan is in place to achieve the target of 15% coverage by March 2015. Referrals from the PRISM team are increasing and this is expected to be a continuing trend. We will specifically target older people and Eastern European communities, since they currently appear to be under-represented in our IAPT referrals. We have also reviewed the quality of referrals, in order to decrease DNA (do not attend) rates. Self-referrals are increasing, following signposting from GPs. This is	

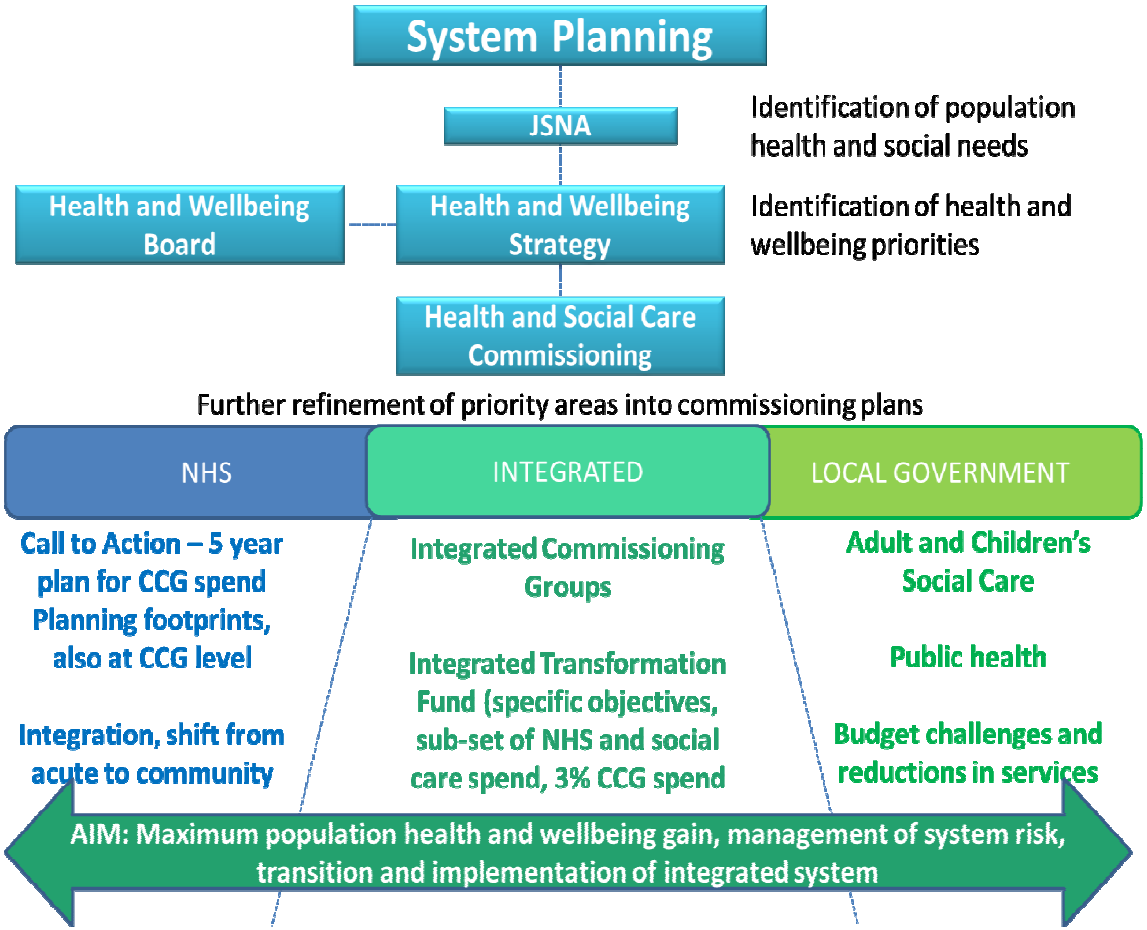
Segment	Key Line of Enquiry	Organisation response	Supported by:
		helpful because people who self-refer are more likely to continue into treatment. We are also working with the provider to increase the productivity of therapists and we have fortnightly reviews with them. **(iii) Reducing the amount of time people spend in hospital through better and more integrated care in the community, outside of hospital** Our PRISM programme is again a key enabler for achievement of this outcome ambition. The proactive and urgent care service proposals describes our approach in detail, as reflected above in the section on urgent care. With our providers, we have developed a number of schemes to increase ambulatory care and more rapid decision making at the front door. Our transformed system includes proactive care in the community, an urgent care hub that integrates primary and secondary care, a care navigator and a strengthened approach to crisis management and discharge. We will also introduce a number of schemes to provide more appropriate support for people with mental illness. We will introduced street triage in partnership with the police in April 2014. We will also signpost relevant 111 calls to a community psychiatric nurse, rather than Accident and Emergency. **(iv) Increasing the proportion of older people living independently at home following discharge from hospital** The following indicators have been developed as part of the Nottinghamshire Better Care Fund to support this. o Admissions to residential and nursing care: Permanent admissions of older	

