

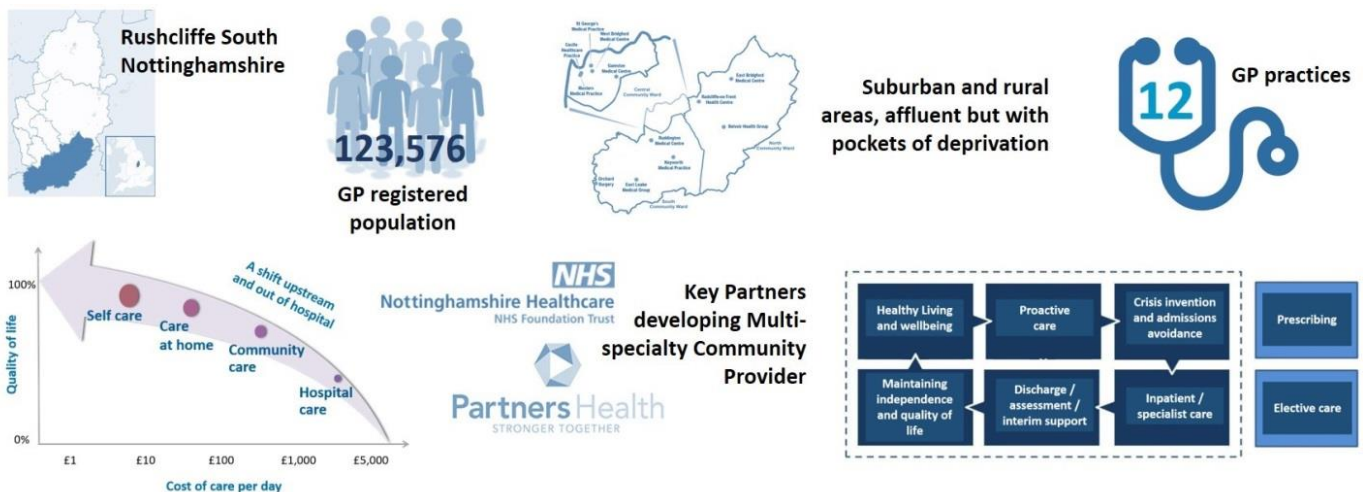
Latest news



Quarter 1 April-June 2017

This document provides an update on the work of the MCP and progress and impact during the first three months of 2017/18.

Key facts:



Since 1 April, Principia has:

- Been announced as part of an early Accountable Care System (ACS) development site as part of the Greater Nottingham Transformation Partnership.
- Been named as an exemplar site by the New Care Models programme for designing services based on patient segmentation, rapid clinical advice and guidance, and co-ordinated discharge planning. Case studies of service improvement and positive impact for patients have been submitted covering these areas for others to access and learn from.
- Had 47 new business cases approved by the MCP Clinical Delivery Group in April, the MCP Governance Group and MCP Finance Group in May.
- Hosted visits from Professor Don Berwick, visiting international fellow at the King's Fund, and Helen Stokes-Lampard of the RCGP.
- Contributed to an NHSE film aimed at promoting the exploration of the MCP model to GPs across the country not currently involved in the New Care Models programme.
- Seen closer working between PartnersHealth and Nottinghamshire Healthcare NHS Foundation Trust in development of the MCP offer post March 2018, including focus on the governance and MoU required to support this.
- Worked with the Nottinghamshire Healthcare Trust communications team to plan baseline awareness data capturing and increased workforce communications across community and mental health teams as well as primary care.

- Hosted a visit by the New Care Models communications team to review Principia communications and engagement to date and been invited to present as part of a panel at the national event for Vanguard and STP communications and engagement leads.
- Had its Enhanced Support to Care Homes initiative featured in a number of print and online publications with reference to IAU published analysis linking the enhanced service to a reduction in hospital admissions.
- Partnered with ImROC to drive the development of the Principia social prescribing model and held three co-production workshops.
- Received a report on progress during the first year of the Primary Care Psychological Medicine (PCPM) service showing a more streamlined pathway, a better patient experience and considerable early improvements in outcomes by providing earlier intervention and active management in the community (Appendix A).
- Commenced planning for the next Principia Showcase event (2 November 2017) to share best practice and learning with local and national organisations.
- Received data showing an 84% improvement in the anxiety and depression score of patients accessing the pulmonary rehabilitation service provided in the community from Cotgrave, Bingham and Lings Bar Hospital.
- Received an audit report and recommendations from Age UK regarding the accessibility and availability of information for carers from Rushcliffe's 12 GP practices and the role of carer champions.
- Submitted a proposal to provide a pop-up university session at NHS Health and Care Expo in September.
- Provided a tool-kit for implementing enhanced support to care homes for upload to the NHS online shared work space.
- Provided a two-page editorial for the summer issue of *Rushcliffe Reports*, delivered to every household in the borough during June (appendix B).
- Planned activity for a second summer of *One You* events, engaging with local people on health and wellbeing and support available to self-care.
- Supported the production of patient-facing information regarding Integrated Personal Commissioning (IPC) and the expansion of the personalisation agenda as part of its early adopter status in partnership with neighbouring county CCGs.
- Produced an infographic showing the number of patients initiated on anti-coagulation following risk profiling and resulting number of strokes saved in Rushcliffe (appendix C).

