Nottinghamshire County Council

Health and Wellbeing Board

Wednesday, 05 February 2014 at 14:00

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

AGENDA

NOTES:-

(1) The formal meeting of the Board will be folowed by a workshop about child and adolescent mental health.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Members or Officers requiring clarification on whether to make a declaration of interest are invited to contact Paul Davies (Tel. 0115 977 3299) or a colleague in Democratic Services prior to the meeting.

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

Notes

(1) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(2) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Paul Davies (Tel. 0115 977 3299) or a colleague in Democratic Services prior to the meeting.

Nottinghamshire County Council

minutes

Meeting	HEALTH AND WELLBEING BOARD
Date	Wednesday, 8 January 2014 (commencing at 2.00 pm)

Membership
Persons absent are marked with an 'A'

COUNTY COUNCILLORS

Joyce Bosnjak (Chair)
John Peck
Martin Suthers OBE
Muriel Wiesz
Jacky Williams

DISTRICT COUNCILLORS

Jim Aspinall – Ashfield District Council
Simon Greaves – Bassetlaw District Council
Jenny Hollingsworth – Gedling Borough Council
A Pat Lally – Broxtowe Borough Council
Debbie Mason – Rushcliffe Borough Council
Tony Roberts MBE – Newark and Sherwood District Council
Phil Shields – Mansfield District Council

OFFICERS

	David Pearson	-	Corporate Director, Adult Social Care, Health and Public Protection
A	Anthony May	-	Corporate Director, Children, Families and Cultural Services
	Dr Chris Kenny	-	Director of Public Health

CLINICAL COMMISSIONING GROUPS

	Dr Steve Kell	-	Bassetlaw Clinical Commissioning Group (Vice-Chairman)
	Dr Judy Jones	-	Mansfield and Ashfield Clinical Commissioning Group
	Dr Mark Jefford	-	Newark & Sherwood Clinical Commissioning Group
A	Dr Guy Mansford	-	Nottingham West Clinical Commissioning Group

	Dr Paul Oliver	-	Nottingham North & East Clinical Commissioning Group
	Dr Jeremy Griffiths	-	Rushcliffe Clinical Commissioning Group

LOCAL HEALTHWATCH

	Joe Pidgeon	-	Healthwatch Nottinghamshire

NHS ENGLAND

A	Helen Pledger	-	Nottinghamshire/Derbyshire Area Team, NHS England

NOTTINGHAMSHIRE POLICE AND CRIME COMMISSIONER

Vacancy

SUBSTITUTE MEMBERS IN ATTENDANCE

Tracy Madge	-	NHS England
Kate Allen	-	Children, Families and Cultural Services

OFFICERS IN ATTENDANCE

Paul Davies	-	Democratic Services
Irene Kakoullis	-	Public Health/Children, Families and Cultural Services
Nicola Lane	-	Public Health
Cathy Quinn	-	Public Health

ALSO IN ATTENDANCE

Amanda Sullivan	-	Chief Officer, Mansfield and Ashfield CCG and Newark and Sherwood CCG
Lucy Dadge	-	Director of Transformation, Mansfield and Ashfield CCG
Claire Grainger	-	Chief Executive, Nottinghamshire Healthwatch
Stephanie Cook	-	NHS England

MINUTES

The minutes of the last meeting held on 6 November 2013 having been previously circulated were confirmed and signed by the Chair, subject to the following amendments:

Councillor Jacky Williams was present in place of Councillor Stan Heptinstall

Councillor John Wilmott had been present as substitute for Councillor Tony Roberts

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Pat Lally, Dr Guy Mansford, Anthony May and Helen Pledger.

DECLARATIONS OF INTEREST BY MEMBERS AND OFFICERS

None.

MEMBERSHIP OF THE HEALTH AND WELLBEING BOARD

The Chair reported that County Council on 21 November 2013 had agreed to extend the Board's membership to include representatives from each district council and of the Police and Crime Commissioner. She welcomed the new representatives to their first meeting. Reference was made to views expressed at the Council meeting that the Board should have been consulted more formally about the change to its membership.

RESOLVED: 2014/001

That the County Council's decision to extend the Board's membership be noted.

BETTER CARE FUND (FORMERLY HEALTH AND SOCIAL CARE INTEGRATION TRANSFORMATION FUND)

David Pearson and Dr Paul Oliver introduced the progress report on the Better Care Fund (BCF), pointing out that the total budget for 2015/16 would be £54.9m, including capital grants and the information allocation. Plans for the Fund would be presented to the Board on 5 February. Points raised during discussion included:

- What would be the impact of funding reductions on adult social care, referred to in paragraph 14 of the report? - David Pearson pointed out that the scale of budget reductions in the County Council was such that it would not be possible to protect the whole of adult social care. A new adult social care model would be issued for consultation shortly. The BCF Working Group would receive a report on how to protect adult social care from demographic pressures and requirements of the Care Bill and existing legislation, while still being innovative.

- How were the BCF plans being prepared? – Lucy Dadge was overall lead for the programme. There were three sub-groups preparing area-based plans, and a further group working on performance measures. There had been an excellent workshop in December which had explored the links and differences between the plans.

- The BCF was targeted at primary and community care as well as adult social care, and would be an additional challenge for acute trusts.

- There was more to health than medicine. Examples existed elsewhere to show that reallocating budgets could lead to significant change. Local examples included the Assessment and Treatment Centre at Bassetlaw District Hospital,

and the PRISM (Profiling risk, integrated care and self-management) programme in Newark and Sherwood.

- It was important to engage with workforces about the plans.

- Social problems such as unemployment and debt impacted on health. Ashfield District Council was developing a radical plan in relation to this.

- Disabled Facilities Grants (which were being incorporated into the BCF) assisted discharge from hospital by providing adaptations to people's homes. It was recognised that some district councils topped up the budget for DFGs in their area. The BCF pooled budget did not negate partners' existing responsibilities, meaning that district councils would have to consider how much they wished to spend on such work.

RESOLVED: 2014/002

That an extraordinary meeting of the Board be held on 5 February 2014 (alongside the planned workshop) to approve the draft two year Better Care Fund plan based on the emerging themes covered in the report.

MID NOTTINGHAMSHIRE INTEGRATED CARE TRANSFORMATION PROGRAMME UPDATE

Amanda Sullivan introduced the update report on the Mid Nottinghamshire Integrated Care Transformation Programme (ICTP), including proposals under each of the four work streams, communications and engagement, and the next steps. Public feedback for the programme, which would be branded Better Together, had been positive. Both CCGs' governing bodies would receive a full report on the programme shortly.

She responded to questions and comments, indicating that the full report contained much more detail, and linked with the JSNA (Joint Strategic Needs Assessment) and Health and Wellbeing Strategy. It was indicated that the Department of Health was planning to issue guidance to NHS England and CCGs about aligning their plans with Health and Wellbeing Boards.

Other comments from Board members included that people with complex needs were most at risk; and that some people (for example people living on their own) did not think about or discuss their potential care needs.

RESOLVED: 2014/003

(1) That the Integrated Care Transformation Programme (Better Together) be noted.

(2) That, subject to the continued engagement of seldom heard groups, satisfactory external evaluation and equality impact assessment, the ongoing ICTP communications and engagement activity be considered appropriate.

NHS SUPPORT FOR SOCIAL CARE FUNDING

The report outlined arrangements for the transfer of s.256 funding from the NHS to the County Council to support services which benefit health. Services funded in this way had been maintained during the period of NHS reforms. The paper outlined proposals for the current financial year only.

RESOLVED: 2014/004

That the Board note the allocation of the s.256 funding for 2013/14 as approved by the Adult Social Care and Health Committee on 29 October 2012 and further considered by that Committee on 6 January 2014 in respect of those posts and services which require funding up to March 2014.

AUTISM SELF ASSESSMENT FRAMEWORK

David Pearson introduced the report, drawing attention to amended wording for paragraph 7(a), the last part of which now read:

> Within the health service complex diagnosis can be carried out by specialist referral to Nottingham City or Doncaster but there is a need to consider further post diagnostic support from health for people with Asperger's e.g. speech and language therapy, occupational therapy services, psychology and behavioural support. The diagnostic pathway for people with Asperger's needs further evaluation and review to determine its use and effectiveness.

Differing views were expressed about the degree to which this was an example of joined-up working and whether Health and Social Care were making equal progress. It was pointed out that the report recognised areas where there was more work to be done.

It was explained that for children with Asperger's, there was close working across education, social care and Health. Children might be referred by their school, and be supported in school or at home. For severe cases, there was an established pathway.

RESOLVED: 2014/005

(1) That the report be accepted, and the priorities described in the report across Health and Social Care for the 2014/15 Autism Action Plan delivered by the Integrated Commissioning Group for Mental Health, Learning Disability and Autism, the priorities being:

- diagnosis and post diagnostic support pathways
- data collection
- training and
- awareness raising in older people's services.

(2) That all partner organisations be requested to roll out autism awareness training and undertake reasonable adjustments within their organisations to ensure equality of access for people with autism.

HEALTHY CHILD PROGRAMME AND PUBLIC HEALTH NURSING FOR CHILDREN AND YOUNG PEOPLE

Kate Allen, Irene Kakoullis and Stephanie Cook introduced the report. Comments made during discussion included:

- There was some concern about giving notice to existing providers before an alternative specification was in place. This created uncertainty.

- The proposals introduced more coordinated and equitable services, at a time of reducing local authority budgets.

- Would it be possible to double the number of Health Visitors? – It was expected that sufficient numbers of nurses would come forward for Health Visitor training. Health Visitor courses were over-subscribed.

- Would there be assurances about the impact on the outcomes framework? – New specifications should provide better feedback on outcomes than present arrangements.

- Poor information from current providers did not necessarily mean that they were providing a poor service.

- There were concerns about the impact of ending sight and hearing tests for all children. - Evidence shows that school nurses were not effective at identifying hearing and sight problems. Hospitals did equivalent checks on babies soon after birth.

- Were there any thoughts of linking with services in Derbyshire or Derby City, for example? – Each local authority would commission services suited to its area. However they would learn from each other during the process.

- The proposals could create different silos from the existing ones. How would these services integrate with other children's' services?

- Safeguarding and integration with local primary care should be reflected in specification.

- What would the Health and Wellbeing Board do when faced with difficult decommissioning decisions in the future?

- A workshop session could be used to explore concerns about changing providers.

In light of the discussion, an amended recommendation was agreed, as follows:

RESOLVED: 2014/006

(1) That the report and the comments made during discussion be noted.

(2) That a further report be presented to the Board on the Healthy Child Programme and Public Health Nursing for Children and Young People in 2-3 months.

HEALTHWATCH NOTTINGHAMSHIRE UPDATE

Joe Pidgeon and Claire Grainger introduced the report on Healthwatch's activities since its establishment in April 2013. They circulated copies of the first issue of "Have Your Say", which was aimed at a wider audience.

Board members congratulated Healthwatch on its achievements so far. They recognised that the summary of complaints was based on the relatively small number of complainants. However, with so many of the complaints being about access to GP and nurse appointments, it was understandable that Healthwatch would wish to prioritise this topic.

Claire Grainger observed that the next report from Healthwatch would reflect a larger number of complaints. Where a pattern of complaints was developing, Healthwatch would follow them up. Healthwatch was attending health scrutiny committees and was involved in the care transformation work in south and mid Nottinghamshire. Complainants were referred to other complaints processes where appropriate.

Joe Pidgeon referred to the value of developing a protocol for Healthwatch, health scrutiny and the Board to help them with their work.

RESOLVED: 2014/007

That the update report on Healthwatch be noted.

WINTERBOURNE PROJECT UPDATE

David Pearson introduced the report, highlighting that it might not be possible to move all affected services users by the target date of June 2014, where there were complex care needs or specialist accommodation was required. The Board recognised that the report addressed concerns raised at an earlier meeting.

RESOLVED: 2014/008

(1) That the content of the report and the progress being made to commission suitable care and accommodation for people currently placed in hospital settings be noted.

(2) That an update report be presented in May 2014 focusing on the pooled budget scope, individual accommodation arrangements and resource requirements going forward.

SUMMARY OF THE 2014/15 GENERAL MEDICAL SERVICES CONTRACT NEGOTIATIONS

Dr Jeremy Griffiths introduced the summary of the contract negotiations. Issues covered by the contract included accountability, unplanned admissions, and patients being able to register at practices outside their home area, which had huge implications potentially. In response to questions and comments, he explained that seven day working was not part of the contract, and that extended hours would only apply to some days of the week.

Tracy Madge indicated that NHS England was preparing its primary care commissioning plans, which would be published alongside the CCGs' plans in February. There was a shared theme of extending access to GPs. The plans would be presented to the Board.

It was pointed out that the GMS contract was part of the broader transformation of primary care, and that further changes lay ahead.