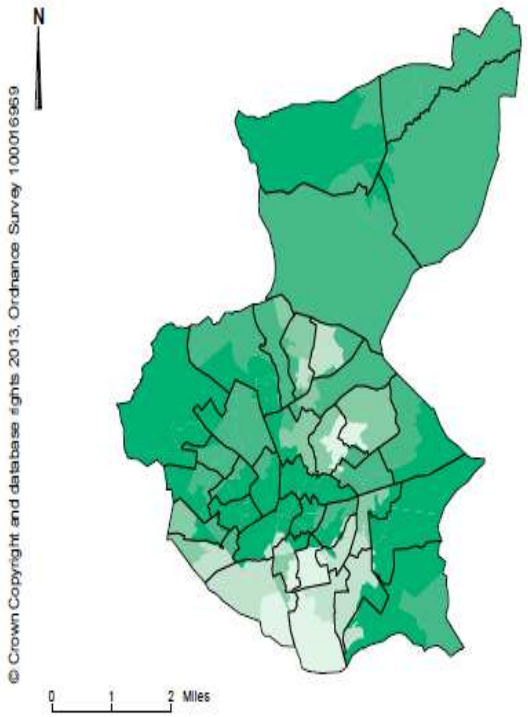
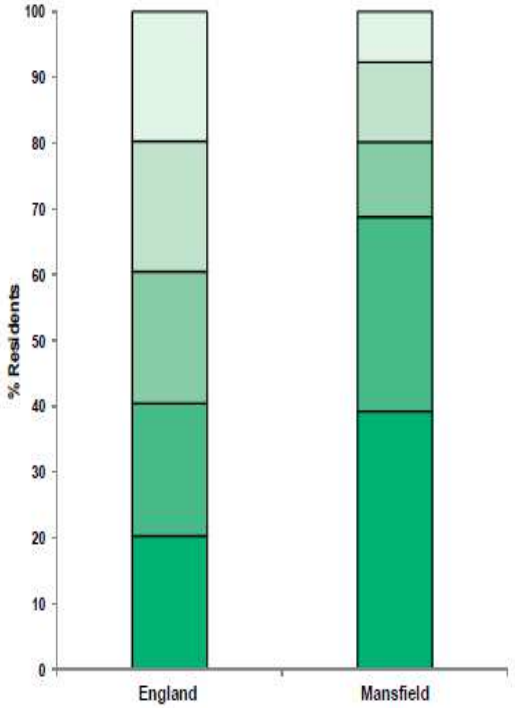
Segment	Key Line of Enquiry	Organisation response	Supported by:
		people (aged 65 and over) to residential and nursing care homes, per 100,000 population o Effectiveness of Reablement: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement / rehabilitation services Our contribution to the indicator will be to instigate the following initiatives: • Transfer to assess, move people from hospital into assessment beds / home while they are assessed for on-going care packages. • Build on the successful rehabilitation model that was introduced at Newark Hospital Fernwood Unit in 2012 and implement this at the Kings Mill Hospital site. The intensive therapy model has resulted in fewer admissions to residential care following admission to hospital and the ability to return to a home environment. • Social workers are part of the PRISM virtual ward teams and are therefore able to influence care packages before the expectation of residential care is established. **(v) Increasing the number of people having a positive experience of hospital care** Our local hospital Friends and Family Test scores benchmark well. NHS Choices feedback is also largely positive. We have worked collaboratively to establish a CQUIN for 2014/15, which will be applied across Nottinghamshire and Derbyshire. This includes: • One external (minimum of 3 complaint files to be submitted) and one or more internal (minimum of 12 complaint files) to be peer reviewed. Peer review panels will review files against the Patients' Association Good Practice Standards	

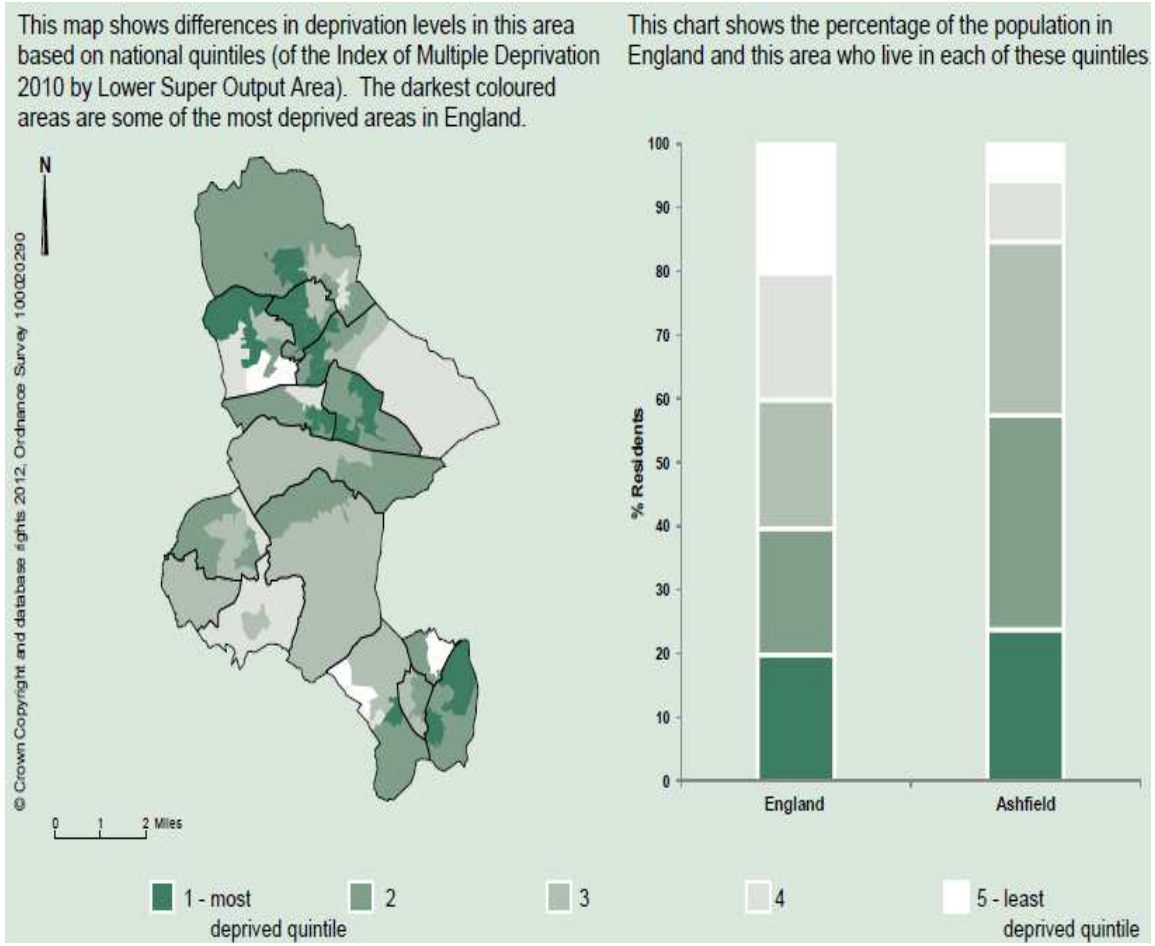
Segment	Key Line of Enquiry	Organisation response	Supported by:
		for complaint handling. • The provider will undertake a complaint handling satisfaction survey. • The provider will develop an improvement plan with agreed milestones for 2014/15/16. **(vi) Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community** We have developed a primary care quality framework that will be used to monitor improvements in primary care, including satisfaction with GP in-hours and out-of-hours services. Our integrated community teams, working closely with GP practices will also have a demonstrable impact on patient satisfaction. As part of our primary care strategy, we will review access and workload management in each practice and will develop improvement plans in light of the findings. **(vii) Significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care** We have made significant improvements in mortality rates in our local hospitals. Sherwood Forest Hospitals was one of the Keogh trusts because the HSMR was elevated. We have a joint mortality working group, with active membership from primary and secondary care senior clinicians.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		The extent of improvement to date is shown below:  Particular improvements have been made in the management of sepsis, stroke, pneumonia and heart attacks. However, further work will be particularly focussed on acute kidney injury and cancer.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		Our independent mortality review also reviewed the impact of day of admission to hospital. All local providers have a 20% increased mortality rate for Sunday admissions. The reasons for this are not clear. It may be that patients are less likely to be admitted to hospital on a Sunday unless they are extremely ill. This is being investigated in more depth. Seven day working will also be implemented, in line with national guidance. The analysis also indicated that patients who died in hospital had more ward moves on average than patients who survived. The reasons for this are not clear and require further investigation. There may be a link with particular clinical conditions, but this cannot be determined until individual case notes are reviewed. This analysis supports the 'right care first time' policy and does not support multiple moves. There was no link between bed occupancy percentages on the wards and deaths, although there were more deaths when more people were in hospital. Further work is underway to review the underlying causes and actions will be taken to reduce the number of transfers between wards. **C. <u>Improving health inequalities</u>** The deprivation indices for Mid-Nottinghamshire vary considerably, with particular levels of challenge in Mansfield and Ashfield. These differences mean that commissioning strategies have to be localised in order to reflect local population requirements. Our plans are based on JSNA findings. We have adopted a collaborative approach to planning, in order to reduce health inequalities as effectively as possible. We are actively working in partnership with the Health and Wellbeing Board and recently co-presented at Health and Wellbeing Strategy consultation events in each locality. Our	

