B. Project Initiation Documents for High Impact Areas, Supporting Workstreams and Enablers

PIDs for High Impact Area 1 – Promote wellbeing, prevention, independence and self-care

Executive sponsor: Barbara Brady	
1. Priority projects within HIA and expected completion dates	**2. Main impacts on closing 3 gaps**
• Improve core activities for the prevention of ill-health and disease • Provide comprehensive advice and information, promote technology based solutions for targeted information on self-care and develop ways for people to access and manage their own information • Build strong and resilient communities and people, using a co-produced approach to enable the expansion of the voluntary and community sector to deliver agreed strategic priorities	**Health & Wellbeing** ▪ Delivery of core prevention activities will address the underlying risk factors (smoking, alcohol, diet and nutrition, physical activity, weight management and mental wellbeing) which contribute to poor healthy life expectancy ▪ Develop and support individuals and their communities to build resilience in order to share responsibility for maintaining health and well-being **Finance & Efficiency** ▪ Prevention of disease and reduction of its severity through healthy lifestyles activities will reduce demand for health and social care contribution to care and quality and finance gaps ▪ Promoting independence and self-care throughout the health and social care system is an effective way of managing demand, reducing costs and delivering positive outcomes for citizens. ▪ Build on best practice and align resources to maximise use of resources across the partnership ▪ Net saving by 2021 will be up to £34m (modelled average of £31m)
3. Key enablers	**4. Key decisions that still need to be made (and deadlines for resolution)**
Workforce: - Workforce training of health and social care staff in healthy lifestyles and mental health identification, advice and signposting to deliver prevention - Cultural change around shared care, self-care and MECC will required workforce training Estates: - Accommodation will be required for the delivery of self-care hubs within the community - Sites will be required for the provision of Information Access Points IM&T: - Improved connectivity - Roll out of FLO - Access to own health records	▪ STP and political commitment to the current investment in core prevention activities funded through the PH Grant – November 2016 ▪ STP and political commitment to the current investment in independence and self-care activities funded through LA which underpin the activities in the STP – November 2016 ▪ STP and political commitment agreement of additional investment included in these PIDs – December 2016 ▪ Determine how the STP engages with democratic leaders responsible for current investment in prevention (Public Health), independence and self-care activities – November 2016
Main programme risks	**Mitigations**

Lack of organisational commitment to effectively deliver prevention, self-care and independence	Key decision for organisational commitment
Further reductions to current spend on prevention, self-care and independence activities which underpin the delivery of this PID and erode current health and system benefits including those delivered by the CVS	Key decision for STP commitment to current investment
Insufficient capacity to deliver system changes to move towards prevention, self-care and independence	Increased investment request for to support effective delivery
Responsibilities for current LA spend for underpinning activities sits outside STP	Key decision for STP to engage with responsible democratic leaders
Cultural change: embedding independence and self-care requires a cultural change across the workforce to ensure behaviour and practice reflects the new approach	Through workforce development activities

Activity *(X for years with active implementation work planned)*	**Year 1 – 16/17**	**Year 2 – 17/18**	**Year 3 – 18/19**	**Year 4/5 – 19/20/21**
1. Cross organisational commitment to prevention, promoting independence and self-care	X	X	X	X
2. Workplace health policies in STP organisations		X	X	X
3. Tobacco focus – organisational commitment, staff training, identification and management of at risk patients, supportive pathways, increased capacity in services	X	X	X	X
4. Alcohol focus – organisational commitment, staff training, identification and management of at risk patients, supportive pathways, increased capacity in services	X	X	X	X
5. Healthy lifestyles and mental wellbeing communications			X	X
6. Healthy weight, diet and nutrition (inc breastfeeding and physical activity focus - organisational commitment, staff training, identification and management of at risk patients, supportive pathways, increased capacity in services			X	X
7. Workplace health non-STP organisations			X	X
8. Deliver health and social care directories	X	X	X	X
9. Establish and deliver self-care hubs		X	X	X
10. Establish and deliver Information Access Points	X	X	X	X
11. Workforce development for cultural change to advice and information		X	X	
12. Establish a governance structure across the STP area to direct resilience workstream	X			