RESOLVED: 2014/009

That the summary of the 2014/15 General Medical Services contract negotiations be noted.

WORK PROGRAMME

RESOLVED: 2014/010

That the work programme be noted, subject to the inclusion of reports on:-

- Healthy Child Programme and Public Health nursing for children and young people
- Winterbourne View
- CCG and NHS England Area Team commissioning plans.

The meeting closed at 5.00 pm.

CHAIR

Nottinghamshire County Council

Report to the Health and Wellbeing Board

5 February 2014

Agenda Item: 4

REPORT OF THE CORPORATE DIRECTOR FOR ADULT SOCIAL CARE, HEALTH AND PUBLIC PROTECTION AND CLINICAL LEAD, NHS NOTTINGHAM NORTH AND EAST CCG

BETTER CARE FUND

Purpose of the Report

1. To seek approval for the two year operational plans for the Better Care Fund for 2014/15 and 2015/16 for submission to the Department of Health.

2. To explain that because the detailed plans are still being worked on, they will be circulated to Board members shortly before the meeting on 5 February 2014.

Information and Advice

3. At its last meeting on 8 January 2014, the Board received a detailed progress report on the Better Care Fund (formerly the Integration Transformation Fund).

4. The Better Care Fund (BCF) was announced in June 2013 within the Government's spending review. It was described as creating a national £3.8 billion pool of NHS and local authority monies intended to support an increase in the scale and pace of integration and promote joint planning for the sustainability of local health and care economies.

5. In Nottinghamshire, the pooled budgets are £16.1m in 2014/15 and £49.7m (plus additional capital grants) in 2015/16.

6. Access to the BCF will be dependent on agreement of a local 2-year plan for 2014/15 and 2015/16. Plans agreed locally will need to align with national conditions and demonstrate measurable progress in respect of key outcomes. Ministers will ultimately approve any plans.

7. The BCF Working Group has been meeting regularly to develop the plans. The Working Group's members include representatives from the County and District Councils, CCGs, NHS England and NHS provider trusts.

8. The Department of Health requires that the plans be approved by the Health and Wellbeing Board before submission to the NHS England Area Team no later than 14 February.

9. The BCF plan provides comprehensive detail of how the fund will be used to progress integration across health and social care in Nottinghamshire. The plan identifies risks identified through the planning groups that will need to be addressed through the implementation of the plan.

10. Given the timescales in developing the plans for submission to NHS England Area Team, it has not been possible to have public engagement and consultation on the overall plan. However each element of the plan will be consulted upon before any plan is implemented. The outcome of consultation will be reported to the Health and Wellbeing Board in due course.

11. Timescales for preparing the plans have been very tight, with the final meeting of the BCF Working Group being held on 31 January 2014. In view of this, it has not been possible to circulate the plans with this report.

12. The plans will be circulated to Board members by e-mail and published on the County Council's website at the earliest opportunity after 31 January.

Reason/s for Recommendation/s

13. To meet the Department of Health requirement for the Health and Wellbeing Board to approve the plans before submission.

Statutory and Policy Implications

14. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Implications for Service Users

15. It is expected that integrated systems will improve the service user journey and experience. Work will need to be done to assess the impact on existing service provision to ensure any redirection of resources is not detrimental.

Financial Implications

16. Alongside the completion of the plan and its priorities, detailed work has been undertaken to consider the impact of the proposed pool upon existing services, and the sharing of risk. While many of the revenue funding streams are currently committed to core services and assist with pressures in base budgets, the capital allocations are currently the subject of grant conditions and dedicated to one purpose, so the consequences of any dis-investment proposals will need to be considered carefully. For example Disabled Facilities Grants (DFG) are dedicated for use to fund major adaptations in privately owned property and any reduction would have an impact on the availability of grants for this purpose.

Equalities Implications

17. Equality issues will be taken into account as part of the planning process undertaken in the working group. Better integration of services should mean that people receive a more consistent service across the county.

RECOMMENDATION

That the Board

1. approves the Better Care Fund plans for 2014/15 and 2015/16 for submission to the NHS England Area Team.

DAVID PEARSON
Corporate Director for Adult Social Care, Health and Public Protection
DR PAUL OLIVER
Clinical Lead, NHS Nottingham North and East CCG

For any enquiries about this report please contact:

Lucy Dadge, Director of Transformation
lucy.dadge@mansfieldandashfieldccg.nhs.uk / 01623 673330.

Constitutional Comments (SLB 23/01/2014)

18. It is a Department of Health requirement for the Health and Wellbeing Board to sign off the plans before submission, therefore the Health and Wellbeing Board is the appropriate body to consider the content of this report.

Financial Comments

19. To follow.

Background Papers

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

None

Electoral Division(s) and Member(s) Affected

All.

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

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

b) Authorisation and signoff

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

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

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

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

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

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

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

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

c) Service provider engagement

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

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

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

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

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

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

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

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

d) Patient, service user and public engagement

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

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

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

South Nottinghamshire

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

Mid-Nottinghamshire

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

North Nottinghamshire

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

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

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

e) Related documentation

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

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

2) VISION AND SCHEMES

a) Vision for health and care services

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

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

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

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

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

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

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

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

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

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

b) Aims and objectives

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

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

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

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

Our joint objectives are:

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

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

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

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

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

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

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

1. Description of planned changes

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

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

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

7 Day Service Provision and Access

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

The success factors are:

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

Supporting Integration

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

The success factors are:

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

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

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

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

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

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

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

The success factors are:

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

Infrastructure, Enablers and Other Developments

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

The success factors are:

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

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

2. Implications for the acute sector

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

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

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

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

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

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

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

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

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

3. Governance

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

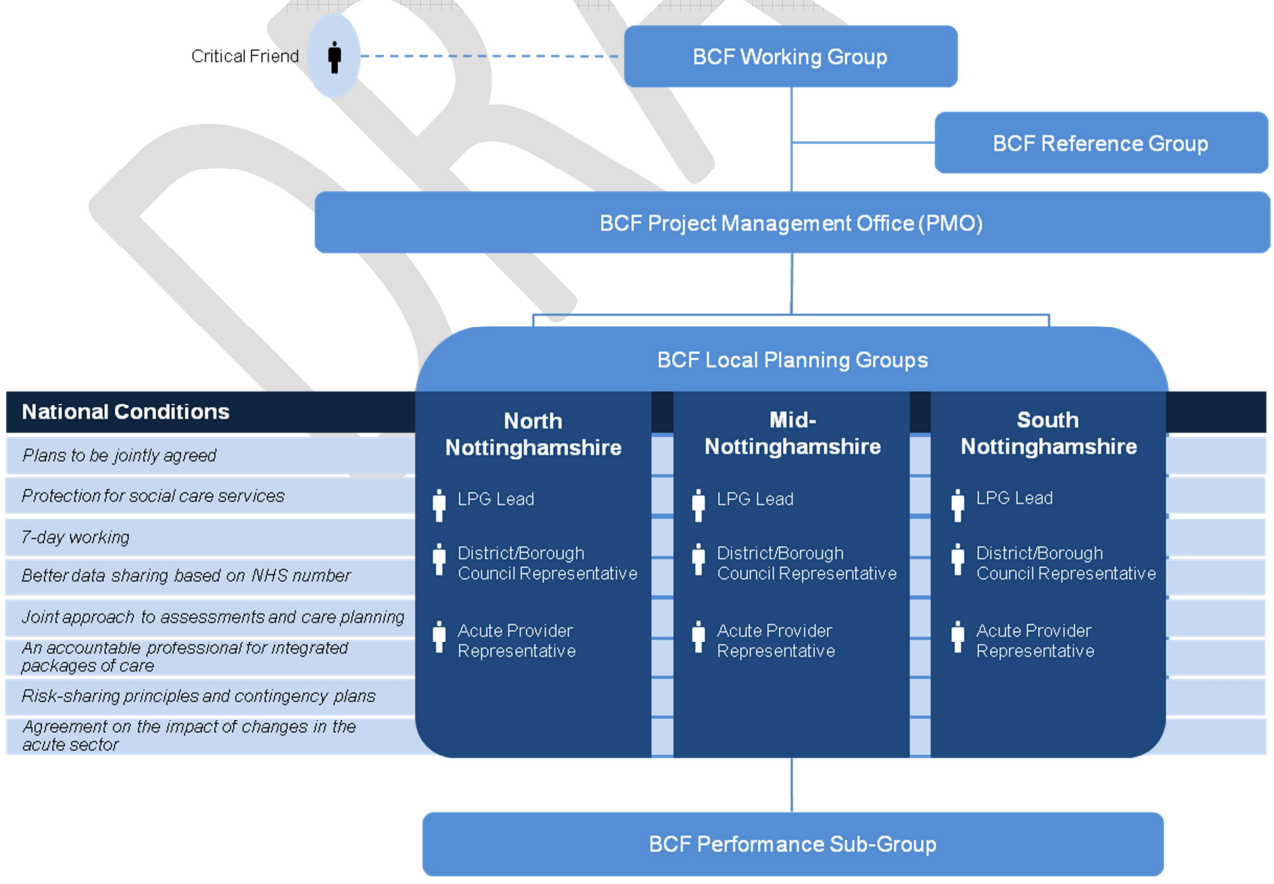
A county-wide BCF Working Group has been mobilised to oversee the development and delivery of a county-wide Nottinghamshire plan for pooled budget(s) under the terms of Better Care Fund. The Working Group is co-chaired by the Chief Executive of Nottinghamshire County Council and a CCG Clinical Chair,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

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

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

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

Our county-wide BCF governance structure is shown below:



3) NATIONAL CONDITIONS

a) Protecting social care services

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

In Nottinghamshire, eligibility is set at Critical and Substantial.

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

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

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

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

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

b) 7 day services to support discharge

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

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

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

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

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

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

c) Data sharing

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

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

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

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

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

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

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

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

d) Joint assessment and accountable lead professional

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

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

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

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

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

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

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

4) RISKS

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

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

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

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

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

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

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority Social Services				
Nottinghamshire County Council	Y	£ 2,939,000	£ 1,964,000	£ 1,964,000
Disabled Facilities Grant	N	£ 3,444,692	£ 3,204,000	£ 3,204,000
CCG				
Bassetlaw CCG	N	£ 7,236,000	£ 7,526,000	£ 8,191,000
Newark and Sherwood CCG	N	£ 3,735,422	£ 7,718,000	£ 10,054,399
Mansfield and Ashfield CCG	N	£ 6,009,578	£ 12,418,000	£ 16,175,601
Nottingham North and East CCG	N	£ 4,367,016	£ 9,115,000	£ 9,115,000
Nottingham West CCG	N	£ 3,101,243	£ 6,180,000	£ 6,180,000
Rushcliffe CCG	N	£ 3,138,533	£ 6,780,000	£ 6,780,000
BCF Total		**£ 33,971,484**	**£ 54,905,000**	**£ 61,664,000**

The funds identified here for investment to deliver specified performance improvements and system integration will be ring-fenced for that purpose only. A governance structure for pooled budgets will be established that oversees local and county-wide performance, include use of the contingency fund. The Performance sub-group will propose the criteria for rules and principles around monitoring, reporting, and the management of variances from plan.