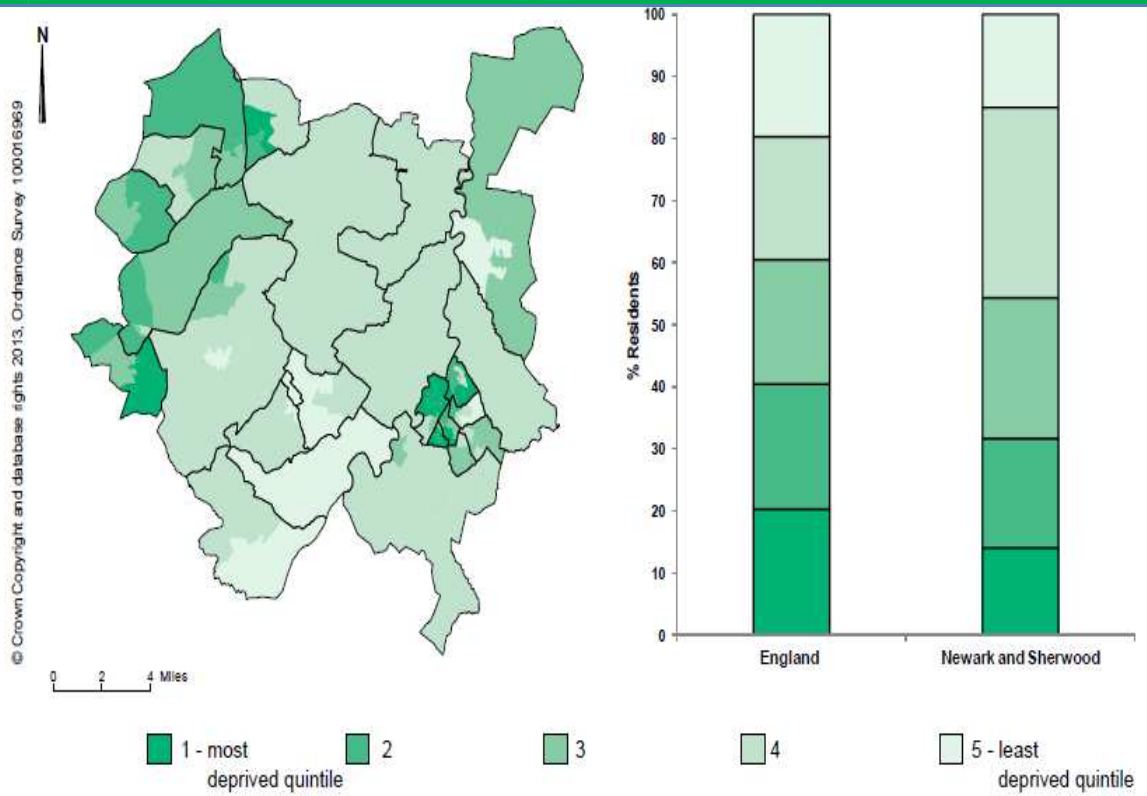
Segment	Key Line of Enquiry	Organisation response	Supported by:
		approach to planning for maximum population gain is shown below:  	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		The levels of deprivation in each locality warrant tailored approaches. These are shown below: **<u>Mansfield</u>** This map shows differences in deprivation levels in this area based on national quintiles (of the Index of Multiple Deprivation 2010 by Lower Super Output Area). The darkest coloured areas are some of the most deprived areas in England.  This chart shows the percentage of the population in England and this area who live in each of these quintiles.  	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		Ashfield:  Ashfield is located directly to the west and south west of Mansfield and there are two	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		separate district councils. Mansfield is largely urban, with a mixture of urban and rural areas in Ashfield. Both areas have been affected by the recession, with many people suffering great hardship as a result of unemployment and benefit changes. In Ashfield, we are developing the former community hospital into a health and wellbeing hub. A GP practice is sited there. In 2013, we introduced new services at the site, such as dementia care, weekend out-of-hours facilities, food bank and the family nurse partnership. In 2014, we will also introduce a community hub with co-location of several inter-related voluntary sector organisations such as the Citizen's Advice Bureau. These organisations will work closely with statutory bodies. The PRISM virtual ward team for that area will also be based there. This has been very warmly welcomed by local politicians and stakeholders. These changes have been agreed following a formal public consultation. There have been some delays in implementation in 2013 because previously allocated capital funding was not allocated in year. We are working closely with NHS England and NHS Property Services to resolve this situation and we hope to receive approval for the building works in July 2014. We are working with partners at neighbourhood level to improve quality of life for people in deprived communities. We are a national early implementer site for Connecting Communities (C2) within a challenged housing estate in Ashfield. This programme empowers local residents and front line practitioners to improve health, wellbeing and local living conditions. This will be developed in 2014. A further project to enhance wellbeing concerns loneliness and isolation. We are a pilot site for a scheme that matches lonely people who are frequent service users. The matching process occurs through a process that has been developed by Meredith Belbin. Kings Mill Hospital is situated on the border between Mansfield and Ashfield.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		Integration of out-of-hours and urgent care services, with a strengthened crisis response centre will help to support this vulnerable community and will signpost them into appropriate support channels. Our work with individual GP practices in the area to support improvements in mortality and introduction of systematic risk stratification. Newark and Sherwood is covered by a further district council and covers a wider, generally more sparsely populated geography. Although there are some areas of significant deprivation in the old coal fields and towns that have lost much of their textile industry, the overall deprivation index is different from Mansfield and Ashfield. There is also a significant gypsy and traveller community around the Newark area and we have an ambassador scheme within that community to help them access care. The deprivation index for the area is shown below: **Newark and Sherwood:**	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		 Newark Hospital has been politically contentious, particularly in light of the re-designation of the Accident and Emergency to a Minor Injuries Unit and Urgent Care Centre. The future of the hospital was a key issue in the recent Newark by-election. Travel times are more challenging, particularly in rural areas. There remains an active campaign group who wish to see increased emergency care at the Newark Hospital site, despite clinical safety constraints. We have developed a strategy for the hospital that will be fully implemented in 2014. We have a transport working group that is localised to Newark and Sherwood and this is developing our transport strategy for that area. The strategy includes emergency and non-emergency transport, building on the well-established volunteer driver schemes in the area.	*A Vision and Strategic Direction for Newark Hospital* *Implementing the Vision for Newark Hospital: Operational Plan*