13. Develop a detailed plan to implement the agreed programme of initiatives to generate greater resilience across the STP area, focusing on areas of greatest need.		X		
14. Invest in the voluntary and community sectors, to support the resilience agenda		X	X	X
15. Devise and produce an on-going social marketing programme		X	X	X
16. Monitor progress against targets and take action as appropriate			X	X

PID for Priority 1.1 – Strengthen core activities for the prevention of ill-health and disease

Priority lead: Rachel Sokal	
Outputs	**Expected benefits (outcomes)**
1. Leadership and organisational commitment to prevention inc. board-level lead for prevention, its integration within the culture, infrastructure, policy and workforce, and the adoption of systematic and consistent approach to prevention messages 2. Communications and health promotion plan to address at-risk groups relating to (for example)healthy lifestyles including smoking, physical activity, diet and nutrition and alcohol; low uptake of immunisation and screening; and key diseases 3. Workplace health All STP organisations to become exemplar employers that facilitate health and wellbeing at work. Support for non-STP organisations to develop health promoting workplace. 4. Workforce Training and information for staff to support patients' adopting healthy lifestyles and promote mental wellbeing through identification, brief advice and signposting including using MECC approach. 5. Prevention services and pathways High quality, evidence based services will be available to support individuals to have healthy lifestyles. Increase capacity of key services (smoking, alcohol, breastfeeding and weight management) to support delivery.	**Health & Wellbeing:** • An increase in healthy life expectancy by 3 years, underpinned by improvements in Life Expectancy in men and women in Nottingham City and Nottinghamshire County • Improve life expectancy for males to 79.9 (city) and 82 (county, and for females to 84.1 (city) and 84.8 (county) • Reduce the slope index of inequality (mortality from causes considered preventable) to 167.8 • Decrease the prevalence of smoking to 18.7% (city) and 16% (county) –in the general population, with separate targets for pregnancy, routine and manual workers • Reduce levels of overweight and obesity in children, aged 10-11 (30 in city and 29.5 county) and adults (59.3% city and 65.5% county) • Reduce levels of physical inactivity to 25.6% (city) and 26% (county) • Reduce alcohol admissions to 696.1 (city) and 585.9 (county) • Reduce organisational staff sickness absence rates • Increase breastfeeding rates to 51.6 (city) and 44.4 (county) • Increased uptake of NHS health checks to 55.8% (city) and 56.6% (county) • Higher birth rate of term babies to 2.08 (city) and 2.12 (county) **Care & Quality:** • A reduction in the need for health and social care by reducing the occurrence and severity of ill-health, thereby reducing reliance on services and allowing resources to be conserved for those in greatest need. **Finance & Efficiency:** • Modelling of the financial gain associated with the full roll out of activities within this PID will see annual net savings in 2020/21 of o £11.7m of NHS costs across the STP o £1.6m of social care costs across the STP