Green light for Accountable Care System (ACS) development

Principia has been named with its Greater Nottingham Transformation partners as one of eight areas nationally to be given the green light to explore the potential for an ACS model of care. Nottinghamshire, with an early focus on Rushcliffe and South Nottinghamshire, was named as an accelerator site at the NHS Confed17 in June. Additional national support will help the STP area further progress its current work based on the previous analysis and design undertaken. The press release to media following the announcement can be found at appendix D.

King's Fund and RCGP visits to Principia

The MCP hosted two high profile visits in June. Professor Helen Stokes-Lampard, Chair of the Royal College of General Practice (RCGP), heard about Principia's progress in engaging local GPs in its enhanced primary care offer and the development of first out-patient appointment clinics in community settings. Professor Stokes-Lampard visited the Community Gynaecology Service at Keyworth Medical Practice and also addressed GP colleagues at a meeting of the CCG's Clinical Cabinet. Following her visit, she reflected on her time with Principia as part of her weekly blog (appendix E).

On 20 June, Principia hosted Professor Don Berwick, visiting International Fellow, and Chris Ham, Chief Executive, from The King's Fund. Key MCP partners joined Principia clinical leads to discuss how vanguard progress in Rushcliffe was being used as learning in the development of an Accountable Care System (ACS) across Greater Nottingham. He urged the local system to keep the quality of care provided to the local population as central to shaping a new accountable model as well as focusing on finance and governance. He highlighted his visit to Principia in a webinar broadcast later the same week, which is available on the King's Fund website.

One You hits the road in Rushcliffe

Following last year's successful 'summer of self-care', Principia will again be providing One You information and engagement roadshows at a number of community events between June and September. Principia would like to thank the Rushcliffe practices' Patient Participation Groups for their support to these events as well. Volunteers will encourage people to take the One You online health quiz and provide information and sign posting to local services and support to help people improve their health and wellbeing, manage long-term conditions better and use access the right NHS service first time. The schedule of events can be found at appendix F.

Defining and co-producing Social Prescribing in Rushcliffe

Principia is working with local social enterprise ImROC to drive the development of the Principia social prescribing offer planned for launch in late 2017. Fortnightly co-production workshops have been established with representatives from organisations including local community and voluntary sector groups, Nottinghamshire Police, local universities and Rushcliffe Borough Council. A new social prescribing offer will span physical and mental health and see health behaviour advisors and community connectors working through Care Delivery Groups to support local people to access help, information and opportunities for peer support and social interaction.

New business cases approved

Principia will progress 47 new business cases following approval to proceed by the MCP Governance Group and Rushcliffe CCG. More than £300k will fund an innovative approach to social prescribing through partnership and collaboration across a number of local agencies and the voluntary sector. A £143k investment in a new frailty pathway will aim to reduce hospital admissions through falls prevention and case management. New community case co-ordinators will be supported by two frailty specialist GPs to establish multi-disciplinary teams focused on proactive management of older patients most at risk of admission. A further £382k funding for end of life care in Rushcliffe is predicted to return around £400k of savings by reducing secondary care bed days,

avoidable admissions and provider costs as well as improving quality and patient experience by helping people die in their place of preference.

Rushcliffe GP supports NHSE film to promote MCP model

Principia's clinical lead for long-term conditions, Dr Neil Fraser, was interviewed for an NHS England film discussing the benefits and challenges of developing an MCP model of care. The film will be used online to promote the exploration of new care models to general practice in areas not currently within the vanguard programme. Dr Fraser stressed the importance of GPs providing leadership in shaping new ways for services to be delivered, saying that the investment of clinician's time in this agenda was valuable as it gave them the opportunity to influence the future of general practice and the community services that support primary care.



Primary Care Psychological Medicine Pilot

One Year On

In the original business case for Primary Care Psychological Medicine we secured funding for 2 years with a review at 1 year to check service delivery and check that outcome were being measured. We are presenting a report of the first 9 months of the service for this purpose. (The service started 22nd September 2016).

1. Background

Medically unexplained symptoms or persistent physical symptoms are a common and costly problem within the NHS. Patients with persistent physical symptoms account for approximately 20% of all new consultations with GPs and often become frequent users of services in both primary and secondary care. It is estimated that persistent physical symptoms costs the NHS around £3 billion a year as patients with such symptoms often receive large amounts of symptomatic investigation and treatment.