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Nottinghamshire will take a three staged approach, which will be influenced by the maturity of the relevant scheme, and mitigating action required:
1. Initially, the responsible organisation will fund where the pressures in the system are (across health and social care)
2. Scope within the BCF fund in 2015/16 to develop services (enhancing capacity within existing schemes where appropriate)
3. Contingency fund outside of the BCF if schemes are not delivering the required change, or achieving the BCF targets

Contingency plan:		2015/16	Ongoing
Outcome 1: risk that interventions to reduce DToCs are not successful	Planned savings (if targets fully achieved)	3,083,460	3,083,460
	Maximum support needed for other services (if targets not achieved)	3,083,460	3,083,460
Outcome 2: risk that avoidable emergency admissions 65+ are not reduced 10% in year 1 and 10% in year 2.	Planned savings (if targets fully achieved)	2,694,884	2,694,884
	Maximum support needed for other services (if targets not achieved)	2,694,884	2,694,884

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment (£000s)	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
7 Day Service Provision and Access									
North Nottinghamshire									
Intermediate Care Rapid Response	Community	£ 1,585,000	£ -	£ -	£ -	£ 1,585,000	£ -	£ -	£ -
7 Day Access to Services	Various	£ -	£ 200,000	£ -	£ -	£ 400,000	£ -	£ -	£ -
Mental Health Liaison	Mental Health	£ -	£ 380,000	£ -	£ -	£ 380,000	£ -	£ -	£ -
Mid-Nottinghamshire									
Primary Care Services: Care homes advanced nurse practitioner Improved primary care access - urgent primary care.	Primary care and TBA	£ -	£ -	£ -	£ -	£ 1,000,000	£ -	£ 1,500,000	£ -
South Nottinghamshire									
7 day working	GP/Community Services Provider	£ -	£ -	£ -	£ -	£ 1,500,000	£ -	£ 900,000	£ -
GP Access	GP practices	£ -	£ -	£ -	£ -	£ 1,842,979	£ -	£ 686,589	£ -
Supporting Integration									
North Nottinghamshire									
Personalised Care	Primary Care	£ -	£ 280,000	£ -	£ 140,000	£ 560,000	£ -	£ 300,000	£ -
Reablement Services	Community	£ 937,000	£ -	£ -	£ -	£ 802,000	£ -		£ -
Discharge/Assessment	Community/Mental Health	£ 310,000	£ 250,000	£ -	£ -	£ 810,000	£ -	£ -	£ -
Mid-Nottinghamshire									
Locality intermediate care teams - proactive care multi-disciplinary teams, low and enhanced intermediate care and the self care hub. PRISM virtual wards. Use of risk stratification tool to target high risk patients. Also includes care navigator - establishing a directory of services for health and social care to maintain people at home.	TBA	£ 3,500,000	£ -	£ 1,000,000	£ -	£ 11,000,000	£ 1,800,000	£ 1,000,000	£ -
South Nottinghamshire									
Personalised care - Tailored care for vulnerable and older people	GP practices	£ -	£ -	£ 519,596	£ -	£ 1,800,000	£ -	£ 1,039,192	£ -
Community Geriatrician	Acute	£ -	£ -	£ -	£ -	£ 100,000	£ -	£ 45,857	£ -
Community Hub Development	Community Services Provider	£ -	£ -	£ -	£ -	£ 90,000	£ -	£ 82,153	£ -
Community Programme	Acute	£ 500,000	£ -	£ 237,561	£ -	£ 500,000	£ -	£ 237,561	£ -
Reablement Services	NCC/CHP	£ 123,721	£ -	£ 74,233	£ -	£ 1,200,000	£ -	£ 720,000	£ -
Transforming Patient Satisfaction									
North Nottinghamshire									
Respite Services	Various	£ 325,000	£ -	£ -	£ -	£ 325,000	£ -	£ -	£ -
Improving Care Home Quality	NCC	£ -	£ 125,000	£ -	£ 60,000	£ 250,000	£ -	£ 130,000	£ -
Telehealth	Community	£ -	£ 285,000	£ -	£ 140,000	£ 470,000	£ -	£ 250,000	£ -
Mid-Nottinghamshire									
Self care service - dedicated and targetted support for patients to self-care and to identify the information and access to support services that they need to enable them to become more involved in their own care and maintain their well-being.	TBA	£ -	£ -	£ -	£ -	£ 160,000	£ -	£ -	£ -
Communications (social marketing). Support for sustained and targeted communications support	CCGs	£ -	£ -	£ 167,000	£ -	£ 100,000	£ -	£ 450,000	£ -
South Nottinghamshire									
Enhanced support to care homes	Community Services Provider	£ -	£ -	£ -	£ -	£ 500,000	£ -	£ 89,673	£ -
Support for Carers	TBC	£ 767,000	£ -	£ 460,200	£ -	£ 666,150	£ -	£ 399,690	£ -

BCF Investment (£000s)	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Telehealth	Community Services Provider/GP Practice/Acute	£ -	£ 70,298	£ 10,581	£ -	£ 70,298	£ -	£ 10,581	£ -
Protecting Social Services									
North Nottinghamshire									
Protecting Social Care Services	NCC	£ 2,227,000	£ -	£ -	£ -	£ 2,277,000	£ -	£ -	£ -
Mid-Nottinghamshire									
Protecting social care services	NCC	£ 6,245,000	£ -	£ -	£ -	£ 6,245,000	£ -	£ -	£ -
South Nottinghamshire									
Protecting Social Care Services	NCC	£ 7,645,000	£ -	£ -	£ -	£ 7,645,000	£ -	£ -	£ -
Intermediate Care Bed Based	Care Homes/Community Services Provider	£ -	£ -	£ -	£ -	£ 2,698,800	£ -	£ 407,750	£ -
Addtional Support to Social Care	NCC	£ 214,565	£ -	£ 128,739	£ -	£ 214,565	£ -	£ 128,739	£ -
Community Capacity - Rapid response (includes interim homecare)	Home Care Providers	£ -	£ -	£ -	£ -	£ 1,061,000	£ -	£ 397,250	£ -
Facilitating Discharge									
North Nottinghamshire									
Equipment Services	Voluntary	£ 667,000	£ -	£ -	£ -	£ 667,000	£ -	£ -	£ -
Mid-Nottinghamshire									
Specialist intermediate care team	TBA	£ -	£ -	£ -	£ -	£ 3,800,000	£ 600,000	£ 1,800,000	£ -
South Nottinghamshire									
Early Supported Discharge	Community Services Provider/Acute	£ 500,000	£ -	£ 500,000	£ -	£ 500,000	£ -	£ 300,000	£ -
Home Care/OT	Community Services Provider/NCC	£ 400,494	£ -	£ 240,296	£ -	£ 400,494	£ -	£ 240,296	£ -
Equipment Services	Voluntary	£ 135,714	£ -	£ 81,428	£ -	£ 135,714	£ -	£ 81,428	£ -
Intermediate Care at Home	Community Services Provider	£ -	£ -	£ -	£ -	£ 500,000	£ -	£ 300,000	£ -
Infrastructure, Enablers, and Other Developments									
North Nottinghamshire									
Disabilities Facilities Services	District/Borough Councils	£ 532,000	£ -	£ 319,200	£ -	£ 532,000	£ -	£ 319,200	£ -
Mid-Nottinghamshire									
Developments to support the implementation of the Better Together scheme, including: Information management and technology Organisational Development Implementation support	TBA	£ -	£ -	£ -	£ -	£ 125,000	£ 1,400,000	£ -	£ -
Disabilities Facilities Services	District/Borough Councils	£ 1,057,000	£ -	£ 634,200	£ -	£ 1,057,000	£ -	£ 634,200	£ -
South Nottinghamshire									
Transformation Programme Management	CCGs	£ 250,000	£ -	£ -	£ -	£ 650,000	£ -	£ -	£ -
Disabled Facilities Grant	District/Borough Councils	£ 1,281,000	£ -	£ 768,600	£ -	£ 1,133,000	£ -	£ 679,800	£ -
County-wide across Nottinghamshire									
Social Care Capital	NCC	£ 2,939,000	£ -	£ -	£ -	£ 1,964,000	£ -	£ -	£ -
Other projects yet to be fully planned up	TBA	£ 239,692	£ -	£ 143,815	£ -	£ 147,000	£ -	£ 88,200	£ -
Total		**£ 32,381,186**	**£ 1,590,298**	**£ 5,285,450**	**£ 340,000**	**£ 57,864,000**	**£ 3,800,000**	**£ 13,218,160**	**£ -**

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

All schemes within the Nottinghamshire BCF plan will contribute towards the nationally and locally set performance metrics - schemes are aligned to the national conditions on the "Finance - Schemes" sheet:
- Delayed Transfers of Care
- Avoidable Emergency Admissions
- Admissions to residential and care homes
- Effectiveness of Reablement
- Reduction in direct admissions into long term care from hospital settings (local)

Nationally set metrics will be measured as defined in the technical guidance. For the Avoidable Emergency Admissions, the target has been set only in-line with the improvements in performance anticipated in relation to the BCF plan schemes, i.e. for our resident population aged over 65 years (and not children, young people or younger adults).

The local metric is measured in the following way:
- numerator: Admissions to long-term residential and nursing care from an acute setting
- denominator: Admissions to residential and nursing care : Permanent admissions of older people (aged 65 and over) to residential and nursing care homes
- expressed as a rate per 100 admissions

This metric targets a vulnerable cohort in our population and links with our objectives of keeping people as independent as possible for as long as possible. It also relates to the priorities in Nottinghamshire's Health and Wellbeing Strategy. Data will be collected quarterly.

In addition to this, each local planning group will oversee performance against a number of locally identified key metrics such as:
- nursing home admissions (and those directly from hospital)
- residential home admissions (and those directly from hospital)
- DTOCs, reason G (patient or family choice)

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We will use the nationally developed indicator, however, will continue to monitor existing measures until this is in place, such as the Friends and Family Test, provider satisfcation data, Personal Social Services Adult Social Care Survey, and the Carers Survey.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

BCF Working Group is co-chaired by representatives from the CCGs and Nottinghamshire County Council, Mick Burrows (Chief Executive, Nottinghamshire County Council) and Dr Paul Oliver (Clinical Lead and Chair, Nottingham North and East CCG). This group will assume overall responsibility for achievement of the BCF plan.

Local planning groups for North, Mid and South Nottinghamshire are responsible for agreement, planning and implementation of schemes and metrics within their planning areas. They will oversee the delivery of each local scheme and address variations in performance.

In the development of this plan, a subgroup of the BCF Working Group was formed to consider the metrics and financial benefits. - the BCF Performance Subgroup. Membership of the group includes Nottinghamshire County Council (adult social care and public health), CCGs, and acute and community providers. Targets have been aligned with locally agreed targets for each CCG.

The BCF plan has been approved by:
- Health and Wellbeing Board
- the six Nottinghamshire CCGs
- Nottinghamshire County Council
- Local planning groups, which include members of the above and also representation from acute and community providers, and District/Borough Councils

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

N/A

Metrics		Current Baseline (as at…)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	649.18	N/A	602.44
	Numerator	970		953
	Denominator	149420		158191
		(April 2012 - March 2013)		*(April 2014 - March 2015)*
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	83.20	N/A	86.49
	Numerator	630		653
	Denominator	755		755
		(April 2012 - March 2013)		*(April 2014 - March 2015)*
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	395.43	389.06	382.89
	Numerator	20084	22398	14810
	Denominator	634884	639656	644651
		(April 2013 - November 2013)	*(April - December 2014)*	*(January - June 2015)*
Avoidable emergency admissions (composite measure)	*Metric Value*	173.65	170.20	165.89
	Numerator	16613	8197	8044
	Denominator	797235	802680	808159
		(April 2012 - March 2013)	*(April - September 2014)*	*(October 2014 - March 2015)*
Patient, ser vice user and carer experience (composite measure)		See above	N/A	See above
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes (local metric)	*Metric Value*	64.97	38.04	34.42
	Numerator	217	369	328
	Denominator	334	970	953
		(April 2012 - March 2013)	*(April 2013 - March 2014)*	*(April 2014 - March 2015)*

Description of Planned Changes – Schemes

Please note: *In addition to the schemes listed in this document, CCGs across Nottinghamshire are also working up further schemes to support the BCF outcomes and metrics that are not currently included in the pooled BCF arrangements.*

Theme	Schemes	Timescale for Delivery
1. 7 Day Service Provision and Access	**NORTH NOTTINGHAMSHIRE**	
	Intermediate Care Rapid Response – provides immediate support to people to avoid hospital admission	Year 1
	7 Day access to services – across GP and community providers to support hospital discharges	Year 1
	Mental Health Liaison – working 24/7 across the Bassetlaw hospital site	Year 1
	MID-NOTTINGHAMSHIRE	
	Primary care services: Care homes advanced nurse practitioner Improved primary care access - urgent primary care	Year 2
	SOUTH NOTTINGHAMSHIRE	
	7 day working - Develop a seven day offer of access to GP/community services	Year 2
	GP Access – work with the Urgent Care Board to develop access to Primary Care services	Year 2

Theme	Schemes	Timescale for Delivery
2. Supporting Integration	**NORTH NOTTINGHAMSHIRE**	
	Personalised care - Tailored care for vulnerable and older people – a comprehensive and co-ordinated package of care for patients over 75	Year 1
	Reablement Services – Independence and Reablement within the Hospital, enhanced Reablement services	Year 1
	Discharge/Assessment – multi agency single point of assessment for patients	Year 2
	MID-NOTTINGHAMSHIRE	
	Locality intermediate care teams - proactive care multi-disciplinary teams, low and enhanced intermediate care and the self-care hub. Virtual wards. Use of risk stratification tool to target high risk patients. Also includes care navigator - establishing a directory of services for health and social care to maintain people at home.	Year 1/2
	SOUTH NOTTINGHAMSHIRE	
	Personalised care - Tailored care for vulnerable and older people – a comprehensive and co-ordinated package of care for patients over 75	Year 2
	Community Geriatrician – Geriatric/Health Care of Older People provides comprehensive geriatric assessment in community settings, linking with primary care and community services in a planned approach. Consultant geriatricians provide expertise to multi-professional teams working with complex patients and provide case review and direct patient care with smooth access to secondary care as appropriate. Also provide education, training and mentorship for staff and advice to support the development of services. Supports a reduction in unnecessary hospital attendances	Year 2
	Community Hub Development – develop the GP/social care/mental health input to the Hub model	Year 2
	Community Programme – To meet people's needs as close to their normal residence as possible, by creating efficient, evidence-based health and social care systems which are perceived as seamless by patients, users and carers	Year 1/2
	Reablement services – additional social work posts and to develop reablement/intermediate care approaches to support the discharge of older people from hospital	Year 1/2