	• This is in addition to the annual net savings in 2020/21 of current investment from LA Public Health grants of: o £48m of NHS costs across the STP o £6.7m of social care costs across the STP
Resources to deliver (and whether secured)	**Enablers**
• Revenue funding (£000s): (not secured) Year 1 (2016/17) - £350 Year 2 (2017/18) - £1,350 Year 3 (2018/19) - £4,205 Year 4 (2019/20) - £4,205 Year 5 (2020/21) - £4,205 • Capital funding: None	• Workforce: Work force training of health and social care staff in healthy lifestyles and mental health identification, brief advice and signposting
Major milestones towards full implementation	**Main risks and mitigations**
• Output 1: Organisational commitment to prevention including identification of a board level champion by mid-2017 • Output 2: Policies in place across organisations which support health in the workplace by March 2018 • Output 3: Priority staff groups trained in MECC with a focus on smoking and alcohol by March 2018 • Output 4: Specialist stop smoking and alcohol support staff in place in key provider organisations and effective mechanisms to identify and support at-risk patients (e.g. stop before op); and increased capacity within stop smoking and alcohol services by March 2017 • Output 5: Agreement and commencement of delivery communication plan 2018/19 • Output 6:All key staff trained in MECC with a focus on stop smoking, alcohol, weight management and mental wellbeing 2018/19 • Output 7: Increased capacity of weight management and breastfeeding support services 2018/19 • Output 8: support to non-STP organisations for workplace health 2018/19	• Risk: The “baseline” HLE and ROI is eroded because LAs reduce funding for existing basic public health service provision not specifically identified in the STP but which is essential for delivering and sustaining it. Mitigation Evidence of health and financial impact modelled to support investment. STP and political commitment to maintaining funding for prevention • Risk: Execution of the proposals and on-going policy work is undermined by lack of current capacity or further reductions to public health workforce Mitigation -inclusion in PID of additional management resources to support upscaling of prevention. STP and political commitment to maintaining funding for prevention • Risk: Funding for the required additional capacity in public health services is not sustained Mitigation Additional and recurrent investment sought through STP • Risk: Too few pathways and STP staff are enabled to deliver the increase in good quality referrals to prevention services Mitigation Provide PH input to supporting themes to assist in bid development and implementation planning • Risk: Lack of commitment to prevention from STP organisations Mitigation Provide PH input to supporting themes to assist in bid development and implementation planning

PID for Priority 1.2 – Increase availability and usability of information and advice

Priority lead: Helen Jones / Clare Gilbert	
Outputs	**Expected benefits (outcomes)**
1. Health and Social Care web Directories in place across City and County 2. FLO medication reminders in place in care homes 3. Provision of targeted information on healthy living through targeted marketing, direct communication and use of apps to all people within STP footprint 4. All GP practices are able to provide virtual consultations with a focus on care homes 5. All citizens have access to Welfare Rights services in place 6. Workforce trained to support a culture change in relation to self-care 7. Workforce apply Make Every Contact Count approach 8. 15 Self-care hubs developed 9. 18 Information Access Points developed 10. Social prescribing rolled out to be used by health and social care staff	**Health & Wellbeing** There will be an increase in: • Proportion of people feeling supported to manage their condition NHSOF 2:1 • Proportion of people who use services who have control over their daily lives ASCOF 1B • Proportion of people using social care who receive self-directed support, and those receiving direct payments ASCOF 1C • Proportion of patients taking part in screening programmes for Breast, Bowel and Cervical Cancer • Proportion of eligible patients receiving vaccination/immunisation - Seasonal Flu/Shingles/Child Immunisation • Proportion of eligible patients undertaking health checks • Increased feelings of well-being based on Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) There will be a decrease in: • The percentage of citizens requiring packages of care from adult social care • The percentage of unplanned admissions for individuals with long term conditions • The percentage of citizens experiencing social isolation **Care & Quality:** • Citizens are better equipped to make informed choices • Advice and information services align to the preferred choice of the citizen • High levels of user/carer satisfaction evidenced by evaluation • % of citizens stating that as a result of the information they received they were empowered to manager their situation • % of workforce stating that as a result of the web based solution they were able to offer up to date, valuable advice to citizens and their carers. **Finance & Efficiency:** The proposals provide the potential for cost saving or cost avoidance by enabling citizens and their carer to better manage their condition through a better

