Clinical Commissioning Group Five Year Plans 2014 - 19

Update to Nottinghamshire County Health and Wellbeing Board

5 March 2014

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NHS England Draft Planning Guidance – Dec 2013

National picture	Commitment to transforming outcomes for patients Forecast of financial gap of £30 billion by 2020/21
Mandate to commissioners	Set local ambitions for improved outcomes Plan transformation of services over 5 years Two year detailed operational plan

What does this mean in practice?

- CCGs form ‘Units of Planning’
  - Bassetlaw
  - Mid Notts
  - South Notts (including City CCG)

- ‘Units of Planning’ work with providers and partners to design and deliver a 5 year strategy (including Local Authorities)

- Engagement with patients and the public underpins this process (‘Call to Action’)

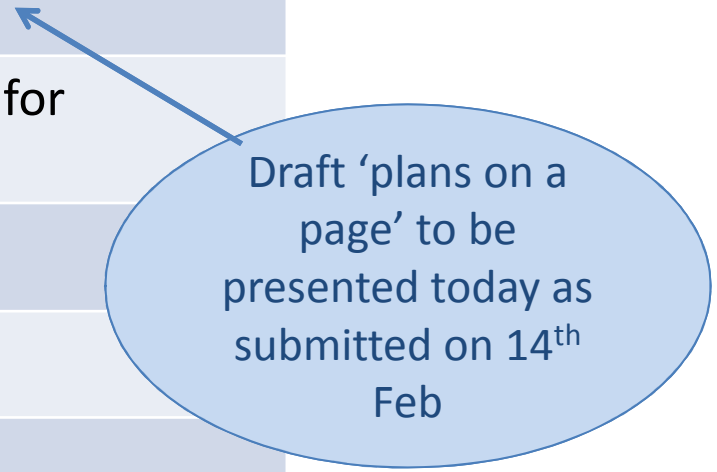
- Tight national timescales
  - Draft strategy by 4 April (with initial draft by 14 Feb)
  - Final strategy by 20 June

Together we need to think very differently about how we plan, commission, deliver and use services

A Call to Action: engagement

National requirements for submission

	Sections of 5 year plan following NHS England template
1	5 year 'plan on a page'
2	System vision and statement on vision for integration
3	Improving quality and outcomes
4	Sustainability
5	Transformational interventions
6	Governance overview
7	Values and principles



South Notts – organisations involved

Nottingham City CCG	County Health Partnerships
Nottingham North and East CCG	Nottingham CityCare Partnership
Nottingham West CCG	Circle Partnership
Rushcliffe CCG	EMAS
Nottingham University Hospital Trust	Nottingham City Council
Nottinghamshire Healthcare Trust	Nottinghamshire County Council

South Notts – highlights from Plan on a Page

Five Year Strategic Vision:

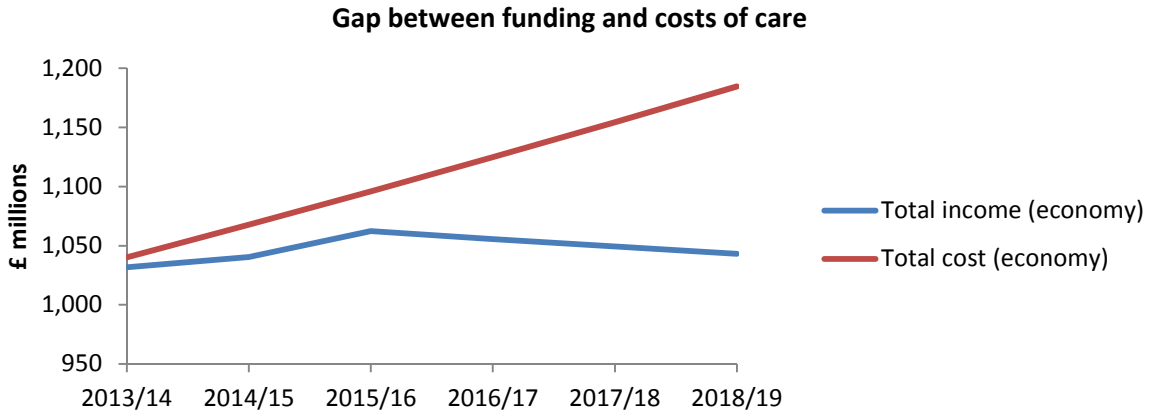
Supporting independence, personalisation and empowerment through the provision of compassionate and seamless integrated health and social care.