The Nottingham Primary Care Psychological Medicine service was set up as a two year pilot in September 2016 as part of Rushcliffe MCPs vanguard programme along with Nottinghamshire Healthcare NHS Foundation Trust's Department of Psychological Medicine. The pilot was designed to provide a liaison psychiatry service to the population of Rushcliffe; for patients with persistent physical symptoms and those with severe physical health problems where liaison psychiatry would be considered useful.

The service is delivered in a primary care/community setting by experienced liaison nurses and a liaison psychiatrist who also works in the local acute trust. The service offers a holistic, integrated service to improve the management of people in primary care presenting with; complex medically explained and non-explained symptoms, multiple referrals to secondary services, distress and functional impairment, polypharmacy and excessive unnecessary investigations or interventions. Common input includes: case management; diagnosis of mixed medical and psychiatric morbidity; training, supervision and support for GPs and other professionals and educating patients.

2. Aims and Objectives

The main objective is to see if developing a service for patients with persistent physical symptoms, or those with severe physical health problems would benefit from a specialist service based within

primary care. To provide a more streamlined service pathway and a better experience and outcomes for patients.

The service would provide earlier intervention for the patient and active management in the community, thus reducing secondary care investigations and admissions leading to a decreased cost for this cohort of patients. In addition the primary care and community care teams have access to liaison psychiatry support to facilitate a better understanding and education in the management of these patients.

3. The PCPM Service

Targeted Patient Cohort:

- Diagnosis of complex mixed medical and psychiatric morbidity such as patients with complex persistent physical symptoms for example, patients with multiple sclerosis or motor neurone disease where the physical health intervention has not produced results; in this case exploration of psychological aspects of the illness may well lead to symptom improvement
- Patients who have frequent admissions as inpatients where a clear diagnosis has not been made
- Patients with negative diagnostics which have failed to show a cause for the symptoms being presented

Provision of Liaison Psychiatry to the most complex patients by offering:

- 10 clinics per week
- Capacity to see 80 patients per annum
- Based at GP practices and in patients' homes

4. The Results So Far

Here we present the results of our study and the very positive narrative feedback of patients and GP referrers (please also see the vignettes included in the Appendix)

Both the Clinician Reported and Patient Reported Outcome Measures are statistically significant. Patient Reported Outcomes show improvements after only 3 months that are clinically meaningful and statistically significant. In a group of patients with complex chronic physical health matters to get this improvement is a remarkable achievement.

Table 1. Clinician Reported Outcome Measure

Patients seen for 3+ sessions	n	before	after 3 or more sessions	p=
CGI	15	2.9	1.4	0.002

The Clinical Global Impression (CGI) is rated on a 7-point scale, with the severity of illness scale using a range of responses from 1 (normal) through to 7 (amongst the most severely ill patients). CGI scores range from 1 (very much improved) through to 7 (very much worse).

Therefore the change above suggests a significant improvement.

Table 2. Patient Reported Outcome Measures

3 month analysis	n	before	3 months	p=
PHQ - 9	19	14.4	7.5	0.021
GAD-7	23	12.8	7.9	0.286
EQ-5D-5L	19	13.7	8.8	0.002
Core-10	18	19.5	11.6	0.0001
Thermometer	19	47.2	68.2	0.013

These were established using the sign test.

Key:

PHQ-9 (depression)

The GAD-7 (anxiety)

EQ-5D-5L (physical, mental health combined measure)

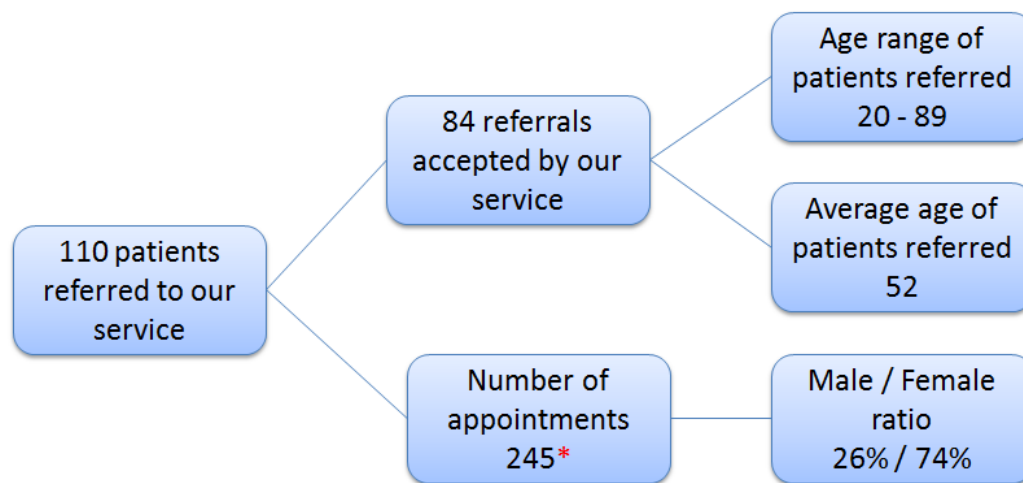
Core-10 (physical, mental health combined measure)