	understanding of their needs and through being given the mechanism to support themselves or to seek lower cost community based support
Resources to deliver (and whether secured)	**Enablers**
• Revenue funding (£000s): (not secured) Year 1 (2016/17) - £0 Year 2 (2017/18) - £383 (£183 R) Year 3 (2018/19) - £972.5 (£787.5 R) Year 4 (2019/20) - £1,537.5 R • Capital funding: None	**Workforce:** • Cultural change around shared care, self-care and MECC will required workforce training **Estate** • Accommodation will be required for the delivery of self-care hubs within the community • Sites will be required for the provision of Information Access Points **IM&T:** • Improved connectivity • Roll out of FLO • Roll out of virtual clinics in GP practices and care homes • Access to own health records
Major milestones towards full implementation	**Main risks and mitigations**
Output 1: by December 2016 mapping existing provision is required **Output 2:** by January 2017 Launch of new LION directory is required **Output 3:** by April 2017 Alignment of NHY and LION Directories across the STP footprint] **Output 4:** by September 2017 Evaluation of current self-care hubs and agreement of preferred model **Output 5:** by September 2018 Employment of project manager to source locations for information access points and self-care hubs **Output 6:** by March 2019 Workforce Development Programme around cultural change **Output 7:** from April 2019 Workforce change embedded within ongoing management, supervision and training structures **Output 8:** from October 2017 Recruitment of staff for self-care hubs **Output 9:** from April 2017 New self-care hubs rolled out **Output 10:** from January 2017 Information Access Points are required **Output 11:** from April 2017 Citizens and Workforce Engagement	• **Risk:** Insufficient finances to provide effective roll out **Mitigation:** Some key components can be met through existing funding streams • **Risk:** Inability to achieve buy-in from all partners including District Councils, GPs, providers etc **Mitigation:** Communication and engagement with partners Ensure services are co-produced • **Risk:** Inability to bring about cultural change in workforce **Mitigation:** Workforce training and application of evidence based approaches • **Risk:** Inability to bring about cultural change in public • **Mitigation:** Workforce training and application of evidence based approaches. Public focussed education campaigns Ensure services are co-produced • **Risk:** Lack of community and voluntary sector provision to provide community based support **Mitigation:** Commissioning models needs to ensure funding of locality based provision

	• **Risk:** Services are designed for the majority and do not target minority groups including children **Mitigation:** Ensure directories are fully accessible. Provide a broad variety of contact routes. Co-produce services with community

PID for Priority 1.3 – Build resilient communities and people

Priority lead: Jane North	
Outputs	**Expected benefits (outcomes)**
By a process of mapping, on-going engagement and co-production we will deliver : 1. An agreed definition, understanding, and measure of resilience 2. A baseline of the current level of resilience in different communities within the Nottinghamshire STP area 3. A framework for monitoring development of resilience over time 4. An overview of all significant programmes/initiatives currently aiming to increase resilience in communities within the County 5. A common understanding of which existing programmes/initiatives are proving most successful in areas of Nottinghamshire and why 6. A common understanding of what type of stimulation, support or particular initiatives are required to generate greater resilience within the scope of the STP, and which programmes are to be considered 'best practice'. 7. A detailed plan to implement the agreed programme of initiatives to generate greater resilience across the STP area, focusing on areas of greatest need 8. Increased investment in the voluntary and community sectors, to support the prevention agenda 9. Increased use of community centres by the local population 10. Lower number of referrals to vulnerable people's panel 11. Lower number of inappropriate GP appointments, lower inappropriate ED attendances and lower inappropriate emergency admissions for non-medical needs (eg housing or money problems, loneliness) 12. Significant drop in demand for low level support on all statutory services 13. Increased number of people being supported by the voluntary sector	**Health & Wellbeing:** • Individuals feel more connected with their local community, responsible for finding their own solutions and enabled to do so if they need some support. • People are more willing and empowered to support others outside of their family. • Lower levels of isolation and loneliness. • Greater levels of wellbeing, reported satisfaction and enjoyment of life. **Care & Quality:** • Quality of service from statutory provision rises as the number of inappropriate referrals/ attendances reduces, so there is more time and resource to focus on people who have acute or more complex problems and needs. **Finance & Efficiency:** • Well targeted projects (arising from co-production process) enable savings to be realised by reducing demand for statutory services (ie enable budget reduction). • There will be greater economies of scale by expanding best practice in a comprehensive and coherent way, • There will be synergistic impact by pooling our knowledge and resources across the STP area • Modelling of the financial gain associated with the full roll out of activities within this PID will see the following net savings o £9m 2017/18 o £14m 2018/19
Resources to deliver (and whether secured)	**Enablers**
• Revenue funding (£000s): (not secured) Total additional revenue funding requested one-off over three years: £5.75 million Year 1 (2016/17) - £0 Year 2 (2017/18) - £2,250	• Workforce: Posts for mapping and co-production work, and/or to be sourced externally. Will impact on current staff who work in this area as they will need to work together across organisational boundaries.