Theme	Schemes	Timescale for Delivery
3. Transforming Patient Satisfaction	**NORTH NOTTINGHAMSHIRE**	
	Respite Services – service users patient satisfaction	Year 1
	Improving Care Home Quality: - Overarching housing and care home strategy for older people - Care home residents risk stratification and lead clinicians for each home - Leadership training for care home sector - Workforce plan for care homes - Training programmes for care home staff	Year 1/2
	Telehealth – to support patients to manage their own care	Year 1
	MID-NOTTINGHAMSHIRE	
	Self-care service – dedicated and targeted support for patients to self-care and to identify the information and access to support services that they need to enable them to become more involved in their own care and maintain their well-being.	Year 2
	Communications (social marketing) –To enable local people to access appropriate services by identifying ways that can help them choose the right care at the right time, by specifically targeting resources to identified target groups.	Year 2
	SOUTH NOTTINGHAMSHIRE	
	Enhanced support to care homes - Community based, multi-disciplinary in-reach services (which compliments healthcare delivered by the GP) which proactively addresses the health needs of residents in residential and nursing care homes. Offering holistic assessment and timely responsive support to meet the health and end of life care needs of residents. Promoting improved collaborative working between the care home, primary care and community services. To deliver improved case management, that focuses attention away from reactive care, emergency call-outs and crisis management.	Year 2
	Support for Carers – provides carer support including short breaks, respite	Year 1
	Telehealth – to support patients to manage long term conditions through the 'Flo' Telehealth model	Year 2

Theme	Schemes	Timescale for Delivery
4. Protecting Social Services	**A range of schemes across the county, including:**	
	Protecting social services - Care for the elderly in the community - Intermediate care services reviewed and enhanced - Community model developed and implemented - Community nurse support to Primary Care - Review and enhance Community Matron model	Year 1/2
	Community Capacity - Rapid response (includes additional homecare) – to provide interim home care services to people in hospital awaiting discharge due to a delay in the start of their regular homecare services	Year 2
	Support to Social Care - Memory Assessment Service – supports social care input to early diagnosis for dementia scheme - Mental Health Intermediate Care Services - specialist intermediate care teams in each CCG for older people with Mental Health problems and dementia. - Advocacy services - Support to the Multi Agency Safeguarding Hub	Year 1/2
	Intermediate Care Bed Based – development of approach following new pilot at Gedling Village	Year 2

Theme	Schemes	Timescale for Delivery
5. Facilitating discharge	**NORTH NOTTINGHAMSHIRE**	
	Equipment Services – to support increased demand for equipment to support people to remain in their own home and to facilitate discharge	Year 1
	MID-NOTTINGHAMSHIRE	
	Specialist intermediate care team	Year 2
	SOUTH NOTTINGHAMSHIRE	
	Early Supported Discharge – work with NUH and community services to develop early discharge systems and approaches	Year 1
	Equipment Services – to support increased demand for equipment to support people to remain in their own home and to facilitate discharge	Year 1
	Home Care/Occupational Therapy – additional support for interim homecare, occupational therapy to support assessment	Year 1

Theme	Schemes	Timescale for Delivery
6. Infrastructure, Enablers and Other Developments	**A range of schemes across the county, including:**	
	Developments to support the implementation of the Better Together scheme in Mid Nottinghamshire including: - Information management and technology - Organisational Development - Implementation support	Year 2
	Transformation Programme across South Nottinghamshire – to provide strong leadership across the South CCGs to lead the development of joint integration projects across Health and Social Care to oversee the strategic development and implementation of the integration agenda.	Year 2
	Disabilities Facilities Services - to support adaptations to dwellings occupied by disabled people	Year 2
	Other Projects to be fully developed and scoped	Year 2

Bassetlaw
A Community of Care and Support.

Vision	Better care for the frail and elderly	More and better care and support at home and in places nearby.	A high quality personal and efficient service from local doctors, nurses and other professionals, who they work for will not matter.	A high quality local Hospital with 7 day working, easy access, and essential services like a 24 hour Emergency Department, and consultant-led maternity unit.	Same day local care, with access to the right health care professional.	More support for independent living with enhanced sheltered housing choices.	Patients with a mental health condition to receive an excellent service.	Care homes to be an integral part of our local community
Outcomes	**Improved access to services for people with urgent problems, including clear information and alternatives to face to face appointment where appropriate.**	**Improved community services built around the primary care team and caring for more people in their own homes.**	**Improved care home quality, more clinical input, co-ordinated care and transparency.**	**Improved access to mental health services focusing on urgent problems, vulnerable patients and integration with primary health care teams**	**Improved discharge processes focusing on early senior review, access to alternative services and appropriate care planning.**			
Program	**Urgent Care**	**Care for Elderly in Community**	**Care Homes**	**Mental Health Services**	**Supporting people after acute illness**			
Program Goals	• Improved model of same day care in Retford and Worksop • Improved model of same day care for villages. • Improved care out of hours.	• Improved intermediate care • New model of community based geriatric care (inc. Care Homes). • Primary Care Teams co-ordinating person centred care.	• New enhanced range of accommodation for older people. • Quality assurance framework across nursing and residential sector. • Alternative short-term service in care home setting. • New support living arrangements shared links and respite.	• Improved link between physical and mental health services. • Increased emphasis on prevention and early intervention. • Increased integration with primary care teams.	• Independence & Re-ablement unit. • Re-ablement pathways. • Community based assessment.			
Supporting Projects	• Increased capacity in primary urgent services. • Joint working to sustain A&E service. • Review of our of hours model.	• Primary care led team-working • Developing community geriatric service. • Identification and care planning for most vulnerable. • Improved communications and records sharing. • Responsible clinician. • Improved access to intermediate care services.	• Develop a care home quality dashboard/transparent quality assurance. • Care plans for patients with medical input. • Pharmacy and community service input. • Enhanced dementia nurse specialist access. • Develop alternatives to care homes where appropriate.	• 24 hour access to mental health services in A&E. • Identification and care plans for frequent users and vulnerable patients. • Integration and record sharing with primary care. • Improve focus with mental health problems and increased physical illness risk.	• Enhanced early senior review an discharge planning with early involvement of patients and social care team. • Improved access to intermediate care and alternatives to acute hospital beds. • Communication around delayed discharges and identification of barriers. • Discharge to assess model. • Care plans for vulnerable patients and clearer community input to ATC and A&E.			
Shared Values	Trust each other	Collaborate for the patient and service user	Be transparent	Share resources	Invest Our Time	Talk to local people and our staff	Build long term solutions.	Quality and Safety comes first	Our community is more important than any one organisation.	Share Skills	Provide Leadership	Encourage people to innovate.

Newark and Sherwood Clinical Commissioning Group | Mansfield and Ashfield NHS Clinical Commissioning Group | Nottinghamshire Healthcare NHS Trust | Sherwood Forest Hospitals NHS Foundation Trust | Nottinghamshire County Council

Mid-Nottinghamshire NHS Integrated Care Transformation Programme (ICTP)

Presentation to the Nottinghamshire County Council Health and Wellbeing Board

June 5th 2013

Transformation Partnership – leadership vision

- During 2012 and in light of economic and demographic pressures, Health and Social Care leaders agreed that a whole-system strategic service review was required to identify options for a sustainable health economy across Mid-Nottinghamshire.
- Both Commissioners and Providers of services to the locality have agreed that the work must focus on meeting population health needs, and that whilst organisational impacts will be differential, they must not take precedence over reaching a system-wide solution.
- It was recognised early on that to create a whole system solution would require **fully integrated hospital, community, primary and social care**
- This requires incremental and transactional service improvement, but also **transformational change**.
- Patients, not organisations, must be at the centre of the transformation; and able to manage their own care where possible and easily access the right services at the right time.
- The first phase of work comprising detailed analysis of current baseline, together with clinical leadership to scope new ways of working that meet population health needs completed in April. This has produced a **"blueprint" for how services should look in 3 to 5** years. This now needs wider stakeholder engagement to support implementation over 1 to 2 years.

What do we mean by integrated care ?

Definition

Integrated care refers to a way of organising services whereby the patient's journey through the system of care is made as simple as possible. It is:

"*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)*

Five principles

- Integrated care must focus on those patients for whom current care provision is disjointed and fragmented, mainly complex patients with co-morbidities.
- Effective clinical 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.
- Financial and non-financial incentives must be aligned to provide the conditions to ensure that care delivery is of high quality and cost-effective.

What do we know about our local services ?

Through discussions with care professionals, patients and their representatives and carers the following were established as key challenges to how care is delivered to the public:

•Poor communication across organisations and a lack of integration of services;

•A lack of understanding of the services available and how to access these services;

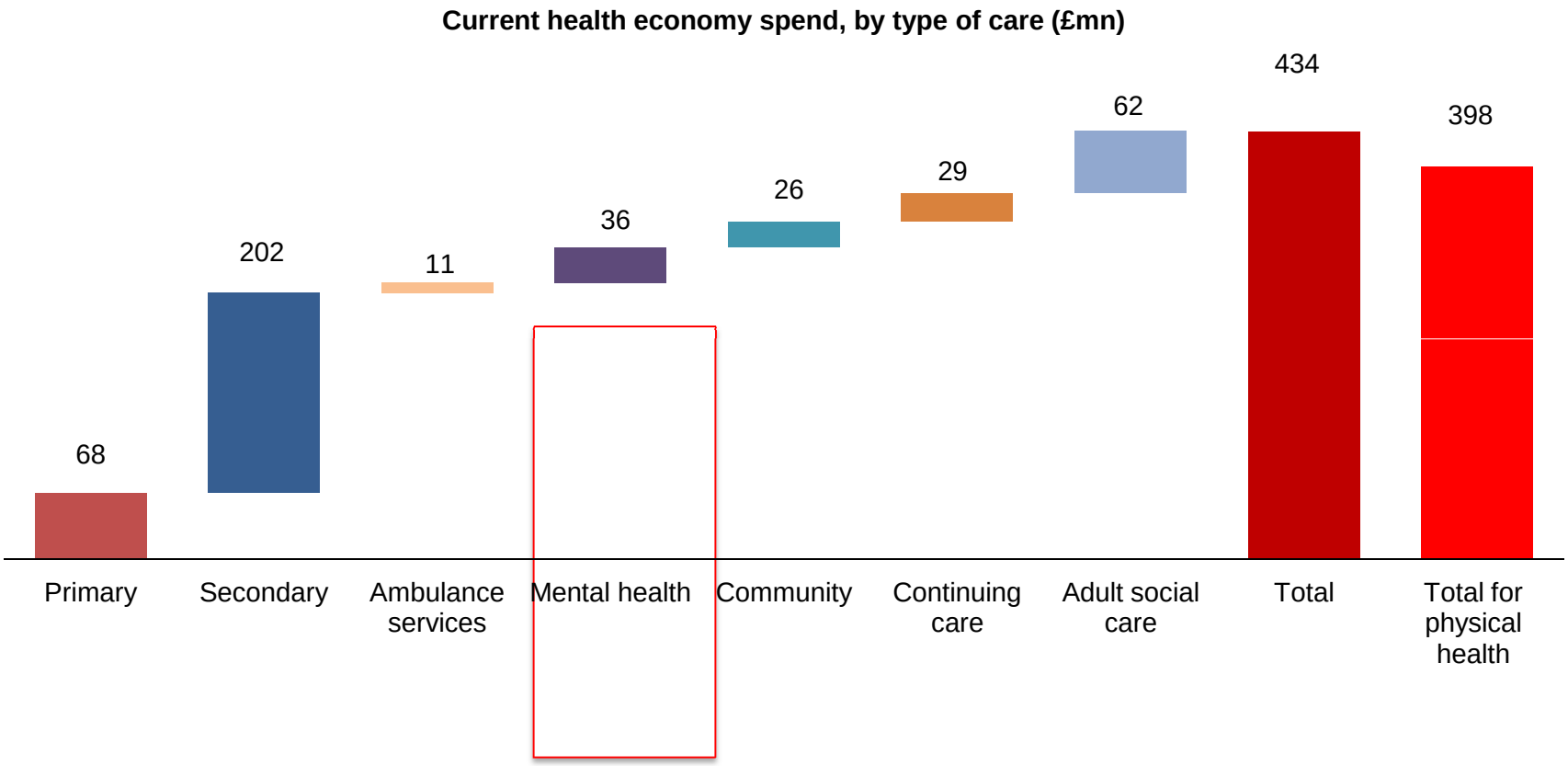
•A lack of focus on prevention and treatment of patients in an out of hospital community setting

•A significant increase in the number of frail and elderly people in the population who require higher levels of care

•A significant increase in the number of births, putting an increased demand on services

•The relatively low proportion of local people accessing the local acute hospitals for elective services

How much do we currently spend on local services ?