Segment	Key Line of Enquiry	Organisation response	Supported by:
		In summary, our approach to reducing inequalities is as follows: • Plans are aligned to the JSNA and Health and Wellbeing Strategy for the county. • CCGs have developed integrated community teams that are locally based and risk stratify their populations, with more proactive care management. • Local facilities are tailored to local population needs. • We have included wider determinants of health in our commissioning plans.	
	Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	The blueprint for system change was completed in April 2013 and was endorsed by the following organisations: • Mansfield and Ashfield CCG • Newark and Sherwood CCG • Nottinghamshire County Council • Nottinghamshire Healthcare Trust • Sherwood Forest Hospitals EMAS contributed to the service strategy and are now active members of our Mid-Nottinghamshire Programme Board. Nottingham University Hospitals also endorse the strategy and are working with us as part of the system-wide Board. All parties formally signed up to this strategy through the Better Together Programme Board. Further detailed discussions about implications for individual organisations have taken place at contract management and board-to-board levels. The Health and Wellbeing Board have endorsed the strategy on two occasions – in May 2013 the blueprint was presented to the Board and was fully supported. In January 2014, an update report was presented following development of the detailed service proposalss. Full endorsement was again provided. The strategy will be presented to the Health Scrutiny Committee in February 2014, although the Committee has had early sight of initiatives such as PRISM, independent mortality review and the Newark Hospital Vision.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		We also intend to engage with our local Clinical Senate and have shared information about the Mid-Nottinghamshire blueprint with them. As we move further ahead with sustainability plans, we will confer with the senate as required. Our NCAT report suggested that we may need to engage with a senate outside of our area should conflicts of interest arise. We are also working with our local Strategic Clinical Networks to ensure that appropriate specialty pathways are commissioned.	
	How does your plan for the Better Care Fund align/fit with your 5 year strategic vision?	Mid-Nottinghamshire CCGs coordinated the Better Care Fund plan, working closely with neighbouring CCGs and colleagues at Nottinghamshire County Council. The Better Care Fund plan was developed with a bottom-up approach, incorporating plans from three planning footprints: South Nottinghamshire, Mid-Nottinghamshire and North Nottinghamshire. Overall KPIs and financial profiles are an aggregate of all three areas so that alignment with CCG submissions could be ensured. We have a Nottinghamshire Working Group, chaired by the Chief Executive of Nottinghamshire County Council and there is an agreed delivery structure to support implementation of the plan. We have recently recruited a Programme Manager to work on behalf of all constituent organisations and to establish the pooled budget arrangements for 2015/16. The post holder will be hosted by Mansfield and Ashfield CCG. The Better Care Fund is essentially a sub-set of our overall strategy and financial plan, with complete alignment across our ambitions for the local population.	
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	An extensive engagement programme was carried out and key themes have informed the development of our strategy. We spoke to over 1,000 people and also had over 500 written responses to our questions. We had wide coverage on local media and visited around 20 seldom heard groups to obtain their particular views. The key influencing themes were: • Support for better coordination and joined up services	*Report of engagement and public responses submitted to January GBs*

Segment	Key Line of Enquiry	Organisation response	Supported by:
		• Need for professionals to communicate better with each other and service users • Agreement that care closer to home is better • Need for better GP access • Need for support for carers People generally appear to appreciate that there is a need for change and that services are not sustainable in their current form, even though that may result in fewer hospital beds within a local hospital that has high PFI costs.	
	Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included?	We have mapped public feedback as part of the service proposals development, in order to show how this has influenced our plans. The CCG Governing Bodies approved the service proposals, along with the mapping, at their February meetings. Examples of 'you said, we did' actions are as follows: **You said** We want better GP access. **We Did** We are working with GP surgeries to introduce new ways of working. The Clinical Commissioning Groups (CCGs) and NHS England's Local Area team are working on a Primary Care Strategy to support new ways of working which would integrate with the proposals of Better Together. **You said** We are concerned about staff motivation, workload and training. **We Did** We have done detailed work on the workforce implications of our plans, including numbers, skills mix and training to ensure that there are appropriate numbers and grades of staff. **You said**	