Year 3 (2018/19) - £3,500 • Capital funding: None **No revenue currently secured.** Note - Local Authorities and CCGs already invest in services and initiatives to develop community resilience; there is no existing comprehensive summary of all this work and investment. This will be identified by the mapping stage.	
Major milestones towards full implementation	**Main risks and mitigations**
• Outputs 1 - 7 to be achieved by the end of year 2 (April 2018) • Outputs 9-13 to be achieved by the end of the year 3 (April 2019). Progress tracking towards these outputs will be reported every 3 months to allow review, discussion and appropriate action to be taken as necessary, using the evaluation framework (output 3).	• Risk: Risk of failing to target new and existing investment in the most effective way to realise expected savings Mitigation: Use of a coproduction method which involves communities and voluntary sector stakeholders, to ensure key priorities and gaps are identified and funded. • Risk: Risk of not monitoring outputs and outcomes effectively so savings are not evidenced Mitigation: Development of an evaluation framework and methodology recognised as a priority action in Y1/Y2.

PIDs for High Impact Area 2 – Strengthen primary, community, social care, and carer services

Executive sponsor: Dawn Smith	
1. Priority projects within HIA and expected completion dates	**2. Main impacts on closing 3 gaps**
▪ Improve access to and resilience of primary and community care ▪ Increase support for healthy lifestyle and secondary prevention for all people and increase early detection of conditions, in particular cancer and dementia ▪ Provide coordinated primary, community, mental health and social care support for people with high and rising risk through multidisciplinary teams (MDTs) ▪ Improve self-care and management through information, education and use of technology ▪ Enhance care to people in care homes through extended primary and community support	Health & Wellbeing: • Improving healthy life expectancy - Support people with physical and mental long-term conditions to manage their condition well and live longer fuller lives • Equip all our citizens better to manage their own health and wellbeing and prevent the development of ill health, from learning healthy habits early in childhood through to coping with the challenges of old age Care & Quality • Strengthen primary, community and social care services to better support healthy living, offer services closer to people's homes and communities, and empowering the workforce to work outside of its boundaries in the best interest of the patient/citizen. • Identify treatable problems as early as possible so they can be managed proactively and closer to home, minimising the impact and consequences of ill health • Drive a significant reduction in unwarranted variation in all settings of care, to ensure patients receive consistently high quality service in every encounter with health and social care and making best possible use of resources • Ensure that all clinical services are delivered safely, meeting and, where possible, exceeding national standards Finance & Efficiency • Initiatives in this HIA will capture £50m in net savings in 2020/21 • Non-elective admissions to be reduced by 20-40% in 2020/21
3. Key enablers	**4. Key decisions that still need to be made (and deadlines for resolution)**
• **Workforce**: Upskilling of GP and community staff in early detection, accordance with GP Forward View • **Estates**: By 2019, develop an operational estates plan to deliver vision on scaling up GPs in consolidated locations • **IM&T**: Risk stratification tool infrastructure; technology solutions to promote healthy lifestyle, connectivity in care homes; infrastructure to share patient records and test results	Agreement of Risk profiling - Agree stratification point at which health and social care indicators will be used to proactively manage health and social care. The role of a generalist workforce and how staff can be empowered, supported and engaged to work outside of current boundaries in the best interest of the patient/citizen. Patient responsibility - How can we engage with the patient/citizen to empower them to proactively live a healthier life to reduce later impact What does a generalist MDT workforce look like and how can this be tailored to meet geographical needs.
Main programme risks	**Mitigations**