Sources: Newark and Sherwood CCG Integrated Plan, Community data, CCGs' 'Plan on a page' documents, Audit Commission Value-for-money profiles

Why do this work now ?

The population of over 75s in Nottinghamshire is set to increase by 25% by 2020. For Mid Nottinghamshire alone, the impact of the projected population growth in 2013/14 amounts to;

- Circa **4,000 additional A and E attendances**
- Circa **2,200 additional non-elective admissions**
- Circa 23,000 additional occupied bed days = **66 additional beds**

Whilst the current overall spend across this health economy is £434m, by the end of FY12/13, there will be a financial gap of **£19m.** Population growth and costs of provision are due to increase far ahead of funding, meaning that:

- Long term conditions currently account for 50% of GP consultations and 70% of hospital in-patient bed stays. The number of people with long term conditions is expected to rise by over 250% by 2050
- In 5 years, the **£19m** gap will have grown to **£70m, i**n 10 years, the gap will be **£140m**

The current health and social care system of provision is unsustainable

Blueprint proposals– Maternity and children's care

Initiative	Quality benefit	Measure
Short stay paediatric assessment unit – offers assessment as opposed to admission	Consultant led, but with community nurse support, providing better decision-making. Less stressful for patients as fewer and shorter hospital stays	Reduce short stay admissions by up to 70%
Short stay ante-natal assessment unit – 24 hours	Less time in hospital, enhanced delivery outcomes, and additional support to complex social care needs	Reduce short stay admissions by up to 50%
Paediatric referral optimisation	Increased clinical input to reduce inappropriate referrals and un-necessary emergency admissions. Less stressful for patients and improved support for GPs.	Reduce emergency admissions by 20%. Make better use of out-patients clinics
Integrated Children and Young Peoples Health Care Programme	Providing co-ordinated support to enable children and young people with complex needs to lead normal lives, improve safeguarding outcomes and the social, health and economic prospects of carers	Reduced emergency admissions and in-patient lengths of stay

Implementing these initiatives could give rise to financial savings of £4m p.a.

Blueprint proposals– Elective services

Initiative	Quality benefit	Measure
Review and improve referral processes	Reduction in inappropriate referrals frees up clinic time for better use. May result in more patients being able to access local services where they are viable and high quality	Where referral rates exceed national average, they will be normalised
Service viability review	**Ensure that services are commissioned on basis of best outcomes, and that patients can receive the right highest quality secondary services in their locality with appropriate tertiary support/referrals as required**	**More high quality secondary care services provided from local hospital facilities**

A work in progress, but ……

Implementing these initiatives could give rise to financial savings of £7m p.a.

Blueprint proposals – Urgent Care; responding to crises for the whole population

Initiative	Quality benefit	Measure
Crisis Hub/clinical navigator	Improves patient experience, removing their problems navigating around providers, and keeps them at home where possible Avoid un-necessary A and E attendances	Reduce A&E attendance by 12% and admissions by 10%
Integrated urgent care service at Newark and Mansfield – "single front door" – primary, social, community and A&E/MIU and assessment/ clinical decision units	More clarity for staff/patients on appropriate care pathway when in crisis, and better experience from reaching right destination quickly Less variation in service and more capacity through joint working with secondary and primary care	Productivity improvement across A&E and GP out of hours of 20% Reduction in NEL length of stay =3,500 bed days
GP Provision – same in the early evening as early morning	Fewer sub-acute patients will present early evening where the demand profile is significantly greater than the regional average	Reduction in A&E attendances and resultant admissions
Streamlining urgent care referrals – enhanced role for ambulance service	Ambulance service and other providers working together to improve decision-making before making transfers to urgent care settings should result in more patients being treated at home/in the community, rather than being conveyed to hospital	Increased availability of ambulances Reduce A&E attendances and admissions

Implementing these initiatives could give rise to financial savings of £10m p.a., but will require re-investment in community and other services

Blueprint proposals…. Integrated pro-active care for frail elderly and those with long term conditions

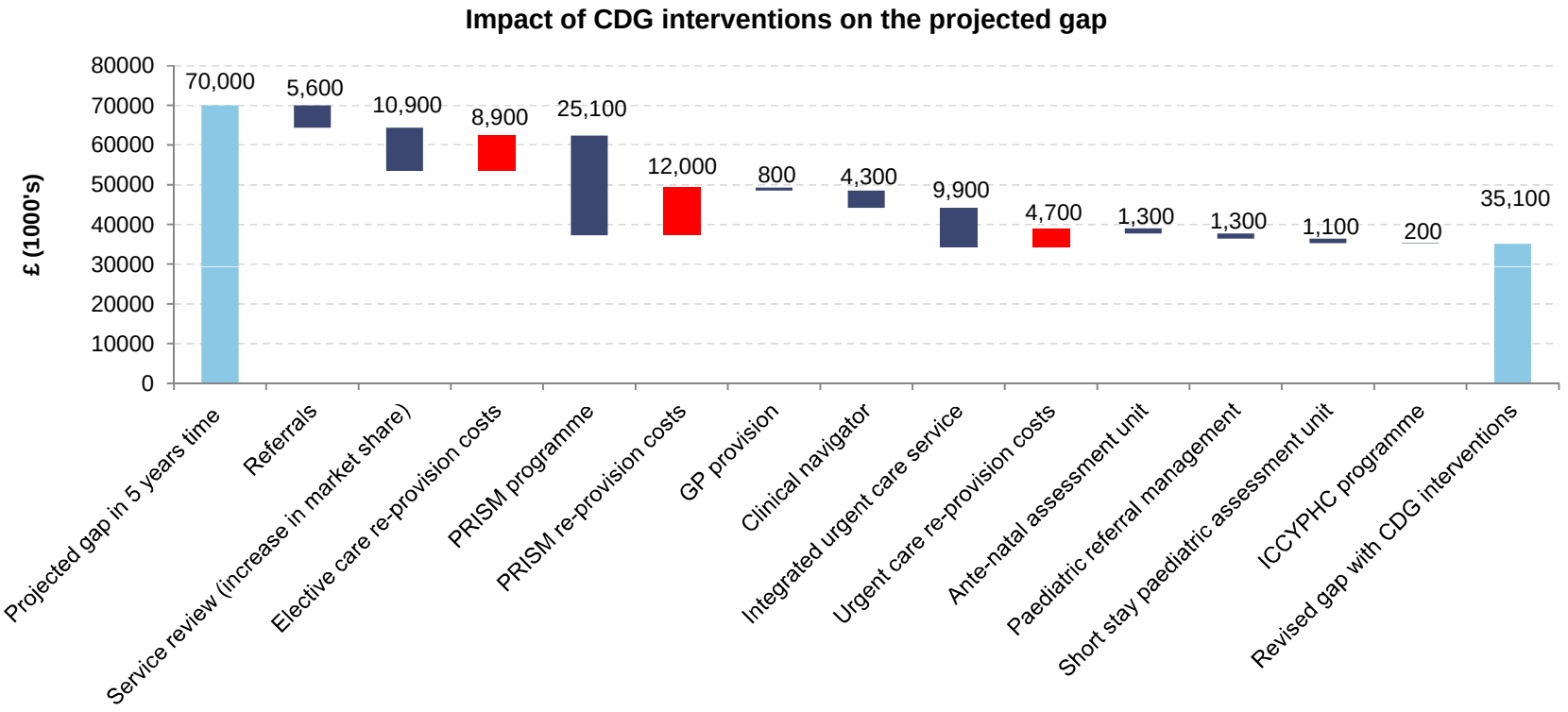
Initiative	Quality benefit	Measure
Enhance domiciliary and intermediate care	Patients able to live more independently, stay at home longer, and have emotional, physical and social care needs assessed together	Reduce hospital admissions and re-admissions and length of stay Reduce nursing/care home use
PRISM – Profiling Risk Integrated Care Self Management	By identifying and case-managing at risk citizens within the community, emergency admissions will be reduced and the outcomes for the frail elderly and those with long-term conditions (including cancer) will be improved Patients and carers will be more involved in managing their own care and will feel less isolated	Reduce admissions by up to 30% and re-admissions by 10% Reduce length of stay by 30% Reduce prescribing costs by £1m Reduce residential care demand by 25%
Extend the integrated community discharge service	Better patient and carer experience Reduction of hospital acquired complications Prompt and pro-active identification of end of life care Patients discharged for assessment where possible – reducing burden of S2 and S5 assessments	Increased discharges to home and reduced time from discharge to home Reduced patients in long term care Reduced average length of stay
Enhanced management of patients in care homes	Improved care for patients in care homes by offering more intensive health treatment should reduce hospital acquired complications, maintain function level of patients and improve end of life care	Reduce number of admissions from care homes, and length of stay for care home admissions

Implementing these initiatives could give rise to net financial savings of £13m p.a., but will require circa £12m re-investment in community and other services

Summary financial impact of blueprint proposals

Financial Savings

The graph below provides a breakdown, by intervention, of the estimated savings (against current model / cost of provision) to be made through the delivery of the future model of care. In summary, the interventions identified will reduce the potential 5 year financial gap of **£70m** to **£35.1m**.



Source: PwC analysis – This analysis is based on the PRISM programme achieving a 30% reduction in admissions

What does integrated care look like in practice?

Already piloted in Newark and Sherwood, the locality based "virtual ward" or multi-disciplinary team (MDT) comprising:

- Community matrons
- District nurse
- Occupational therapist
- Physiotherapist
- Mental health worker
- Social worker
- Health care assistants
- Voluntary/third sector workers
- Ward co-ordinator/manager

Underpinned by …..

- Increased provision of intermediate care beds (Step up and Step down)
- Community based clinics (e.g. cardiovascular disease, COPD, diabetes) with secondary consultant specialist support
- Rapid Assessment and Intervention Service
- Care homes integrated into the “virtual wards”, so patients treated as if they were in their own home
- Specialist case managers for COPD, heart failure, diabetes and care homes
- GP practice teams integrated and aligned with “virtual ward teams”
- Improving provision of carer support, information and education
- Engagement of voluntary sector services to improve patient/carer support

How does integrated care make a real difference ? A case study ….

Pat's story;

- 60 year old lady, endocrines disease, recurrent pneumonia (due to complex lung and heart disease), anxiety and previous history of alcohol abuse
- Risk score of 98% risk of admission – admitted every winter for the last 4 years with recurrent chest symptoms
- Discussed at MDT and admitted to "virtual ward" – input from respiratory physio, OT, mental health worker and community matron
- Learnt new breathing techniques, knows when to use rescue antibiotics and has a number to call when she feels she needs assessment/advice
- Biggest change to her ability to cope with her illness at home has been work done to reduce her anxiety. Mental health worker has worked with her and her family to help them deal with panic symptoms
- Risk of admission dropped to 73%; she has not been admitted to hospital for over 4 months now, even though she has had 2 chest infections

Some testimonials from the PRISM integrated care pilot……

Community Matron;

- *“ One of my patients had been regularly calling 999 and being admitted to hospital. He is in his 80s and his needs are really social rather than medical. We discussed how we could best give this gentleman the care he really needs. Within 60 minutes our Ward Social Worker had arranged a respite bed. Instead of hours spent on the phone trying to refer, things happened immediately”.*

Social Worker;

- *It’s just fantastic how quickly I can get services in place for my patients – from hours spent previously via phone and e mail trying to refer PRISM integrated care allows it to happen immediately”.*

Nurse;

- *Sitting in the MDT meeting today, listening to all these people involved in caring for your patients, was such a humbling experience. I feel so proud to be part of this project – I think it’s probably the most important thing I’ve ever been involved in as a nurse”.*

Patient;

- *(Before) I only had my GP and Community Matron. I didn’t want to bother people. I felt I would never get better. (Now) I have had less hospital visits, I understand my body better, am determined to carry on, feel more confident and supported.*