Thermometer (physical, mental health combined measure)

- 15 out of 19 (79%) patients reported improvements in the EQ-5D-5L (with 2 no change and 2 worse)
- 11 out of 19 (58%) patients reported improvements in pain scores in the EQ-5D-5L (with 8 no change)
- 13 out of 19 (68%) patients reported improvements in PHQ-9 (with 3 no change and 3 worse)
- 16 out of 19 (84%) patients reported improvements in Core-10 (with 1 no change and 1 worse)
- 14 out of 18 (78%) patients reported improvements in Thermometer (with 1 no change and 3 worse)

The EQ-5D-5L, Core-10 and Thermometer outcome measures show that patients themselves are reporting significant improvement in both their physical and mental wellbeing. At this stage of the project this is incredibly positive. This also demonstrates that a mental health intervention has had positive physical health outcomes for patients. To ensure the integrity of the pilot's results, we are currently exploring options for an independent assessment by the Centre for Mental Health.

Table 3. Referral Data – 20th September 2016 to 31st May 2017



* NB. The number of appointments includes 73 home visits

Table 4. Patient Feedback

Patient feedback has been extremely positive, with all patients either happy or extremely happy with the liaison psychiatry service provided. This is especially significant considering the patient cohort.



5. Potential Financial Benefits

Potential Primary Care Financial Benefits

These patients are also frequent users of primary care; from the 2013 Units Health and Social Care report from the Personal Social Services Research found:

- A single trip to the GP costs the NHS £45
- A telephone consultation with a GP costs the NHS £27
- A home visits from a GP costs the NHS £114
- A prescription from a GP costs the NHS £41 (including drug costs)
- A 15 minute appointment with a nurse in a GP practice costs the NHS £13

Secondary Care Financial Benefits

The psychiatric liaison intervention has a lasting impact on the demand for secondary care clinical services; therefore the financial benefit is a cumulative effect. Consequently, patients seen in the first year by the psychiatric liaison service will prevent ongoing attendances in secondary care, and show a cumulative financial benefit. For the purpose of demonstration, the table below assumes that patients are referred at equal intervals throughout the year; therefore over the 2 year pilot, 80 patients will have completed the full cycle of intervention.

Table 6. Cost and Possible Recurrent Savings (lifted from original business case)

	Sept 2016 to Sept 2018 (2 years)		
80 Patients	Minimum	Average	Maximum
PCPM Service cost	£419.7k	£419.7k	£419.7k
Possible savings	£482.6k	£2,046.7k	£3,561.0k
Net Savings	£62.9k	£1,627.0k	£3,141.3k

Based on a review of complex liaison cases and the impact of liaison psychiatry on occupied bed days in July 2015; results showed possible savings on occupied bed days per patient could range from between 29 days (minimum), 123 days (average) and 214 days (highest). At an average bed day cost of £208 (spell £2,500 average length of stay 12.5 days) savings are predicted above.

6. Funding Requirements for Year 2 of The Pilot

Table 7. Funding Requirement

Funding has already been agreed and is calculated for the second year as follows (as per original agreement):

Clinical Service Costs	WTE	2017/18 FYE
2 x sessions of a medical consultant per week	0.2	£24,998
2 x Liaison Nurses	2.0	£86,936
1 x Data Analyst/admin support	0.8	£21,899
Staff sub-total		£133,833
Non-pay (travel/training/consumables)		£10,110
Contribution to indirect costs and overheads at 15%		£21,591
Margin at 10% - AMH directorate (local management)		£16,553
Total Annual Cost to NHT		£182,087
Estates - room rental 1 day per week for 5 rooms		£28,600
Total Annual Cost for Service		£210,687

7. Future Developments

External Review and Roll-out Across Nottinghamshire

The Trust is currently considering the Centre for Mental Health's options appraisal for a formal review of the service. The benefit of an external review would be to validate both the clinical outcomes and financial benefits delivered by the pilot. This would provide evidence to enable future service commissioning decisions to be taken; for example the roll-out of the service over the rest of

Nottinghamshire. All CCGs have expressed considerable interest in this service for their area. The service is also deliberating future development opportunities for the PCPM service; these include the addition of Allied Health Professionals to provide a multi-professional approach to ensure that every aspect of the patient's physical and mental wellbeing are considered holistically.