Segment	Key Line of Enquiry	Organisation response	Supported by:
		It's important to have good communications, including communication with people with learning disabilities and other groups with specific communications needs. **We Did** These have been noted and will be reviewed as part of the Equality Impact Assessment and where possible will be included in our service specifications. **You said** When we need emergency care, we want a safe environment, away from drunken people. **We Did** This will be reviewed in the design of the single front door facilities. **You said** There need to be better arrangements for discharge out of hospital, with more coordination between A&E and the ambulance service, and discharge in the right place at the right time (e.g. not in the middle of the night). **We Did** Discharge will be planned on admission so that appropriate services are in place when the patient is ready to leave hospital. Discharge will be support by the transfer of relevant information. **You said** You are cutting too many services at Newark Hospital and moving them to Kings Mill. **We Did** Services at Newark Hospital are being developed as part of the Vision and Strategy for Newark Hospital. These include the Bramley Children's Assessment Unit, Fernwood Community Unit and additional out-patient services. We are also however, bringing a number of services out of the hospital altogether and providing them in the community, closer to people's homes.	

Segment	Key Line of Enquiry	Organisation response	Supported by:
a) Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?	The assessment of our current state is described above (vision section on sustainability of the NHS for future generations). The opportunities and challenges described in the blueprint document have been rigorously tested and challenged as part of the service proposals development process. The levels of ambition within the clinical models are based on the best available evidence to date: • Benchmarked activity / outcomes data (including the Commissioning for Value insight packs). Details of data sources are shown in the blueprint baseline chapters for each care area • Dr Foster commissioning data • PwC benchmark data and analytical modelling • National guidance and NICE standards • Recent national guidance on urgent care and seven day working • Detailed baselines of current costs of provision across providers • Clinical assessments of the likely impact and timing of specific interventions on activity and outcomes, based on detailed knowledge of how local services work • NHS commissioning toolkits • Utilisation reviews	
	Do the objectives and interventions identified below take into consideration the current state?	Yes, as above. The projected financial gap, objectives and interventions are based on analysis of the current state.	
	Does the two year detailed operational plan submitted	Yes, we have targeted our transformation schemes and financial plan to deliver the strategic vision. Within two years, we will have well-established integrated community teams, joined up out-of-hours and urgent care services, as well as better access to	

Segment	Key Line of Enquiry	Organisation response	Supported by:
	provide the necessary foundations to deliver the strategic vision described here?	primary care. We will also have some specialist intermediate care, with step up and step down facilities to support reduced admissions and length of stay in hospital. Our discharge processes will have been streamlined. Our service proposals development process has enabled us to consider the required sequence of events, timelines and milestones in detail. We recognise that this will be an on-going and challenging process that will need significant resource. Having developed a detailed plan around clinical change, we have now established a new PMO to deliver the changes required. We have also established a number of enabling groups to ensure facilitation of the clinical changes that have been described. We also recognise that incentives are not currently aligned. We will take the necessary steps to re-commission integrated care that is more joined up and efficient for people. We have secured external advice to help us with this process. We have also identified provider impacts resulting from the service changes and have shared this information with individual providers. This includes financial and activity changes. Assumptions are aligned in our strategic plans. Providers have shared with us their view of risks and potential mitigating actions and these have been aggregated across the system. Broadly speaking, organisations have identified risks in the following categories: • Risks associated with successful delivery of Better Together (managing the consequences); • risks associated with failure to deliver Better Together (managing failure to meet milestones or achieve impact); • risks associated with the move from individual organisational and sector transactions to integrated services across health and social care (managing the transition).	System-Wide Risk Management: *Shared Delivery and Risk Mitigation 2014/15*

Segment	Key Line of Enquiry	Organisation response	Supported by:

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<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr><td>b) Improving quality and outcomes</td><td>At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?</td><td>
<table>
<tr><th>Ambition area</th><th>Metric</th><th>Proposed attainment in 18/19</th></tr>
<tr><td>1. Securing additional years of life for people with treatable mental and physical health conditions</td><td>PYLL from conditions amenable to healthcare</td><td>5% reduction in the PYLL (rate per 100,000) over the 5 years to 18/19</td></tr>
<tr><td>2. Improving the health related quality of life for people with one or more long-term condition, including mental health conditions</td><td>EQ5D tool in the GP Patient Survey

15% IAPT roll out
50% IAPT recovery rate

≥67% dementia diagnosis rate by March 2015</td><td>Improvement in the EQ-5D score of 5% over the 5 years to 18/19</td></tr>
<tr><td>3. Reducing the amount of time spent avoidably in hospital through better and more integrated care in the community, outside of hospital</td><td>A rate comprised of:

Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Emergency admissions for acute conditions that should not usually require hospital admission

Emergency admissions for children</td><td>Avoidable admissions (composite indicator) to be reduced by -10% each year for patients aged 65+ years.</td></tr>
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</td><td></td></tr>
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			with lower respiratory tract infections		
		4. Increasing the proportion of older people living independently at home following discharge from hospital	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services Rate / 100,000 population permanent admissions to nursing or residential care homes	Level of ambition set at HWB level- both included in BCF plan	
		5. Increasing the number of people having a positive experience of hospital care	FFT score CQUIN indicator: • One external (minimum of 3 complaint files to be submitted) and one or more internal (minimum of 12 complaint files) to be peer reviewed. Peer review panels will review files against the Patients' Association Good Practice Standards for complaint handling. • The provider will undertake a complaint handling satisfaction survey. • The provider will develop an improvement plan with agreed milestones for 2014/15/16.	Both M&A and N&S CCGs to improve their score to a position in line with the current top quintile by 18/19	