System Objectives

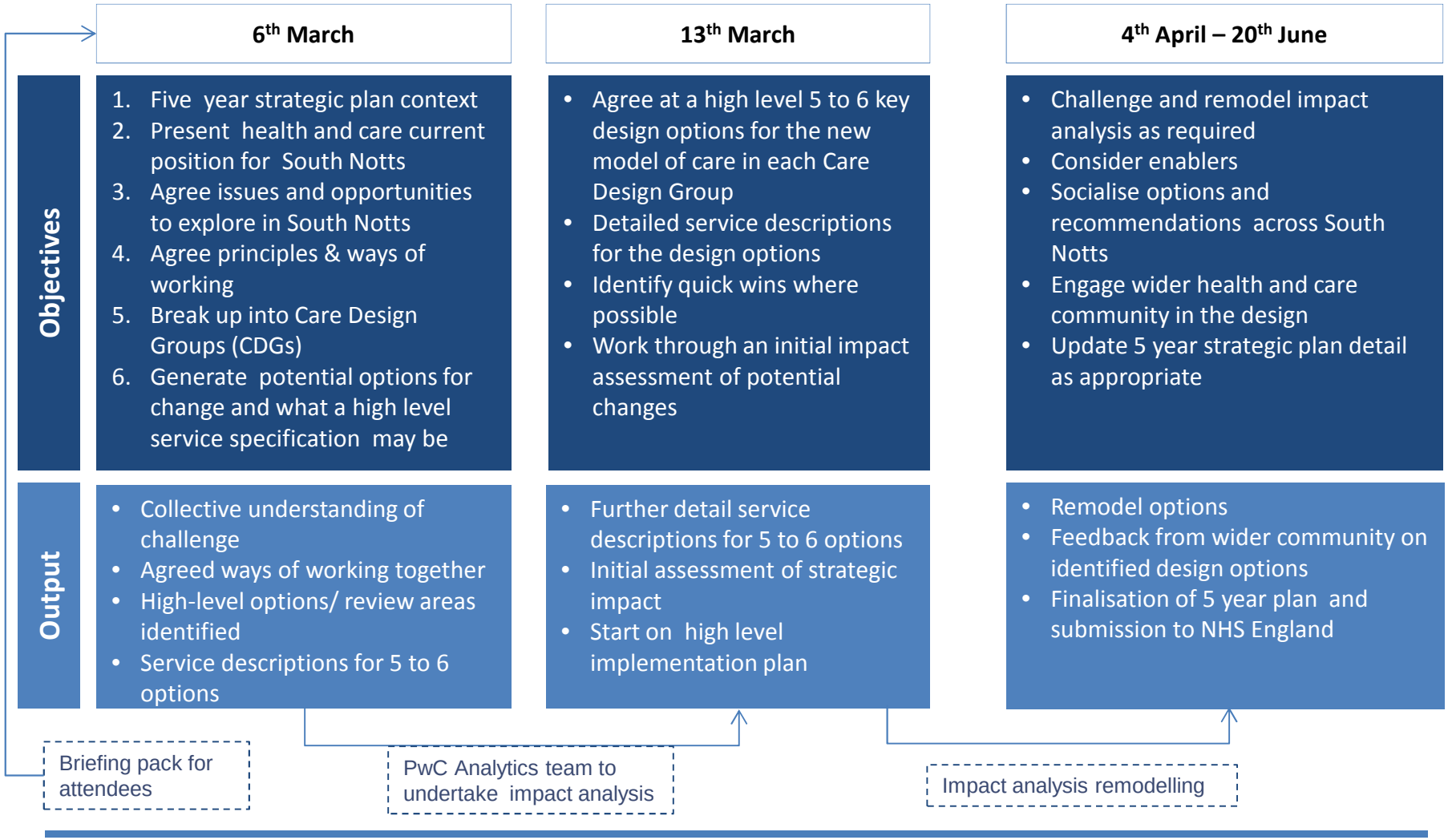
1. *Increase the proportion of people living independently at home*
2. *Reduce time spent unavoidably in hospital through more and better integrated care*
3. *Improve the health related quality of life of those with LTCs including mental health conditions*
4. *Secure additional years of life for people with treatable mental and physical health conditions (Parity of Esteem)*
5. *Engage with the local population to change patient behaviour, promote public health messages and to ensure efficient use of healthcare resources*
6. *Support quality of services – safe and avoidable harm and clinical effectiveness*
7. *Deliver services which optimise patient experience; reflect best practice and deliver the NHS Constitution*