National and International Interest in the Nottingham PCPM Pilot

With an estimated 4.5 million people in the UK with a long-term physical condition and co-morbid mental health problem such as depression or anxiety, there has been significant interest in the PCPM service. Dr Schofield recently presented to over 200 delegates at the King's Fund on how the pilot was instigated and the preliminary findings after 6 months. Dr Schofield has also disseminated initial intelligence to the King's Fund communities who are looking at integrated care and at the Faculty of Liaison Psychiatry's Annual Conference May 2017 (an international conference).

The service is also mentioned in the King's Fund [Mental health and new models of care](#) (May 2017) *"As part of its vanguard programme, Rushcliffe MCP in Nottinghamshire has developed a primary care psychological medicine service. This focuses on supporting people with persistent physical symptoms and others who frequently attend primary care, and is delivered by experienced liaison nurses and a liaison psychiatrist who also works in the local acute trust. Common input includes: case management; diagnosis of mixed medical and psychiatric morbidity; training, supervision and support for GPs and other professionals; and educating patients."*

8. Conclusion

The Clinician Reported and Patient Reported Outcome Measures are clinically meaningful and statistically significant; such clinical improvement in a group of patients with such chronic physical health matters is a remarkable achievement at this stage of the pilot. The feedback from both patients and GPs has been incredibly positive, with the number of referrals in excess of the original estimates.

The PCPM service is providing a more streamlined pathway, a better patient experience and considerable early improvements in outcomes by providing earlier intervention and active management in the community.

9. Recommendations

MCP Clinical Delivery Group members are asked to note the progress and contents of this paper and to confirm funding for the second year of the PCPM pilot.

Report by Dr Chris Schofield, Consultant Liaison Psychiatrist

Department of Psychological Medicine
Nottinghamshire Healthcare NHS Foundation Trust

Appendix to paper above

PCPM Vignettes

Patient 1 referred by GP with medically unexplained speech difficulties and jaw clenching. She has a diagnosis of situs inversus totalis which was diagnosis in mid-teens. Prior to this many medical errors were made due to this being missed. This made her understandably, not trust the healthcare professionals that there was no medical explanation to her jaw clenching despite seeing many experts in the field. She held down a very demanding job with significant responsibilities but due to not being able to speak she lost her job and for the 1st time had to take benefits to support her son and herself. She received regular medication reviews by a psychiatrist, fortnightly home visits with a mental health nurse and support and reassurance were provided. Problems and goals approach. Therapeutic relationship built. Walks along the river to practice mindfulness and demonstrate the positive effects of distraction and exercise. Psychoeducation provided about the mind and body and how they affect each other. S.M is now aware of how her mood affects her jaw. She feels more able to cope. Her mood has improved and her jaw is only a slight concern to her. She is now able to speak coherently is insightful about how to keep well and function as a mother and is back at work as a teacher. The estimated financial benefit of the PCPM intervention due to her benefits would have been approximately £18,500 per annum. The service also shows wider system savings as it was probable that this person may not have returned to work.

Patient 2 referred by GP with high levels of anxiety, medically unexplained mobility issues and pain in groin. This led to social isolation. Multiple GP visits and hospital visits had not improved things for him. He was assessed by psychiatrist and mental health nurse, prescribed Sertraline and seen fortnightly by the mental health nurse. The care plan involved anxiety management, CBT approach, graded exposure work and home visits and confidence building out in the community. He no longer uses a wheelchair. He walks outside in his local community using a frame on his own. He socialises with friends every day. His mood has improved and he no longer panics/startles. He walks unaided in his parts of his house. He understands and accepts that there is a psychological component to his difficulties. His level of functioning has increased considerably.

Patient 3 referred by GP with high levels of anxiety in context of severe COPD. He had significant GP and secondary care input. He was isolating himself at home, had low mood and poor motivation. He experienced interpersonal relationship difficulties with his wife and had many safety behaviours as a response to a feared catastrophe (losing his breath). He was assessed at home by a mental health nurse and seen fortnightly. By using various psychological approaches and liaison with the psychiatrist for prescribing advice, he is no longer low in mood or isolating himself at home. He has stopped many of the safety behaviours and is rebuilding the relationship with his wife. His anxiety levels have reduced considerably.

Appendix B

RUSHCLIFFE Reports

SUMMER 2017

RUSHCLIFFE - GREAT PLACE • GREAT LIFESTYLE • GREAT SPORT

NEWS FROM YOUR CCG 12

In good health working together to improve patient care

Health and care organisations across Rushcliffe have been exploring new and innovative ways to design and deliver health and care services over the last two years.

All twelve Rushcliffe GP practices have come together as PartnersHealth, and are playing a crucial role in driving these changes and the integration of services. Rushcliffe Clinical Commissioning Group (CCG), patients, hospital colleagues and community service providers, and PartnersHealth are working in collaboration under the name 'Principia' to try these new ways of working. Principia's aim is to make services more convenient and accessible to patients – as well as providing better value for the NHS.