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		6. Increasing the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in general practice and in the community	Composite indicator comprising: (i) GP services (ii) GP out-of-hours services	Both M&A and N&S CCGs to improve their score to a position in line with the current top quintile by 18/19	
		7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Hospital deaths attributable to problems in care. Indicator in development. Improving the reporting of medication errors MRSA zero tolerance Clostridium Difficile reduction	Both M&A and N&S CCGs to see a 10% reduction in the number of hospital deaths following an emergency admission. MRSA zero tolerance C-Diff in line with DoH objectives	
	How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?	We have developed plans to reduce potential years of life lost in a number of ways: • Strategic partnership groups within localities (resulting in initiatives such as the food bank and Citizen's Advice Bureau in Ashfield Health Village) • Joint mortality working group across primary and secondary care • Independent mortality review, identifying areas of improvement by postcode area and GP practice			

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		• Discussion through CCG Clinical Executives Improvements in proactive and urgent care (ref, quality of life for people with long-term conditions, reducing the time spent in hospital, enabling older people to live at home longer after discharge from hospital) have been developed in a number of ways: • Public engagement programme, linked to development of the blueprint • Mid-Nottinghamshire Urgent Care Working Group • Proactive and Urgent Care – Care Design Groups for service proposals development. (Membership includes clinicians from primary, community, out-of-hours, ambulance, secondary care, care professionals, public and patient representatives). Patient experience levels of improvement (in and outside of hospital) have been targeted in areas that members of the public have reported as areas for improvement. For example, Sherwood Forest Hospitals was found to have poor complaint handling. Although significant work has been undertaken in this area, a CQUIN will be helpful to build on and embed some of the changes that have been made.	
	What data, intelligence and local analysis was explored to achieve the ambitions?	Benchmark and other sources of evidence were used, as described in the section on our current position. Our programme of public engagement also influenced development of the plan, as described above.	
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	Yes. JSNA data are provided at a detailed local level, enabling application to CCG plans.	

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	How have the Health and well-being boards been involved in setting the plans for improving outcomes?	The Mid-Nottinghamshire plans have been presented to the Health and Wellbeing Board on two occasions. The Board has also enabled discussions about specific topics, in order to inform our plans. These include integration, carers, children's services, primary care strategy, mental health. The CCG Governing Bodies have regular updates concerning the Health and Wellbeing Board. The CCG Clinical Chairs are members of the Board and officers receive copies of the papers. Wider Health and Wellbeing Board stakeholder events have also been used to inform plan development at CCG level.	
c) Sustainability	Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	Yes. All schemes have been developed with an understanding of net savings, once the required implementation costs have been factored into the plan. This approach is reflected in the waterfall chart on page 25.	
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	Yes. The plan includes demographic growth forecasts, as well as increases in multiple long-term conditions and increased healthcare costs associated with dementia and old age. The focus of the plan is on patient and population need, not buildings or organisational interests. Plans have been developed by clinicians across all settings.	

<table>
<tr><th>Segment</th><th>Key Line of Enquiry</th><th>Organisation response</th><th>Supported by:</th></tr>
<tr><td></td><td>Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates?</td><td colspan="2">The plan on a page is a summary of the schemes described within the strategy. The financial plan is also derived from the strategy and defines the financial consequences and timelines of strategy delivery. As such, these are fully aligned.

Service proposals assumptions have been developed alongside NHS planning guidance to ensure affordability and the appropriate phasing of schemes.</td><td></td></tr>
<tr><td>d) Improvement interventions</td><td>Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the :
• Overall aims of the intervention and who is likely to be impacted by the intervention
• Expected outcome in</td><td colspan="2">Intervention One<table><tr><td>Aim and description</td><td>Reduce the time spent avoidably in hospital through integrated care and better community services (development of an integrated proactive and urgent care system)
Specific interventions include:
• Development of a self-care hub to provide information and knowledge for people with long-term conditions
• Improved access to primary care
• Enhanced community services, based on PRISM model for integrated care teams
• Enhanced intermediate care
• Care and crisis navigation (incorporating a care navigator and crisis response teams)
• Integration of acute and community urgent care services (single front door, linking specialist intermediate care team with single front door, enhanced discharge process)</td></tr><tr><td>Outcome (including reference to outcome ambitions and 6</td><td>15.1% reduction in A&E attendances at SFH

19.5% reduction in non-elective admissions at SFH</td></tr></table></td><td></td></tr>
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Segment	Key Line of Enquiry	Organisation response		Supported by:
	quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline • Enablers required for example medicines optimisation • Barriers to success • Confidence levels of implementation The planning teams	**characteristics)**	10% reduction in non-elective readmissions 12.6% reduction in occupied / excess bed days at SFH 25% reduction in admissions into residential and nursing homes 30.5% reduction in bed days at SFH When aggregated together, this set of interventions creates a strategically different model of care, with a greater proportion of care moving outside of the acute hospital setting. The new system will help to achieve all of the outcome ambitions and the first four characteristics of a high quality and sustainable system.	
		Costs (financial and non-financial)	Recurrent operating costs - £15.1 million 5-year non-recurrent transition costs - £4.5 million Recurrent financial benefits - £25.5 million	
		Implementation timeline	PRISM virtual wards rolled out – June 2014 Provider selected to deliver self-care – June 2014 PQQ developed and issued for integrated care system – March 2014 Contract awarded to new providers – December 2014 New integrated way of working goes live – April 2015 (with further phasing / refinement as new roles come	

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	may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.		on line and workforce changes take place)	
		Enablers required	IMT Information sharing and electronic workflow / e-referral will be essential. The use of TPP SystmOne as a basis for information sharing. Risk stratification capability. System-wide portal to integrate required information sets. Organisational Development Joint OD programme across providers and commissioners in 2014/15. Build service transformation capability at SFH. Workforce Development of new ways of working and a skilled workforce. Medical recruitment. Development of specialist roles, particularly ANPs, specialist nurses, AHP advanced roles. Estates Capital works to support the changed service model. Consolidate the legacy estate at Kings Mill Hospital. Rebalance NHS activity currently delivered in leasehold or NHS owned estate to maximise use of best estate.	
		Barriers to success	Lack of capacity to deliver the programme – mitigated by a PMO and rigorous management of implementation / milestones. On-going engagement with the public and staff will be critical, in order to build support and momentum for the required changes.	