Integrated care – the headlines

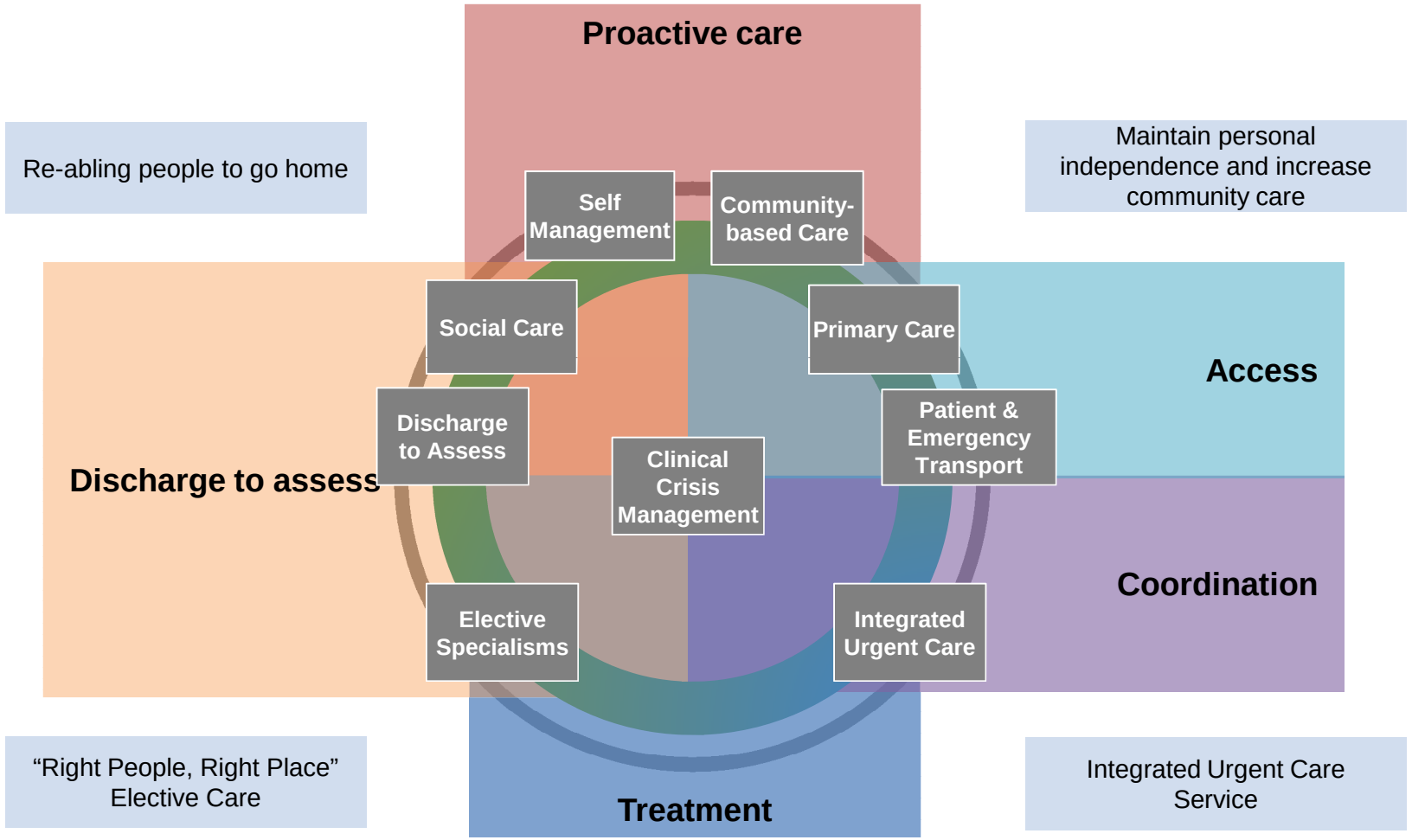
Before	The future
Different people looking after various conditions for a single patient	Integrate care across the whole system and embed care planning and shared decision making in to everyday practice
Hospital often the only option for a patient when their condition worsens	Incorporate a population wide approach to care and not just a reactive response
Services only available within office hours with little or no joined up arrangements out of hours	Deliver services where patients need them and make access available seven days a week

Systematically implement;

Risk profiling, integrated services, care planning and self-management

Fewer unplanned admissions, better patient outcomes and satisfaction, improved quality of care

Future Model of Care for Health and Social Care Services



Conclusions

Truly integrated health and social care in Mid Nottinghamshire should;

- Enable care to be at home or close to home wherever possible, thus optimising patient and carer independence
- Improve the experience of patients in crisis – offering a “single front door” approach where all of the services come together; acute, community, mental health, primary and social care
- Significantly reduce acute hospital admissions, freeing up in excess of 100 acute beds
- Provide opportunities to use our best quality local hospital facilities to increase sub-acute and intermediate care capacity
- Bridge at least 50% of the projected financial gap based on current population health projections
- Create a more highly skilled workforce, with time to innovate

Next steps - learning from other systems

Positive precursors for success of the Transformation Partnership

- Foundation of joint working between health and social care exists
- Shared understanding of integration
- Joint desire to deliver vision regardless of organisational challenges
- Strategy fits with JSNA

Possible challenges

- Cultural differences between professional groups
- Different workforce terms and conditions
- Technology solutions for data/information sharing
- Differential financial pressures

Ensuring success ….learning from other systems

- Establish joint governance and accountability early on
- Have a high tolerance of risk to achieve the vision – don't be scared to press on even if every detail isn't worked through
- Use front-line teams to design services and don't miss simple and inexpensive innovations that can have a major impact
- Invest in organisational development and change management to overcome cultural and organisational differences, financial and other risks
- Base the strategy on benefits to patients … then specify, communicate, monitor delivery, and iterate

And …..

- Health and Wellbeing Board actively engaged to ensure that transformation is evidence based and responds to local community's needs through joined-up provision

Next steps - timescales

A detailed delivery "roadmap" is being prepared, but key steps include;

Immediately

- Individual organisations continue to work through the impacts of the new integrated care models e.g. financial, workforce, estate
- Care professionals and stakeholder/citizens representatives to take forward detailed design of new services and pathways

Summer 2013

- Engagement exercises to run alongside development of new models of care
- CCG and Local Authority commissioning forum to be established to develop appropriate commissioning/contracting models
- On-going evidence-based analysis of outcomes of new care model
- System-wide estate and ICT strategy to be developed

2014 onwards

- Changes to be implemented from years 2015/15, with whole system changed embedded within 5 years

South Nottinghamshire Integrated Care

Benchmarking and Better Care scheme analysis

17 January 2014
Draft

pwc

Introduction

This pack is designed to give a very high level view on the benefits that may be associated with Better Care fund schemes in the three county CCGs. We have done this in two ways – by looking at the overall ambition of the schemes compared with other areas where we have worked and by benchmarking current performance to give an indication of the scale of improvement possible.

We have benchmarked the relevant trusts using the following indicators:

1. Delayed transfers of care
2. Admissions per 100,000 patients
3. Average length of acute stay

When analysing these indicators, we have looked at national benchmarks but also compared them with them with the following health economies , where we have done work and know the scale of their ambitions:

- Mid Nottinghamshire
- Northamptonshire
- Lincolnshire

Other health economies have much higher targets but expect to make a higher investment

Metric	Example 1	Example 2	Example 3	Facilitated by
A&E attendances	Decrease 10% for over 75s Decrease 20% for over 65s	12% reduction overall	30% reduction for over 65s	Proactive community support teams to support frail and elderly. Crisis response team for patients at risk of being admitted. Support to primary care and ambulance service to direct to most appropriate care location. Community discharge programmes
Emergency admissions	Decrease by 20% for over 65s	9.5% reduction	30% reduction for over 65s	
Readmissions	n/a	10% reduction in 30 day rate	n/a	
Reduction in long term care	15% reduction for over 65s	25% reduction in long term care	30% reduction in residential home spend	
Length of Stay	Reducing average length of stay from 7 to 5 for over 75s	12.6% reduction in overall bed days	23% reduction for one trust 8% for another	
Investment	**£9m**	**£14m**	**£35m**	

Significant savings may be possible based on other economies targets even with lower investment

Approach

We have estimated the benefits achievable from the Better Care schemes in the three county CCGs using similar schemes that we have seen elsewhere. We have scaled these to the level possible in South Notts using three different methods: population, number of acute admissions and level of investment.

We have made use of the following standard groupings rather than looking at the individual interventions as many of them work together.

1. Support to thrive (S2T)
2. Transfer to assess (T2A)
3. Choose to admit (C2A)

	South Notts benefits	Est benefits scaled by pop	Est benefits scaled by acute admissions	Est benefits scaled by expected investment
Support to thrive	Tbc	£2m-3m	£2m - £3m	£0m-2m
Transfer to assess	Tbc	£20m - £30m	£20m - £30m	£2m-£4m
Choose to admit	Tbc	£15m – £25m	£15m - £25m	£3m-£5m

Looking at the size of the population and the number of acute admissions you would expect very large benefits to be possible if schemes were implemented similar to ones that we have seen elsewhere. However these schemes all required significant investment and using this as a scaling factor makes the benefits more modest – although still higher than current plans.

Note that this analysis makes no consideration of the varying level of current performance and so opportunity in other areas.

The high DTOC figures are in line with the national median at NUH but below upper quartile performance

Delayed transfers of care

The table to the right shows that South Notts has a relatively reasonable monthly average DTOC per 100 admission than the three other acute trusts under consideration and also England as a whole. Only the two trusts in Lincolnshire have performed better than NUH. For non-acute trusts, South Notts has a higher DTOCs per 100 admission than all other areas.

NUH is in line with the national median and so has some room for improvement – 2 per 1000 admissions compared with the upper quartile. It is low compared with some other health economies that are targeting significant savings in this area ,suggesting that it is unrealistic savings to expect savings of £5m + as they have.

Area	Acute Trusts	Monthly avg DTOCs (Sep to Nov 2013)	Monthly avg admission	Monthly avg DTOCs per 100 admission
South Notts	NUH	988	16,019	6
Mid Notts	Sherwood Forest	875	6,922	126
Northants	Northampton General	884	8,020	11
Lincs	United Lincs	648	12,730	5
	Northern Lincs & Goole	181	8,701	2
England		119,844	1,262,136	9

Acute trusts quartiles	Monthly average delayed transfers of care per 100 admissions (Sep to Nov 2013)
Upper quartile (better performing trusts)	4
National median	6
Lower quartile (worse performing trusts)	10
National mean	8

Area	Non acute Trusts	Monthly avg DTOCs (Sep to Nov 2013)	Monthly avg admission	Monthly avg DTOCs per 100 admission
South Notts	NHT	1,140	356	320
Northants	Northants Healthcare	396	201	197
Lincs	Lincs Community	163	150	109
	Lincs Partnership	132	100	132

NUH is a high performer in terms of length of stay

Average length of acute stay

We have identified 15 trusts as a comparable peer group to NUH. We selected these peers based as those most similar in terms of volume and case mix.

NUH is a high performer on this metric – it is significantly better than the national average and in the upper quartile compared with its peers. This suggests a limited opportunity for improved performance overall but there may still be specific specialties or types of patient that could be targeted so it is worth considering this more detailed analysis.

Peers	Mean Los
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	**3.9**
England	5.2
Peers upper quartile	4.0
Peer median	4.2
Peer lower quartile	4.5

	Peer trusts
1	BARTS HEALTH NHS TRUST
2	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
3	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST
4	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST
5	LEEDS TEACHING HOSPITALS NHS TRUST
6	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST
7	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
8	**NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST**
9	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST
10	MID YORKSHIRE HOSPITALS NHS TRUST
11	SOUTH LONDON HEALTHCARE NHS TRUST
12	UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST
13	SOUTH TEES HOSPITALS NHS FOUNDATION TRUST
14	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST
15	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

NHS
Nottingham North and East
Clinical Commissioning Group

NHS
Rushcliffe Clinical Commissioning Group

NHS
Nottingham City
Clinical Commissioning Group

NHS
Nottingham West
Clinical Commissioning Group

Greater Nottingham's vision of integrated care for older people

Nottingham University Hospitals NHS
NHS Trust

Nottingham CityCare Partnership

Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

Nottinghamshire County Council

Nottingham City Council

County Health Partnerships NHS
Providing health services in your community

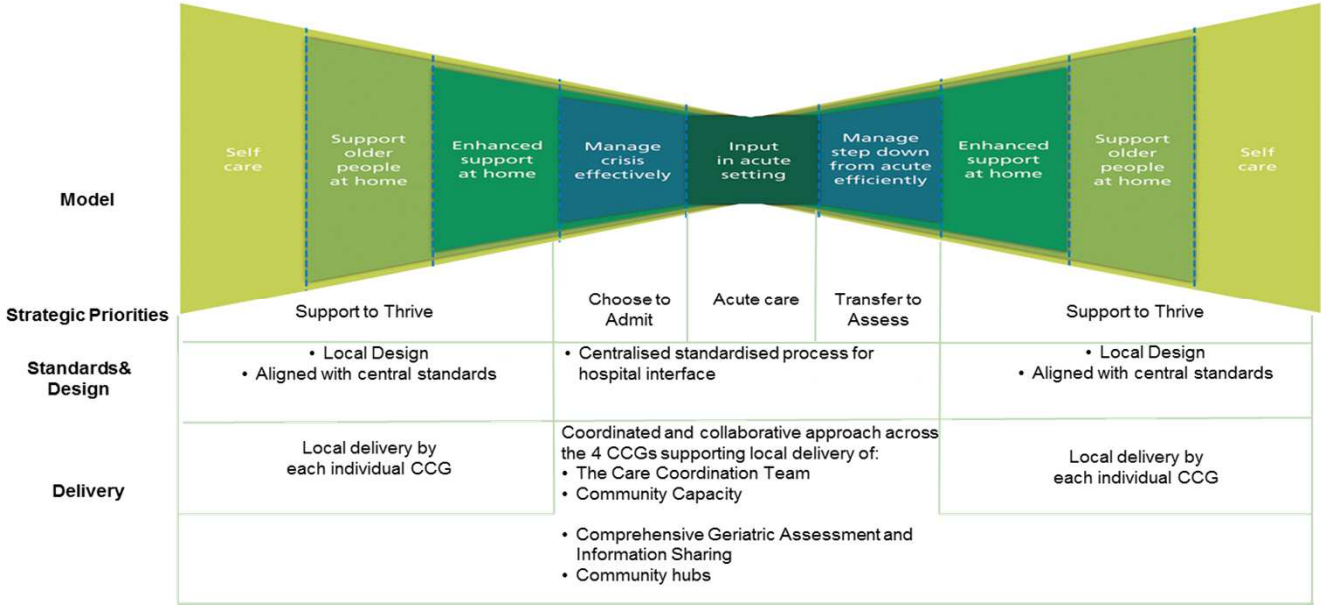
Greater Nottingham – Integrated care for older people

Frail Older People Programme
Greater Nottingham

Contents

Greater Nottingham – Integrated care for older people

The Greater Nottingham health and social care economy (CCGs, local authorities, practices and citizens) has come together to develop a vision for integrated care for its older people. Although integrated care is the aspiration for all citizens, a decision was made to focus on older people because of the growing numbers of older people and an increase in the complexity of their needs. It is anticipated that improving the co-ordination and delivery of services for older people will improve services for other citizens as well.