Insufficient non-recurrent funds available for the enabling/implementation costs during first 3 years of implementation	Identify preliminary transitional funding requirements and refine over the next 3-6 months Define a robust Strategy Plan to provide confidence to the regulator
Individual organisations cash-flow requirements are not met in interim-years	Perform detailed modelling of impact of projects to each organisation Receive support from NHSE/other regulators during first years of implementation (e.g. request system balance, not organisational balance)
Financial savings targets are not met	Continue to drive financial improvement plans through local transformation/service improvement plans at each organisation/locality level Include a joint strong oversight of implementation of projects, overseen by Finance Directors Group, and reporting to GNPB.Continue deep focus on identifying transformation funding to enable double running of key services whilst transformation is being implemented Implement alternative initiatives described in section 5.2.3 if the fixed cost (assumed 30%) cannot be taken out in its totally after 6-12 months of implementation
Suggested scale and pace of implementation across organisations is not met	Put a strong programme governance and reporting in place that identifies key milestones and actions/ways of working required to deliver Launch and sustain a capability building programme among Programme Office and Project Leaders Launch and sustain a Leadership development programme across GN Partners
Beds capacity increase over next 3 years because providers efficiencies are not enough to keep them stable	Ensure alignment of commissioners and providers on this objective (keep beds increase as flat by delivering organisation efficiencies) Develop alternative care models in the community (as described) to manage demand of secondary care resources
Not enough supply of care professionals to deliver the added capability and capacity in the community	Continue intensive support from Local Workforce Action Board and on-going leadership and support from Health Education East Midlands Relentlessly implement the projects within section on workforce of this GN Strategy Plan

Implementation activity	**Year 1**	**Year 2**	**Year 3**	**Year 4/5**
17. Ensure all citizens have access to a GP 8am-8pm, 7 days a week, designed around the needs of local populations	X	X		
18. Increase use of technology will to support more people to book GP appointments and access advice online and through telephone consultations	X	X		
19. Provide swift access for local people to community services, particularly mental health and social care services	X	X		

20. Support the primary care workforce to evolve including through seeing an expansion of the roles played by therapists, community nurses, healthcare assistants and clinical pharmacists	X	X		
21. Support GP practices to develop into Federations to achieve benefits from operating at scale	X	X	X	X
22. Accelerate implementation of the 10 High Impact Actions to relieve pressure on GPs and increase the proportion of their time that they are able to spend with patients	X	X		
23. Upgrade and make more efficient use of primary care and other NHS and local authority owned estate – including considering where co-locating services would make it easier to deliver swifter access to diagnostics and more integrated care			X	X
24. Increase early detection of chronic and episodic conditions, in particular cancer and dementia, where we know that earlier detection can make a significant difference to patient outcomes	X	X		
25. Identify and reduce unwarranted variation in the quality of primary, community and social care, including by reducing variation in the treatment of people with chronic conditions			X	X
26. Standardise and monitor clinical thresholds for referrals by GPs into secondary care to make sure that people consistently receive the right care for their needs	X	X		
27. Enhance medicines management to improve patient safety and avoid waste – through (a) achieving prescribing standards and ensuring medicines are prescribed and managed in safe and cost effective manner, and (b) targeted medicine reviews to check that people are taking the right drugs	X			
28. Increase quality of end of life care planning so that more people die in accordance with their wishes	X	X		
29. Ensuring we meet new access and waiting time standards for mental health services, including access to psychological therapies and treatment for psychosis	X	X		
30. Increase support for healthy lifestyles and better identify people at risk of developing long-term conditions	X	X		
31. Provide coordinated primary, community, social care and mental health support for people with high and rising risk through multi-disciplinary teams, operating across local Care Delivery Group footprints	X	X		
32. Improve self-care and management through information, education, greater use of technology and social prescribing	X	X		
33. Build on the lessons from care home vanguards to deliver enhanced primary and community care to people in care homes, including through use of technology and ensuring each care home is supported by a single general practice.	X	X		
34. Implement and expand access to Integrated Personal Commissioning budgets		X		

PID for Priority 2.1 – Improve access to and resilience of primary and community care