Principia is attracting national attention for its success in Rushcliffe – the following examples highlight just some of the areas where we're making a real difference to local people through more integrated care delivery.

Principia **PartnersHealth** **NHS Rushcliffe Clinical Commissioning Group**

Care closer to home

Patients now no longer need to go to hospital outpatient clinics for an appointment for some medical specialities, instead their GP can refer them to community clinics to be assessed by consultants and specialist teams.

Community care on offer includes gynaecology (Keyworth), trauma and orthopaedics (West Bridgford and Bingham), gastroenterology (West Bridgford) and intravenous treatment for osteoporosis (various GP practices and in patients' homes across Rushcliffe).

These new services have helped reduce the need for patients to attend the hospital and has saved the local NHS more than £1m.

28 | **reports**

NEWS FROM YOUR CCG 12

Reducing strokes through proactive care

All Rushcliffe GP practices are now using an easy-to-use tool that helps them to better identify patients with symptoms of atrial fibrillation (AF) – which puts them at risk of having a stroke. Following diagnosis GPs can reduce this risk of stroke starting patients on anticoagulation therapy.

There has been an 18% reduction in AF-related strokes in Rushcliffe between since 2015 – and it is estimated that at least 20 strokes have been prevented.

Reducing hospital admissions and A&E demand

A study by the Health Foundation has shown that Principia's support to care homes has helped reduced the number of A&E attendances, ambulance call-outs and hospital admissions from residential and nursing homes.

Each care home now has a designated GP practice looking after their residents – this improves communication and relationships with care home staff through regular visits to the home. The model also sees integrated community nursing teams going into the home and improved understanding of the alternatives to an ambulance call-out.

Comparing data from Rushcliffe care homes against similar care homes elsewhere, the study found that those receiving Principia's enhanced model of care attended A&E 29% less frequently were admitted to hospital 23% less often.

Effective prescribing in General Practice

Principia invested in a computer-based prescribing system which has been rolled out across all GP practices in Rushcliffe. This supports safe and cost-effective prescribing by delivering patient-specific information to the GPs and Advanced Nurse Practitioners to help decision-making about the appropriate treatment and medication.

Cost savings to the local NHS are predicted to be £160,000 in the first year of implementation – representing a return on investment of 300%.

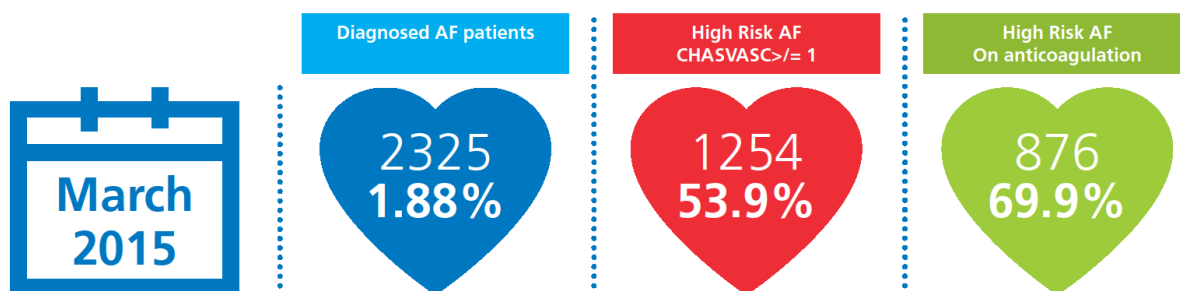
For more on how Principia is improving local services through NHS England's New Care Models programme, visit www.rushcliffeccg.nhs.uk or follow us on Twitter @PrincipiaMCP

RUSHCLIFFE - GREAT PLACE • GREAT LIFESTYLE • GREAT SPORT | 29

Stroke Prevention

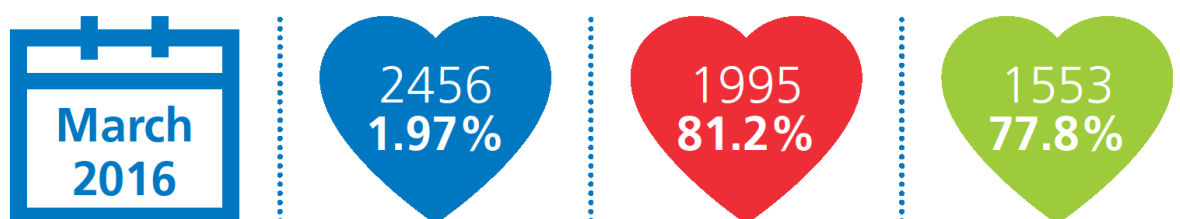


Diagnosis and Management of Atrial Fibrillation in Rushcliffe March 2015-March 2017