South Notts – approach and progress

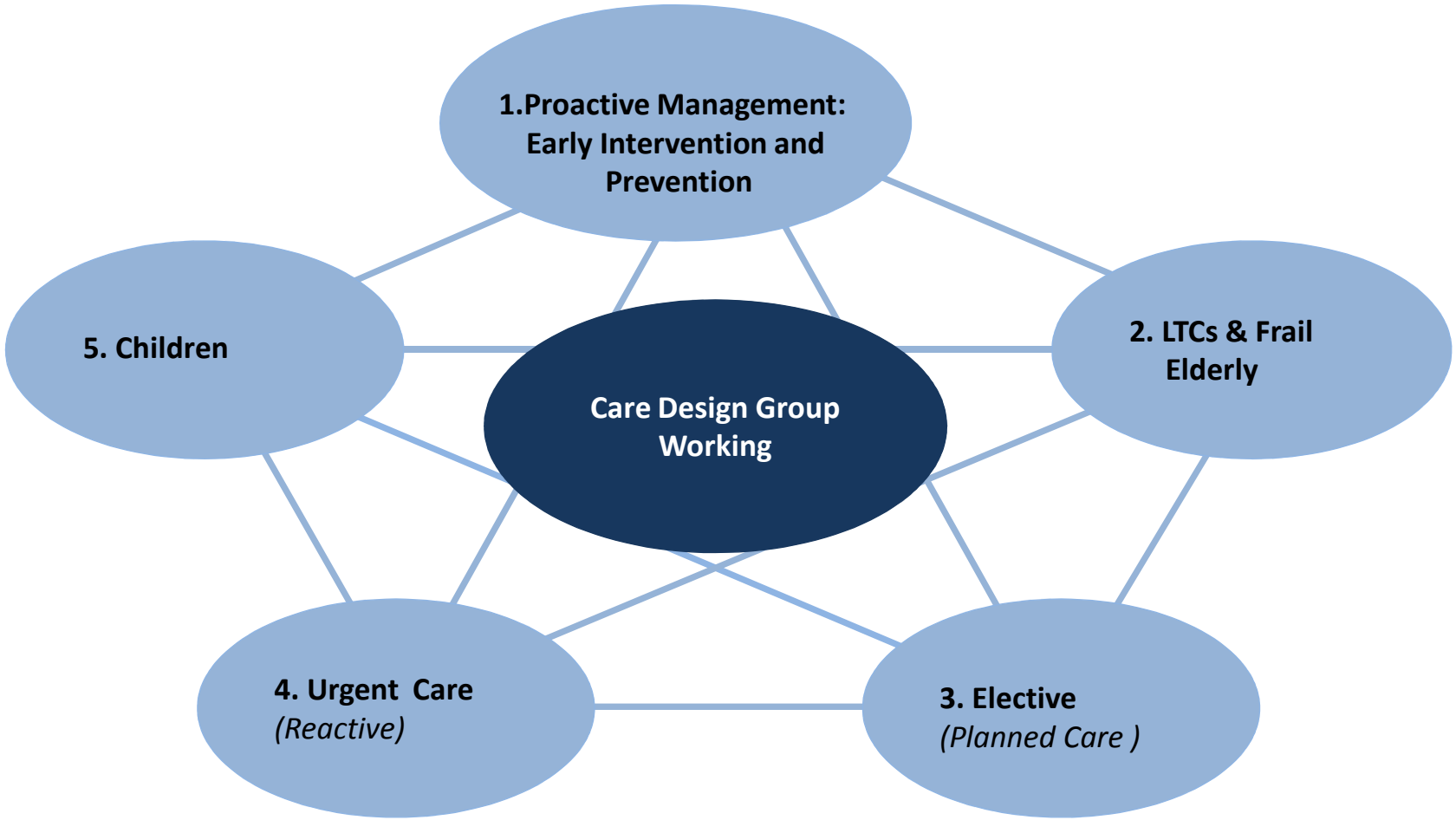
- Governance : South Notts Transformation Board established
- Engagement : many local events culminating in 120 members of the public attending an event on January 29th where we described challenges ahead, conducted a real time voting exercise and held structured discussions
- Financial gap: current estimate £100m over next 5 years



South Notts – strategic planning workshops



South Notts – potential areas for transformation



South Notts – 2 year operational plans

In line with the national CCG planning process, CCGs recently submitted a short operational plan to NHS England. Each CCG must specify a level of ambition within their local priority. The achievement of that level of ambition will ensure that the CCG receives part of their quality premium payment at the end of the year.