Segment	Key Line of Enquiry	Organisation response		Supported by:
			Considerable skills development and training will be required, with lead times for new roles and capabilities. Current contract and payment mechanisms to not support these changes. Services will need to be re-commissioned in order to deliver full benefit. The IMT infrastructure will need to be in place for full benefit to be delivered.	
		Confidence levels of implementation	There is considerable support for these changes among system leaders, which has led to commitment to make the changes happen. However, this is a complex transformation programme. We will introduce some of the changes in 2014/15, in order to support QIPP requirements and to build overall confidence that activity patterns can change if the right community and primary care changes occur. We are confident that this can be delivered with a concerted effort across the system as a whole.	
		Intervention Two		
		Aim and description	**Step-change in the productivity of elective care through development of a referral management system that will systematise best practice in referrals and reinvigorate clinical relationships across primary and secondary care. Specialty reviews will also be used to develop more effective pathways for each area (tranche 1 complete, tranche 2 and Newark Hospital surgical review currently underway).**	

Segment	Key Line of Enquiry	Organisation response		Supported by:
			Specific interventions include: • **Peer to Peer review –** within each GP practice, a peer review of referrals as deemed necessary by each GP. Helps to reduce inappropriate referrals early on. • **Standard referral template and guidelines –** specialty-specific guidelines, easily available on the computer to provide a point of reference before a GP refers a patient. Plus, a pre-populated, standard referral template to aid both GPs and acute clinicians. • **Clinical partnership** o **a.Gateway administration** – processing and checking function ensure quick and correct referrals are made. A key stage in providing shared decision-making for patients who are contacted and given choice on their treatment provider. The Gateway provider will use a comprehensive Directory of Services, updated regularly by service providers, with support from CCGs. o **b.Consultant triage –** review of all referrals (at first) by a specialist consultant to help reduce the numbers of inappropriate referrals coming into outpatient clinics • **Two-way training and development –** a core element, back and forth sessions and dialogue	

Segment	Key Line of Enquiry	Organisation response		Supported by:
			between clinicians to share best practice and learn to improve the referral pathway. • Specialty-level reviews and development of new care pathways	
		Outcome (including reference to outcome ambitions and 6 characteristics)	9.8% reduction in secondary care referrals to secondary care Improved primary care diagnosis and treatment Streamlined pathways of care, with more community provision Improved primary and secondary care interface Reduction in inappropriate referrals This intervention will contribute to reducing the amount of time people spend avoidably in hospital (outcome ambition 3). It will also enhance patient experience (outcome ambitions 5 and 6). The intervention will also contribute to several characteristics of a sustainable system (wider primary care, step-change in the productivity of elective care and specialised care concentrated in centres of excellence).	
		Costs (financial and non-financial)	Recurrent operating costs - £2.1 million Recurrent financial benefits - £4.7 million	

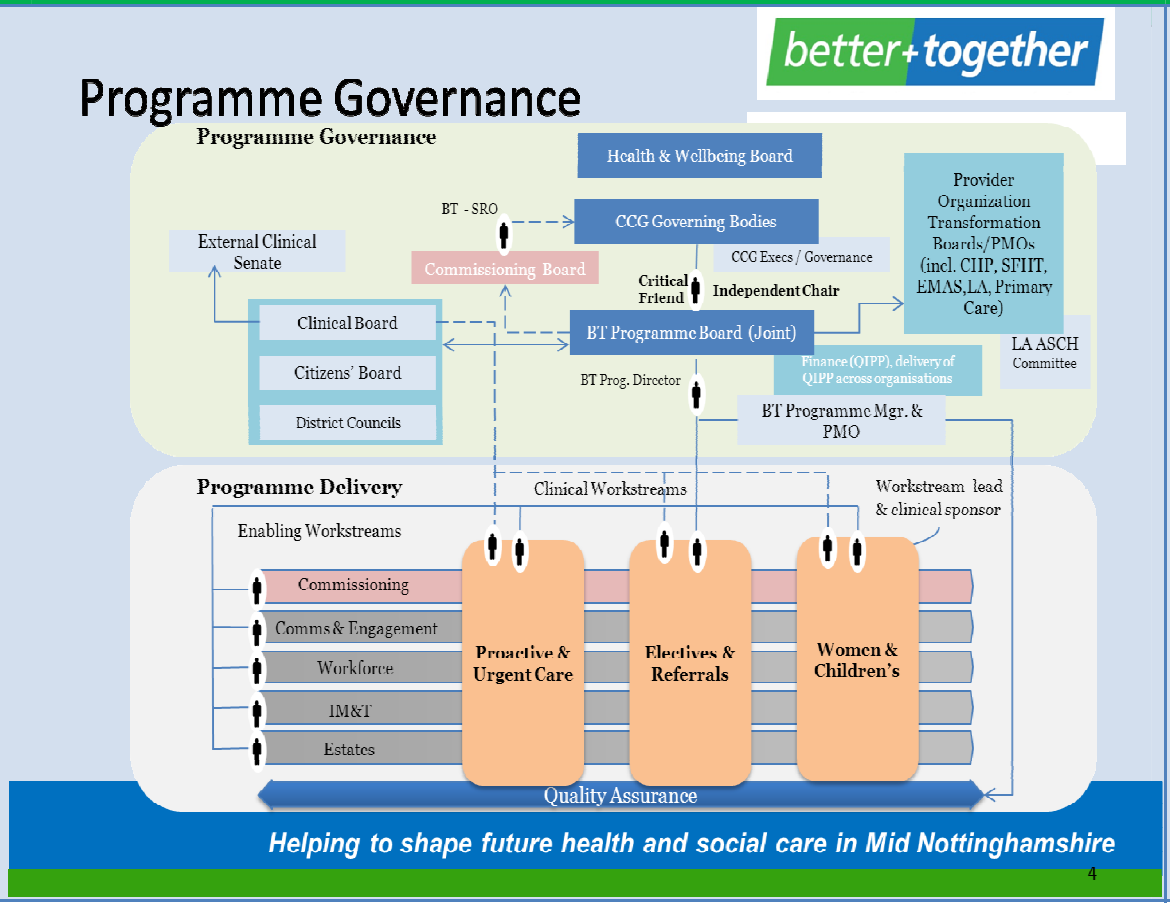
Segment	Key Line of Enquiry	Organisation response		Supported by:
		Implementation timeline	Referral management system implemented – October 2014 Tranche 2 specialty reviews completed – May 2014 Implementation of tranche 1 changes 2014-2016 Implementation of trance 2 changes 2015/16	
		Enablers required	<u>Clinical engagement</u> Behavioural changes across primary and secondary care will be required. Clinicians will be required to help design how the system will work for front line staff. <u>Public communication and engagement</u> People need to know that they will still be able to access care and treatment, although pathways may change. <u>Training and education</u> New systems will need to be familiar and easy to use. <u>Implementation of peer review across all practices</u> The way in which peer review takes place will need to be adapted to suit different sized practices.	
		Barriers to success	Lack of capacity to deliver the programme – mitigated by a PMO and rigorous management of implementation / milestones. On-going engagement with the public and staff will be critical, in order to build support and momentum for the required changes. Considerable skills development and training will be required, with lead times for new roles and capabilities. Current contract and payment mechanisms to not support these changes. Services will need to be re-commissioned in order to deliver full benefit.	