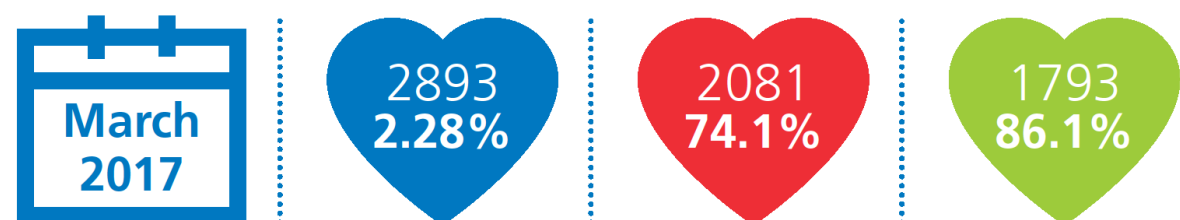
New local GP enhanced specification requiring:

- >95% patients with a CHADSVASC risk score of greater than 1 offered anticoagulation



New local GP enhanced specification requiring:

- >95% patients with a CHADSVASC risk score of greater than 1 offered anticoagulation
- AF case-finding programmes (pulse checks & AliveCor Devices)
- AF Upskilling sessions



568

new cases
identified over 2 years

28

less strokes per year

827

additional patients on
anticoagulation over 2 years

9

less deaths per year



@PrincipiaMCP
#futurenhs



Nottinghamshire Healthcare **NHS**
NHS Foundation Trust

APPENDIX D



Press information

Published 15 June 2017

Pioneering plan to join-up health and social care

Plans have been announced today (15 June) to explore new ways to better join up health and social care services.

NHS, local authorities and healthcare providers in Greater Nottingham are to benefit from new national investment to allow them to begin working towards the creation of a shared 'Accountable Care System'.

Working closely with patients and citizens, the aim will be to find new ways of breaking down barriers between organisations in order to provide a more joined-up approach to delivering healthcare, hospital care, mental health care and social care services to better meet the needs of people locally.

Greater Nottingham – which covers the four CCG areas of Nottingham City, Nottingham North & East, Nottingham West and Rushcliffe – is one of eight areas named in a list of places to be given the freedom as well as financial resources to establish accountable care systems.

In an announcement made today, the Chief Executive of NHS England, Simon Stevens, highlighted these areas* that will lead the way in taking more control over funding available to support transformation programmes – with the combined indicative potential to control around £450m of funding over the next four years – matched by accountability for improving the health and wellbeing of the populations they cover. NHS national bodies will provide these areas with more freedom to make decisions over how the health system in their area operates.

Work to develop the new Accountable Care System will be carried out by the Greater Nottingham Transformation Partnership and build on work already underway to better integrate services that provide healthcare.

For patients and citizens, this will eventually mean:

- More care focused closer to home in the community
 - Hospital care only for those most in need
 - High quality, accessible services
 - Fewer barriers between services from the NHS, local councils and health providers
- Involving local people and patients in how this system is developed will be an essential part of the work going forward.

David Pearson, Sustainability and Transformation Partnership Lead for Nottingham and Nottinghamshire, said: "The local Sustainability and Transformation Partnership is delighted to have the mandate and national support to progress its local transformation of the health and care system for the benefit of our population.

"We have come together over the last year to produce a five year plan for health and social care that articulates why change is urgently needed, what that change might look like and how it can be achieved. The learning from acceleration in Greater Nottingham will benefit the whole STP area and drive innovation.

“We are already making good progress on the national priority areas of urgent care, primary care, cancer and mental health. With national backing and support, including involvement in the national ACS development programme, we are committed to going faster in transforming care and achieving system-wide resilience and efficiency. Our aspiration to work as one, accountable system will see the breaking down of organisational boundaries to streamline services and ultimately improve the experience of patients, carers and citizens.”

The funding from NHS England is part of the Next Steps on the NHS Five-year Forward View – an ambitious plan to create the biggest national move to integrated care of any major western country by 2021. The eight ‘accelerator’ sites will have far more local control and freedom over the total operations of the health and care system.

The STP and the Accountable Care Systems aim to improve standards in care as well as addressing the projected shortfall in funds for the NHS and social care as the population continues to grow bigger and as people live longer.

There are significant gaps in the good health of local people, in the quality of care and in the resources to deliver care.

The transformation will be funded by:

- The new funding from NHS England announced today
- Finding new ways of delivering services that are better quality, more efficient and cost less than they do today
- Working together to better reduce duplication, waste and inefficiencies on a scale not possible by smaller, individual efforts (economies of scale)

Longer-term, by improving the health of the population, there will be reducing demand for health and social care services.