Priority leads: Lynette Daws, Stewart Newman, Tracey Lindley	
Outputs	**Expected benefits (outcomes)**
1. Extend 7-day services in line with national requirements (e.g., GP Forward View and FYFW) and offer 8 am to 8 pm GP services every day, on a rotational basis within each Care Delivery Group 2. Increase capacity and capability in community services (i.e. range of community services across health and social care), including district nurses, occupational therapy, physio, voluntary, community resources and community mental health services (e.g., bringing geriatricians into the community) 3. Upskill the workforce (including GPs, social care and mental health staff), with an initial focus on mental health to enable them to recognise early symptoms of mental health and support the physical health needs of these patients (e.g. to support GP Forward View and Mental Health Forward View with recruitment of 3,000 new practice-based mental health therapists) 4. Facilitate development of federations of GPs to ensure collaboration and scale between practices, starting with practices that already want to collaborate, to enable them to deliver 10 high impact actions in the GP Development Programme	**Health & Wellbeing:** • Early identification of mental health needs; • Improved quality of care in primary care **Care & Quality:** • Improved citizen experience of primary and community care, and carers • Number of patients to go through IAPT **Finance & Efficiency**: • Reduction in A&E visits due to extended access to GPs; • Reduction in Elective and Non-Elective secondary care activity due to improvements in management and population health
Resources to deliver (and whether secured)	**Enablers**
• **Revenue funding:** (1) Central funding from GP Access Programme: £6 per weighted head of population (recurrent) (2) Education and training costs to upskill clinicians: £200k (recurrent over 2 years) (3) Extra capacity required: To be determine based on further work (4) Consultant cost for GP engagement on federation: Approximately £400K (non-recurrent) • **Capital funding:** To be determined with future work	• **Workforce**: Train the workforce to build necessary capabilities; engage workforce to support collaboration across practices; use the workforce model to identify capacity needed • **Estate**: Ensure estate is available to support increase in practice-based services and co-location (where applicable) • **IM&T**: Technology to support sharing of timely patient information across health community • **Prevention**: Improve resilience of primary and community care through enabling independence (see section *Promote wellbeing, prevention, independence and self-care*)
Major milestones towards full implementation	**Main risks and mitigations**

• **Output 1:** 17/18 CCGs implement GP Access Programme (PMCF sites) across CDGs, 18/19 remaining CCGs to implement programmes to improve access. 19/20 all CCGs delivering programmes to improve access. • **Output 2**: By early 2017, identify the capacity needed in community services and current community workforce capacity in hospital that can be transferred to community. By 2018, make necessary investment to match required capacity. • **Output 3**: By 2018, train all workforce on early symptoms of mental health conditions and then determine next areas of priority for primary care upskilling programmes. • **Output 4**: During 2017, facilitate discussion between GPs and provide external capacity (e.g., expert support) to review performance and opportunities related to the 10 high impact actions. By March 2018, all population will be covered by GP federations (at least 1 per CDG)	• **Risk**: Resistance to change and engagement **Mitigation**: Engagement across primary care to understand benefits of change • **Risk**: Workforce shortage **Mitigation**: Support HEE, NHS England with workforce programmes; develop local programme of work to attract people to area and to work in health; education and training to upskill workforce

PID for Priority 2.2 – Increase support for healthy lifestyle and secondary prevention for all people and increase early detection of conditions, in particular cancer and dementia