The model (the 'Bow Tie') has been designed to maintain independence where possible and manage crises effectively when necessary. It builds on the three strategic priorities of '*Support to Thrive*', '*Choose to Admit*' and '*Transfer to Assess*'. The model reflects the requirement for integrating provision at a local level whilst acknowledging the demands of a single acute provider shared by multiple commissioners. The primary collaborative work between the CCGs and the acute provider to date has been a focus on the admission and discharge pathways. The key interface between local service provision (*Support to Thrive*) and '*Choose to Admit*' and '*Transfer to Assess'* will be through the development of community hubs and a care co-ordination team. These in turn will be supported by a standardised process for Comprehensive Geriatric Assessment (CGA), which has planned deliverables in March 2014, and additional community capacity that will be delivered from December 2013.

The work is being overseen by the Strategy and Implementation Group for Nottingham South (SIGNS). This is a group of commissioners and providers that was formed in February 2013 to set the strategy for frail older people across CCG boundaries and oversee its implementation.

The drivers for integrated care – The national context

A number of concurrent pressures and challenges have come together necessitating a new approach to health and social care provision if quality is to be maintained and cost controlled. Examples include a shift from acute provision to care closer to home. This in-turn will require a new focus on prevention over intervention and independence over dependence on services. As a result, local health and social care systems are increasingly looking at integrated care as a solution.

"Integrated care and support needs to extend beyond traditional perceptions of 'healthcare' and 'social care' and into areas involving early intervention, prevention, self-care and promoting and supporting independent living."

Integrated Care and Support: Our Shared Commitment – National Collaboration for Integrated Care and Support (May 2013)

The challenges facing health and social care nationally include:

- Rapidly rising demand attributable to a growing population, a greater proportion of frail and elderly people (often with complex multiple health and social care needs and long term conditions), cost inflation and new treatments becoming available that are able to preserve and prolong life;
- Funding for health services not rising in line with demographic demand and significant reductions in social care funding. Cost pressures on the NHS are projected to grow at around four per cent a year up to 2021/22. If NHS funding is held flat in real terms then the NHS in England would experience a funding gap of between £44 and £54 billion in 2021/22, this would be reduced to a shortfall of £28 to £34 billion if QIPP savings are achieved (Nuffield Trust; A decade of Austerity, 2012);
- A desire by clinicians and leaders to deliver safer care, with better clinical and social outcomes for the population – and as such to deliver better value care (net outcomes per pound spent) with the considerable, but finite, resources available;
- Improving the experience of care, greater integration of health and social care is needed to mitigate the impact of fragmented health and care provision on patient experience. Citizens tells us that there are gaps in service provision, poor transitions between care settings and failures in communication. The Health and Social Care Act places a duty on providers to work more closely together to address these issues; and
- £7.6bn (14%) real-terms reduction in funding from 2010/11 to 2014/15, estimated at 2010 spending review (Financial Sustainability of local authorities, National Audit Office, 2013).

The drivers for integrated care – The local context

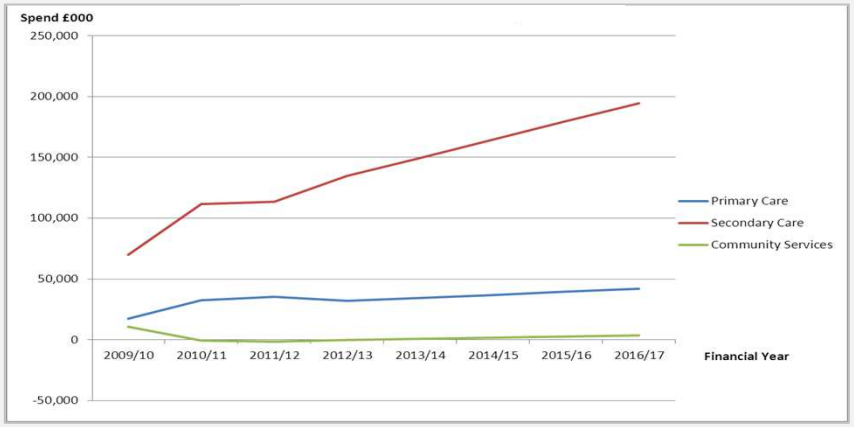
Challenges for Greater Nottingham

The national pressures identified are also being felt locally in Greater Nottingham. A combination of an increasing and ageing population (85,000 over 75's this year rising to over 100,000 by 2025), the shifting expectations amongst citizens around the time and type of care they receive, and a predicted increase in demand, are all placing significant pressure on the health and social care economy.

These challenges are alongside the tough financial pressures with health budgets only seeing small increases and social care budgets decreasing in real terms. For example: Nottingham City Council must save £20m during 2013/14, Nottingham University Hospital Trust (NUH) £50m during 2013/14 and Nottinghamshire County Council £154m over a four year period.

As the following chart depicts, current healthcare spend in the region is heavily focused on secondary care (and is projected to continue to do so in the future if recent trends continue) whilst spend on community and primary care has barely changed. As a result, the disparity between community, primary and secondary care spend has been increasing resulting in negligible investment in the community sector and primary care to assist them to innovate and actively promote the reality of integrated care.

Projected Healthcare Spend – Cumulative Movement Year on Year – Nottingham County PCT



(Source: Financial Update from Nottinghamshire Collaborative Commissioning Congress; Sep 2013).
(NB: Notts County PCT has been reorganised into the CCGs of Nottingham West, Nottingham North and East, Rushcliffe, Newark and Sherwood, and Mansfield and Ashfield).

Changes to meet the challenges

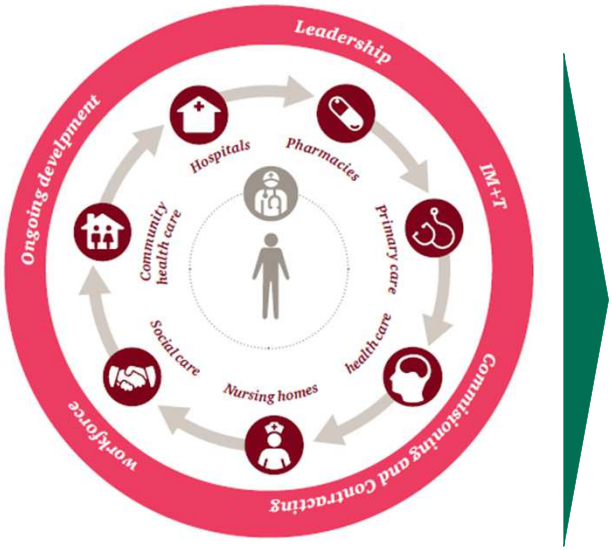
In order to tackle these combined challenges, the organisations involved in the delivery of health and social care in Greater Nottingham recognise that a braver and more radical solution of integrated care is required that will address the following local issues:

- Citizens being admitted into hospital or long term residential care when alternative services could/should have met their needs;
- Citizens remaining in hospital when they no longer need acute services; and
- Citizens who need the care of old age specialists in an appropriate ward in hospital not always receiving it.

The drivers for integrated care for older people – A citizen's perspective

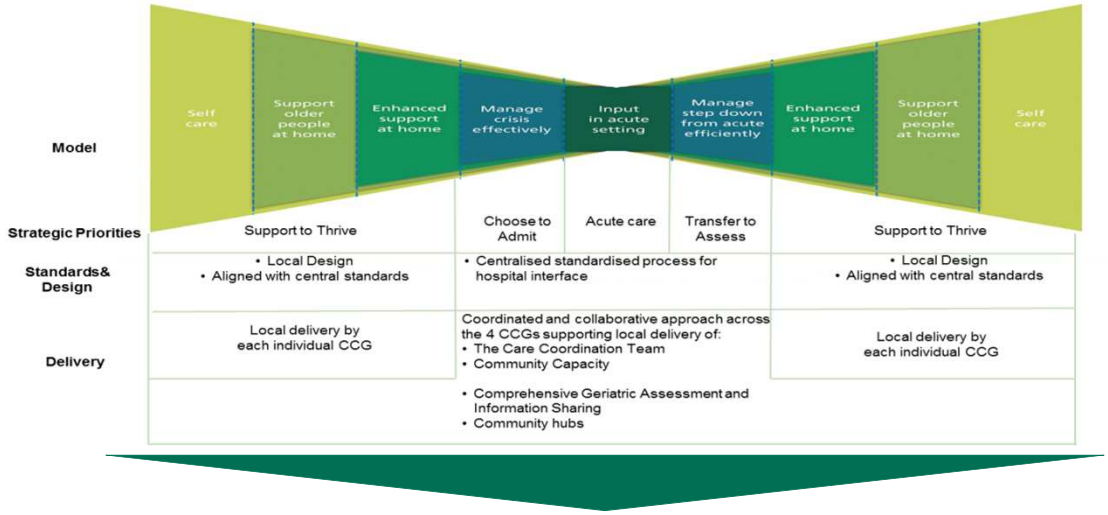
Greater Nottingham's vision of integrated care for older people is important, but it is how outcomes are met and are experienced by the citizen that really matters. The model underpinning integrated care in Greater Nottingham has been designed with the needs of the citizen at its core. Some of the key requirements from a citizen's perspective are summarised below.

The citizen is at the centre of Greater Nottingham's vision



Strategic priorities of Integrated Care	Citizen's requirement of care
Support to Thrive	• My health and social needs are identified as early as possible. • I am supported to manage my own condition at home. • I know where to go and who to contact when I need care.
Choose to Admit	• Community services are there for me if I need support at home or overnight. • When I am unwell I am assessed using Comprehensive Geriatric Assessment. • I will be directed to the right place in the first instance. • Hospital is there for me if I need specialist clinicians to manage my medical conditions until I am stabilised or I need an operation.
Transfer to Assess	• I leave hospital as soon as it is medically safe to do so. • I will only be transferred to long term care or a nursing home if that is the best place to meet my needs.

The model and strategic priorities of Greater Nottingham's vision of integrated care for older people



The care of frail older people is one of the main strategic priority areas identified by the Greater Nottingham care economy and this is reflected in Greater Nottingham's vision for older people:

'Right Care, Right Place, First Time'

Delivery of the vision is through a co-ordinated and collaborative approach, which has been adopted across all of the CCGs and City and County Councils following three strategic priorities:

1. ***'Support to Thrive'*** – Enabling citizens to remain independent in their own homes for as long as possible. Delivered through multiple proactive initiatives, health and social care needs will be identified at the earliest possible opportunity and support will be provided to the individual to enable self-care at home;

2. ***'Choose to Admit'*** – The coordination and delivery of services in the community and at the front door hospital interface to prevent unnecessary admissions into hospital. Coordinated through community hubs (a single point of access) and delivered by multidisciplinary teams; and

3. ***'Transfer to Assess'*** – The coordination and delivery of services in the community and at the back door hospital interface to facilitate early transfer as soon as the citizen is medically safe for transfer. Coordinated through community hubs (a single point of access) and delivered by multidisciplinary teams.