Dr Stephen Shortt, clinical lead for Rushcliffe Clinical Commissioning Group, said: “I’m really pleased Greater Nottingham has been selected to be part of this programme. It’s the right idea at the right time. We’ve made many changes for the better already, but today’s announcement means we are being encouraged and supported to go further and faster for the people of Greater Nottingham.

“No-one can be unaware of the unprecedented challenges facing the health and care system. Despite making good progress, there are still gaps in care and quality, demand is rising and resources are severely constrained.

“We in Greater Nottingham are clear that no one organisation can solve these challenges on its own. We believe we can bring together all those involved in care: the commissioners (those who plan and pay for care) and the providers, including local government, and to inject a greater urgency into integration and shared responsibility and decision making. This will be better for all of our patients and citizens.”

Greater Nottingham and Mid-Nottinghamshire, covering Mansfield and Ashfield and Newark and Sherwood, together form one of 44 STPs nationally.

ENDS

For more information, contact Nick Tully, Communications Manager, on 07825 297199 / 0115 8839592 or email: nicholas.tully@nottinghamcity.nhs.uk

Notes to Editors

*The eight accountable care systems are:

- Frimley Health including Slough, Surrey Heath and Aldershot
- South Yorkshire & Bassetlaw, covering Barnsley, Bassetlaw, Doncaster, Rotherham, and Sheffield
- Nottinghamshire, with an early focus on Greater Nottingham and Rushcliffe
- Blackpool & Fylde Coast with the potential to spread to other parts of the Lancashire and South Cumbria at a later stage
- Dorset
- Luton, with Milton Keynes and Bedfordshire
- Berkshire West, covering Reading, Newbury and Wokingham
- Buckinghamshire

In addition, it is expected that West, North and East Cumbria and Northumberland could join the group of accountable care systems later in the year.

Background

The STP for Nottingham and Nottinghamshire has been produced in response to recent NHS England planning guidance and to deliver the NHS Five Year Forward View.

Local NHS providers, clinical commissioning groups (CCGs), councils, and other health and care services have formed the Nottingham and Nottinghamshire Sustainability and Transformation Partnership - one of 44 in England - to collectively plan how local services will work to improve the quality of care, and their population's health and manage finances across the system.

More detail about the plan – as well as recent public feedback – can be found at www.stpnotts.org.uk.

The planning footprint locally covers Nottingham and Nottinghamshire. Nottinghamshire comes under two separate NHS England regional areas: 'Greater Nottingham / South Nottinghamshire' and 'Mid Nottinghamshire' are part of Midlands and East, and Bassetlaw is part of North of England. NHS England following local discussions determined that Greater/South and Mid Nottinghamshire formed the STP footprint, with Bassetlaw as an associate. The STP footprint for Nottingham and Nottinghamshire covers six CCG areas, eight local authorities and a population of slightly more than one million people.

1. The Greater Nottingham Transformation Partnership

The Greater Nottingham Transformation Partnership consists of:

- NHS Nottingham City Clinical Commissioning Group
- NHS Nottingham North and East Clinical Commissioning Group
- NHS Nottingham West Clinical Commissioning Group
- NHS Rushcliffe Clinical Commissioning Group
- Nottingham University Hospitals NHS Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham CityCare Partnership
- Circle Nottingham Limited
- Nottingham City Council
- Nottinghamshire County Council

The Greater Nottingham footprint covers Nottingham City, Nottingham North and East (covering parts of Gedling, South Ashfield and Eastwood), Nottingham West (Broxtowe and Eastwood) and Rushcliffe.

APPENDIX E

[extract]



My week in focus

I visited the Multispecialty Community Provider (MCP) vanguard in Nottingham yesterday. It was fantastic to meet the GPs in Rushcliffe and hear about the work they have been doing over many years to improve collaboration and integration between services in the area in order to deliver the best care for their patients.

Amazingly, all 12 practices in the locality/CCG have come together to implement this model of care.

Given my background in women's health, I was particularly interested to visit their community gynaecology service which is running a triage pilot involving GPs and a consultant working together to identify referrals that can be dealt with in the community setting.

A big thank you to everyone involved for their warm welcome and for so generously giving up their time to answer my many questions – I learnt a huge amount and they certainly are an inspiring bunch!

Until next week, best wishes,
Helen





Principia summer roadshow / self-care events in 2017

21 April	School Assembly for Year 11 at South Notts Academy
29 April	East Leake Village Event
17 June	Cotgrave Festival
24 June	East Leake Carnival
8 July	Keyworth Show
8 July	Radcliffe on Trent Carnival
22 July	Taste of Rushcliffe (RBC)
2 August	Lark in the Park (RBC)
10 September	Sunday Funday
TBC September	Radcliffe Health Event
20 September	Rushcliffe CCG AGM
18 November	Radcliffe Coffee Morning
TBC November	East Leake promoting Self-Care week in practice
TBC November	East Bridgford Health Event