The Board is asked to note the local priorities for each of the CCGs

Nottingham West CCG and Nottingham North and East CCG	20% of people with diabetes diagnosed less than one year to be referred into some form of appropriate structured education
Rushcliffe CCG	Long term conditions (LTC): • All GP practices CCG sign up to LTC specification • 40% of our eligible +65s with a LTC have a personalised care plan in place by the end of the year

Mid Nottinghamshire Transformation Partnership

Formed in 2013, with leaders from;

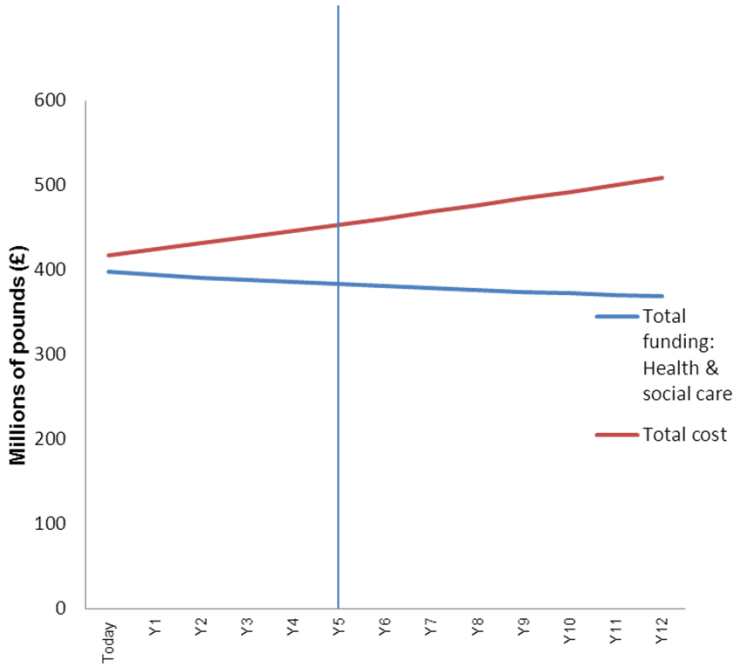
- Commissioners
  - Mansfield and Ashfield CCG
  - Newark and Sherwood CCG
  - Nottinghamshire County Council

- Providers
  - Sherwood Forest Hospitals NHS FT
  - East Midlands Ambulance Service
  - Nottingham University Hospitals NHS Trust
  - Nottinghamshire Healthcare NHS

- "Blueprint" for future sustainability agreed as strategic direction (April 2013) for next 5 to 10 years

Challenge …current service models are not financially sustainable…. this will have to be solved by us !

£70 million projected gap within 5 years



- Relentless focus on the best services and overall best value for the population, not individual organisations
- Half of the financial gap could be solved by implementing the blueprint – the other half still needs to be found
- External PFI subsidies will only be considered once the health and social care system operates as efficiently as possible – propping up services or lack of ambition / execution will add to the financial gap
- If we can't implement the blueprint, we will have to find other (less desirable) alternatives such as closing and centralising more services to make ends meet

We have a moral imperative to make the system fit for purpose for the changing demands of the population – people want to see joined up services and a system that is less complicated to access, retaining universal access

What do we mean by integrated care ?