The strategic priorities of Greater Nottingham's vision of integrated care for older people

'Support to Thrive'

This strategic priority is currently being implemented at a local level with CCG, Council and third Sector support. Due to local circumstances, progress has advanced at different rates for each CCG area but as of November 2013, the focus of SIGNS will start to move towards the 'Support to Thrive' elements of the model and will support the design of local services complementing and effectively interfacing with 'Choose to Admit' and 'Transfer to Assess'.

'Choose to Admit' and 'Transfer to Assess'

The delivery of the two strategic priorities that deal with the interface to NUH is being coordinated via four projects that are due to be implemented on a phased basis between October 2013 and March 2014, consistently across the four CCGs.

1. **Community Hubs** will be based in each CCG and serve as a single point of access for community team referrals following a crisis (i.e. managing referral to the acute) and for the Care Coordination team to contact when ready to discharge. From March 2014, community hubs will take responsibility for coordinating a response to meet the on-going needs of citizens and manage and allocate local health, social care and third sector capacity;

2. The **Care Coordination Team** is based in the acute hospital and will work as one team to coordinate and case manage all supported transfers of care out of NUH;

3. The **Community Capacity** project will assess Greater Nottingham's need for increased community capacity. Initial capacity analysis has shown that there are 32 older citizens who remain in hospital each day when their needs could be met in a community setting if the services were available. This translates into a requirement for additional beds and home based services. By December 2013, an additional 21 community beds will be commissioned that are staffed to meet the needs of the most complex patients as part of an integrated community service. A more strategic review of the on-going needs for community services beyond March will be carried out before then; and

4. **Comprehensive Geriatric Assessment (CGA) and Information Sharing** are the underpinning priorities that support the process changes across the interface with NUH and community hubs. Under the new model the Care Coordination Team at NUH will pass information on patient needs to the community hubs via an electronic referral on SystmOne. The needs of patients will be assessed based on the 5 domains of CGA. By March 2014 there will be an implementation plan on how to record and share CGA across primary care, social care, NUH and community services.

Frail Older People Programme
Greater Nottingham

The principles of Greater Nottingham's vision of integrated care for older people

The four Greater Nottingham CCGs are working with both the City and County Councils and their community providers: CityCare Partnership and County Health Partnerships, to deliver an integrated service through collaborative and co-ordinated approaches.

Collectively a set of shared principles have been developed that align to the SIGNS strategy and address all elements of the bow tie model through a service redesign that is centred on the citizen. These principles are locally owned and implemented within each CCG.

Shared principles supporting the Greater Nottingham vision for Integrated Care for Older People

• An integrated and sustainable Health and Social care service through collaboration with local authority, district council and voluntary sector	• Simplified citizen journey through the implementation of a single integrated adult care pathway	• Virtual Ward model of care: risk stratification tool; MDT's held at each practice; integrated care teams; extended working with mental health services and social care	• Older people enabled to take care of themselves and live independently in their own homes for longer with less reliance on intensive care packages
• 48 hour follow up for frail older patients following an unplanned admission	• Enhanced support for care home residents	• Enhanced support for patients leaving Lings Bar Hospital	• Coordinated response to end of life care
• Crisis response service to support avoidable admissions to hospital	• Clear navigation across health care with key decision making points: community hubs and care coordination team	• Systematic support for long term condition management, for example, implementation of Assistive Technology	• Citizen and carer support, including self-care management, as part of *'support to thrive'.*

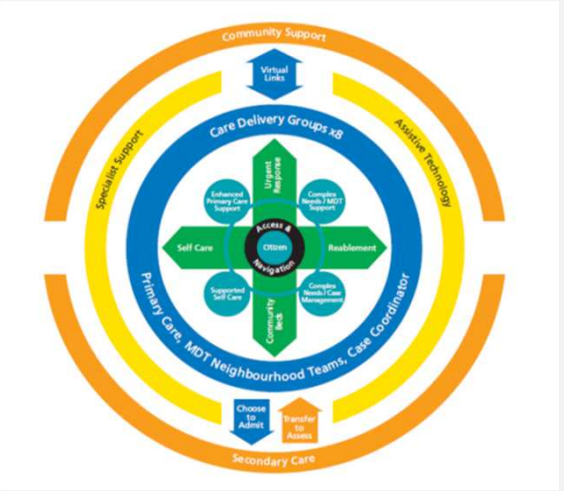
The two examples that follow show how the model for integrated care for older people and its key principles are being planned to be implemented at CCG level (or are currently in place) and apply to the wider adult (over 18) population by Nottingham City CCG and by the County CCGs.

How Nottingham City CCG is planning to implement the vision of integrated care for older people

Nottingham City CCG – Adult Integrated Care

Nottingham City CCG, Nottingham City Council and CityCare Partnership are working together to integrate care as part of the Adult Integrated Care Programme. Collectively they have developed a model that aligns to the SIGNS strategy by addressing all the elements of the 'Bow Tie' model through a service redesign that is centred on the citizen. The overall aim is to:

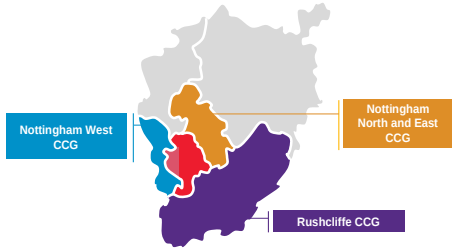
- Simplify the citizen journey;
- Enable older people to take care of themselves and live independently in their own homes for longer with less reliance on intensive care packages; and
- Develop an integrated and sustainable Health and Social care service.



Three key projects will help to deliver this model of care in City CCG:

- The **Coordinated Care** project has created 8 new Care Delivery Groups (CDGs) that will be established from January 2014. These groups of key health and social care professionals will be aligned to a specific geographical area that will enable them to work together around the citizen's needs, share information and combine experience to continuously improve the care they provide. The CDGs will comprise of multi-disciplinary neighbourhood teams linked to GP practices and supported by a care coordinator. This new model will change how health and social care services are commissioned and delivered at a local level. Access to services will be simplified to ensure that citizens receive appropriate support and that navigation around health and social care services is simplified.
- The **Independence Pathway** project involves the planned transformation of the reablement and rehabilitation pathways to allow citizens to remain as independent as possible. Four pathways are being developed that reflect the complexity of the citizen's conditions and needs; Self Care, Reablement, Community Beds and Urgent Response. They will be easily accessible to the citizen through a single front door after a referral from a health or social care professional.
- The **Assistive Technology** project is distinct to the programme but it is recognised that the project needs to support the new model of Coordinated Care. A joint health and social care strategy has been developed to support an early intervention and prevention approach. Commissioning of the service will be done jointly to ensure that assistive technology is embedded into the pathways that enable the citizen to remain independent.

The three South of County CCGs and their work on integrated care for older people



Integrated Care and the South of County CCGs – examples of current services

Across the three South of County CCGs there are a range of local services being delivered to support the strategic priority of '*Support to Thrive'* and integrated care.

There is also an exploration of a proposed service delivery model for acute community care for the County CCGs working in collaboration with the County Council (this work is called 'Blurring the Boundaries'. It is currently being considered and it is anticipated that a decision will be made on whether to implement it in the coming months.

Example of work being considered

Blurring the Boundaries – *acute community care*

The South of County CCGs and the County Council have commissioned the development of a service specification that could deliver the local components of '*Choose to Admit'* and '*Transfer to Assess*' as well as components of the South's intermediate care service (e.g. intermediate care beds). The specification is in an early stage of development and is being considered for approval. This service is referred to as 'acute community care' and has the following definition:

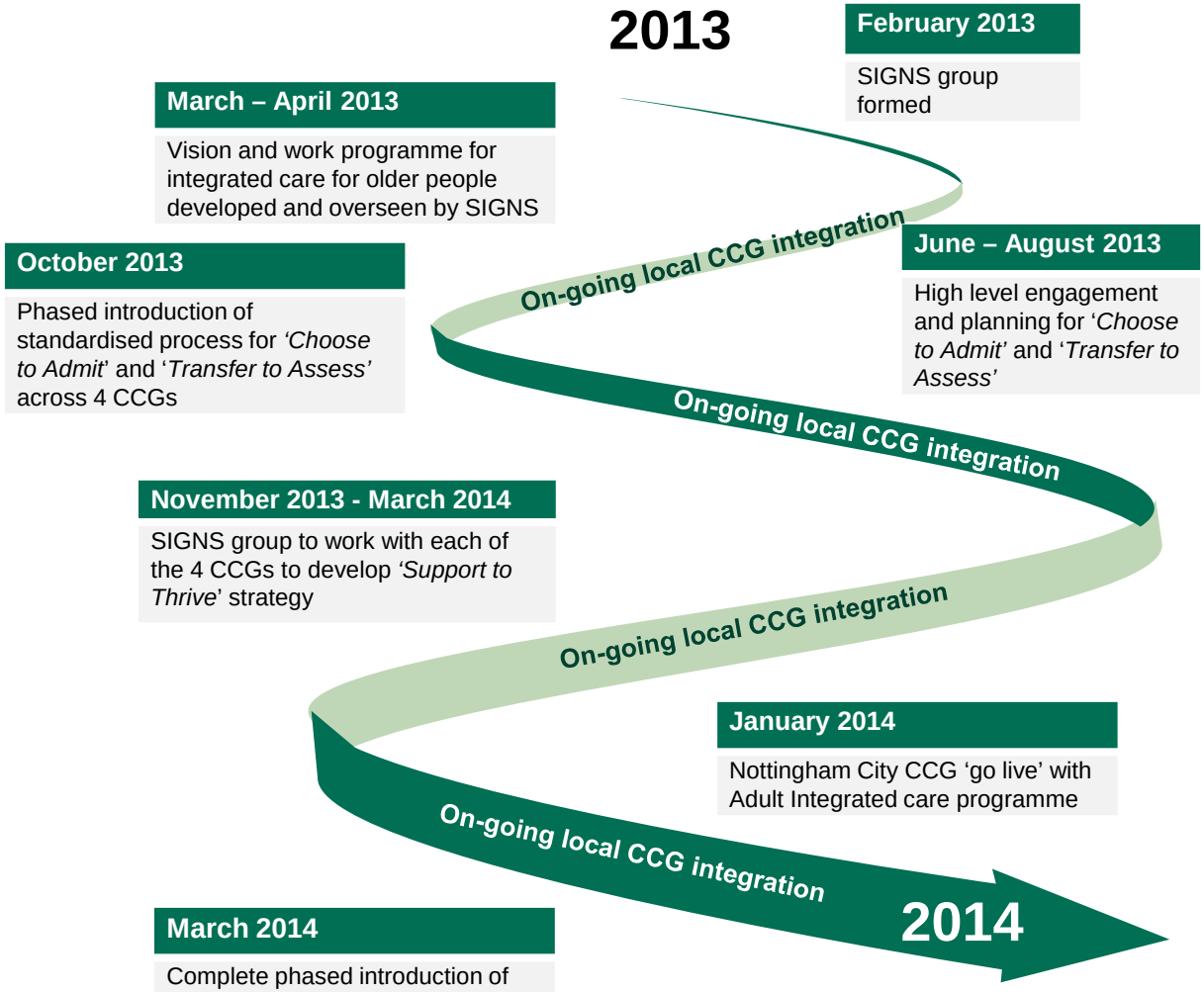
"A range of integrated services to promote faster recovery from illness, prevent unnecessary Acute Hospital admission and premature admission to long term residential care, that supports timely discharge from hospital and maximise independent living."

There are currently a range of different services provided in the South of County that deliver intermediate care and reablement. The main drive for Blurring the Boundaries is to consolidate these services and providers into a single contractual form incentivising them to work together and working to an agreed pain share/gain share mechanism against a range of service specific outcome measures.

Examples of key aspects of the proposed service model include the following:

- The acute community care service would be time limited (up to 6 weeks) with the potential for citizens to be discharged earlier;
- The service would deliver an episode of assessment, treatment and rehabilitation for citizens;
- It would be delivered by a range of health and social care practitioners including access to 24-hour care delivered either at home, in a registered nursing home or in a community hospital setting;
- The balance of home/bed based support would be determined by the lead provider for Acute Community Care services who should consider the balance/range and cost of available 24 hour beds within the locality; and
- The use of bed based services is likely to be for those people who initially need a level of observation, and support and continuous care at all times not available through a home based package.

Greater Nottingham's timeline for integrated care for older people and next steps



Progress has been made across Greater Nottingham on integrated care but translating the vision into a reality for all citizens requires on-going collaborative working and commitment.

The next stage of work is crucial and needs to include:

- A system wide approach around financial implications, risks and benefits;
- A focus on leading the cultural shift required;
- Assuring the quality of care;
- Identifying and agreeing commissioning and contracting models;
- Approaches to sharing patient information; and
- Workforce support and development.