Segment	Key Line of Enquiry	Organisation response		Supported by:
			The IMT infrastructure will need to be in place for full benefit to be delivered.	
		Confidence levels of implementation	A programme of clinical engagement is underway to facilitate this new way of working, particularly for GPs. Views about optimal referral processes are mixed, so a phased roll out may be appropriate. We will introduce some of the changes in 2014/15, in order to support QIPP requirements and to build overall confidence that referral patterns can change if the right community and primary care changes occur. We are confident that this can be delivered with a concerted effort across the system as a whole.	
		Intervention Three		
		Aim and description	**Reduction in unnecessary hospital stays through development of a paediatric short-stay assessment unit, linked to A&E. Implementation of consultant telephone advice and a referral gateway for paediatric consultant referrals.**	
		Outcome (including reference to outcome ambitions and 6	10% reduction in paediatric secondary care outpatient activity	

Segment	Key Line of Enquiry	Organisation response		Supported by:
		characteristics)	20% reduction in paediatric admissions to hospital, with associated reduction in paediatric emergency attendances This will reduce inappropriate paediatric referrals and referrals to incorrect destinations. Inpatient paediatric medicine and surgery at Kings Mill will also be reviewed in 2014. Implementation of the Integrated Care Children and Young People's Healthcare Programme for children with complex needs. This intervention will contribute to reducing the amount of time people spend avoidably in hospital (outcome ambition 3). It will also enhance patient experience (outcome ambitions 5 and 6). The intervention will also contribute to several characteristics of a sustainable system (wider primary care, step-change in the productivity of elective care, a modern model of integrated care and specialised care concentrated in centres of excellence).	
		Costs (financial and non-financial)	Financial benefits continue to be developed	
		Implementation timeline	Review of inpatient services - 2014/15 (with the clinical network) Implementation of paediatric assessment unit – 2015/16 Referral process changes – 2015/16	

Segment	Key Line of Enquiry	Organisation response		Supported by:
		Enablers required	<u>Clinical engagement</u> This will require widespread clinical support and behavioural change. Some new roles and ways of working will need to be developed, in order to support more community level working. Multi-professional teams will be required within community settings. <u>Public communication and engagement</u> People need to know that they will still be able to access care and treatment, although pathways may change. <u>Training and education</u> New systems will need to be familiar and easy to use.	
		Barriers to success	Lack of capacity to deliver the programme – mitigated by a PMO and rigorous management of implementation / milestones. On-going engagement with the public and staff will be critical, in order to build support and momentum for the required changes. Considerable skills development and training will be required, with lead times for new roles and capabilities. Current contract and payment mechanisms to not support these changes. Services will need to be re-commissioned in order to deliver full benefit. The IMT infrastructure will need to be in place for full benefit to be delivered. The review of paediatric inpatient services may result in controversial findings about what should be retained on the current wards. A public consultation may be required.	

Segment	Key Line of Enquiry	Organisation response		Supported by:
		Confidence levels of implementation	This is a complex transformation programme. We will introduce some of the changes in 2014/15, in order to support QIPP requirements and to build overall confidence that activity patterns can change if the right community and primary care changes occur. We are confident that this can be delivered with a concerted effort across the system as a whole.	
e) Governance overview	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	We have well developed governance structures to oversee delivery of the transformation programme, as shown below. The structure has recently been refined, as we have moved from the design to the implementation phase. The structure incorporates three main areas of work; • Joint system working to deliver change in 2014/15 (year 1) and to oversee the transformation programme • Commissioning work stream to develop new contract / payment mechanisms and to commission integrated services • Provider delivery of CIPs and provider development / partnership development for integration of care pathways This is shown below:		

Segment	Key Line of Enquiry	Organisation response	Supported by:
			
f) Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	System leaders agreed that we would work to a common set of values and principles from the outset. A key value was that we needed to work collaboratively, in the interests of the population needs; focussing at system, not organisational, level The Programme Board agreed a set of design principles as follows: Design principles are:	

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		• Prevent illness or crises where possible – and transfer resources (people, physical assets and finance) from reactive services to support this • Shift care into closer-to-home / better value care settings where appropriate • Only provide services where there is the critical mass / volumes for the services to be delivering high outcomes and be economical; provide care locally, but only where it is proven that this delivers better outcomes • Optimise the use of fixed costs such as estates with locally required activity – including acute, community, private and non-healthcare • Provide single points of access for patient, and integrated provision of services • Using all of this to enable the system to cope with growing demand within expected resource constraints; and • To design interventions that once implemented will make a significant contribution towards the NHS Outcomes Framework These principles have been embedded in service proposals and have provided a useful steer for clinical and corporate discussions. We will also use these principles when re-commissioning integrated services. We are currently developing an estates strategy, which will optimise best use of the estate. We have agreed that estates overheads associated with the PFI (c.36%) will not be withdrawn with acute activity changes in the transitional period.	