"*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.*"

Mid Nottinghamshire Health and Social Care roadmap for the next 5 to 10 years

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


1SF
OUR VISION
We will have joined up, sustainable and high quality services across health and social care. People will remain at home whenever possible, supported by a team of people who are working together to meet their need- shifting the focus from the needs or processes of their organisations. Services will be proactive and fleet of foot. People will be supported to develop the confidence and skills to be as independent as possible.
2
System Objective One
15.1% reduction in A&E attendances
System Objective Two
19.5% reduction in non-elective acute admissions
System Objective Three
30.5% reduction in acute bed days
System Objective Four
25% reduction in admissions to nursing and residential homes
System Objective Five
9.8% reduction in secondary care elective referrals
System Objective Six
20% reduction in paediatric admissions to hospital
4
Delivered through:
Development of a self-care hub to provide information and knowledge for people with long-term conditions
Improved access to primary care
Enhanced community services, based on PRISM model for integrated care teams
Enhanced intermediate care
Care and crisis navigation (incorporating a care navigator and crisis response teams)
Integration of acute and community urgent care services (single front door, linking specialist intermediate care team with single front door, enhanced discharge process)
Delivered through:
Development of a referral management system to implement best practice across specialties
Specialty reviews and development of streamlined pathways
Delivered through:
Development of a short-stay paediatric assessment unit
Consultant telephone advice for GPs
Enhanced referral management process
Implementation of integrated care for complex needs
5
Overseen through the following governance arrangements
Mid-Nottinghamshire Transformation Board (strategic partnership board for health and social care)
PMO to oversee delivery
Expert groups for each intervention areas
External advice and critical friend
Governance reporting structure and enabling work streams
3
Measured using the following success criteria
All organisations within the health economy report a financial surplus in 18/19
Delivery of the system objectives
No provider or commissioner under enhanced regulatory scrutiny due to performance or quality concerns
Best value and high quality services for our population
6
System values and principles
Work collaboratively in the interests of population health needs, focussing at system not organisational level
Prevent illness or crises where possible and transfer resources to support this
Shift care into closer-to-home / better value care settings where appropriate
Mansfield + Ashfield + Newark + Sherwood

Pace of change

- To achieve the blueprint ambitions and commissioning intentions in 2014/15, we would need to reduce emergency admissions by 3 per day for Mid-Notts
- 5 ambitions agreed for 2014/15:
  - Integrated community teams (PRISM) roll out
  - Intermediate care redesign
  - Care planning in care homes
  - Transfer to assess
  - Elective referral gateway
- Similar pace of change each year for 3 years

Bassetlaw – A community of care and support

OUR VISION

Better care for the frail & elderly, More & better care & support at home and in places nearby, 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.

Reduction in potential years of life lost (PYLL) from causes to health care.

Health-related quality of life for people with long-term conditions.

Composite measure on emergency admissions.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation

Patient experience of hospital care.

Composite indicator comprised if i) GP Services ii) GP Out of Hours

Hospital deaths attributable to problems in care.

GOALS	PROJECTS
Urgent Care • Improved model of same day care in Retford and Worksop. • Improved model of same day care for villages. • Improved care out of hours.	• Increased capacity in primary urgent services. • Joint working to sustain A&E service. • Review of out of hours model.
Care for Elderly in community • Improved intermediate care. • New model of community based geriatric care (inc. Care Homes). • Primary Care Teams co-ordinating person centred care.	• Primary care integrated led team-working. • Developing community geriatric service. • Identification and care planning for most vulnerable. Responsible lead clinician • Improved communications and records sharing. • Improved access to intermediate care services. • Telehealth wider use of assistive technology
Care Homes • 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.	• 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
Mental Health Services. • Improved link between physical and mental health services. • Increase emphasis on prevention and early intervention • Increased integration with primary care teams.	• 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.
Supporting People after acute illness. • Independence & Re-ablement unit • Re-ablement pathways • Community based assessment	• Enhanced early senior review and 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.

Delivering Transformational Service Models

- Developing joint responsibility for care and support
- Integrated delivery around the person.
- Organisations working across boundaries.
- Professions working together in teams.
- Resources openly shared and pooled.

Underpinned by:

- Increase in 7 day services in Community and Primary Care and in Hospital
- Clinically-led philosophy.

Planned 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 healthcare teams.
- Improved discharge processes focusing on early senior review, access to alternative services and appropriate care planning.

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 come first.
- Our community is more important than any one organisation.
- Share skills Provide leadership
- Encourage people to innovate.

Overseen through the following governance arrangements

- Shared system leadership group overseeing implementation of the improvement interventions is achieved through our Integrated Care Board
- Individual organisations leading on specific projects
- Agreed program management
- Financial framework and principles under development.