Priority leads: Gemma Markham, Simon Castle	
Outputs	**Expected benefits (outcomes)**
1. Empower and train the workforce to identify and respond to early signs of disease and social isolation, and on healthy lifestyle services for weight management, physical activity, smoking and alcohol. 2. Find/ develop and deploy innovative technology (e.g., mobile apps) that promote healthy lifestyle through technology enablement 3. Increase use of NHS Health Checks in particular to support improved access to high risk/low uptake groups 4. Increase early detection of cancer and dementia and other diseases (e.g., increase uptake of national screening programmes, implement NICE referral guidelines and develop GP Direct Access to Diagnostics, pilot Non-specific symptoms referral pathway, pilot Lung MOT service, roll out QCancer Risk Tool within Primary Care) 5. Identify carers to help navigate services across health and social care	**Health & Wellbeing**: • Reduced Smoking Rates • Increase in healthy life expectancy **Care & Quality**: • Lower rate of cancer diagnosis in A&E • Reduced Smoking Rates, Increase in One Year Cancer Survival **Finance & Efficiency**: • Reduced A&E admissions • Increase in stage 1 & 2 cancers (cheaper to treat)
Resources to deliver	**Enablers**
• **Revenue funding:** (1) Development of innovative technology solutions (e.g., mobile apps): (non-recurrent) (2) GPs (recurrent): Increase in GP consultations and MDT community capacity linked to increase in people presenting with signs and symptoms, plus follow up consultation following 2WW referral. To be costed. (3) Secondary care (recurrent): 10-15% pa increase in referrals (£637k-£955k pa) and subsequent diagnostics (£557k-£834k pa). (4) Opt-out referrals to healthy lifestyle services and community services (recurrent): Based on Nottingham City Weight Management, Physical Activity and Smoking Cessation services (only) an additional £2.5million would be needed to support the increased number of referrals based on 50% compliance • **Capital funding**: N/A	• **Workforce**: Need extra capacity to handle the additional referrals in cancer. Need additional community services (e.g., community nursing teams); Train GPs on technology that will be employed to promote healthy lifestyle; Creatively use GP staff to deliver increase use of NHS Health Checks • **Estate**: N/A • **IM&T**: N/A • **Equipment**: N/A • **Other**: N/A
Major milestones towards full implementation	**Main risks and mitigations**

• **Output 1**: By end of 2017/18, complete the training of all GPs and community workforce on early signs of disease and healthy lifestyle services [PID leads to complete] • **Output 2**: By 2016/17 review technology solutions that promote healthy lifestyle. By 2017/18, select the solutions and deploy. By 2018/19, complete engagement and training of all GPs. • **Output 3:** In 2017/18 a targeted NHS Health Checks strategy will be developed to deliver a co-ordinated approach to increase the uptake of high risk/low uptake groups. • **Output 4**: Increasing 2WW referrals 10% pa and reduce cancer conversion rate towards 3% within 2 years. Implement Direct Access by end 16/17. Pilot Non-specific systems pathway by end 16/17. Phase 2 of Lung MOT service implemented by end 16/17. Roll out QCancer Risk Tool end 17/18 (awaiting SystmOne version)	• **Risk**: Update of the deployment of the mobile health apps **Mitigation**: Pilot in a one CCG before rolling out • **Risk**: Workforce capacity across pathway to take on the additional referrals (already under pressure). Impact on waiting times. **Mitigation**: Use the workforce model to identify capacity needed

PID for Priority 2.3 – Provide coordinated primary, community, mental health and social care support for people with high and rising risk through multidisciplinary teams (MDTs)

Priority leads: Hazel Wiggington, Helen Griffiths, Joanna Williams, Neil Fraser	
Outputs	**Expected benefits (outcomes)**
1. Draw on broad range of data from health and social care and redefine risk stratification criteria to categorise each patient into three groups: (1) low risk, where secondary prevention tactics will be employed, (2) rising risk (~11% of population with LTCs/ frailty syndromes), (3) high risk (~3% of population with LTCs/ frailty syndromes). Patients in risking risk and high risk groups will be assigned to MDTs 2. Expand already existing MDTs aligned with Care Delivery Groups boundaries to the whole footprint, covering 30,000-60,000 people. Include social care and mental health staff in the teams 3. Develop health and social care plans (which might also include advance care plans) plans for high and rising risk patients with the MDTs 4. Set up the Nottinghamshire Observatory of Outcomes to create and maintain a registry of disease, share lists of patients with MDTs and share metrics on outcomes and gaps in care (including A&E attendance for ACS conditions) to help MDTs improve their performance	**Health & Wellbeing**: • Quality of life measures (exact measure to be determined) • Increase healthy life expectancy **Care & Quality**: • Increase proportion of people dying in your preferred place of care • Make more robust the coordinated comprehensive perinatal support for women with mental health issues across all CCG's linked to early identification and treatment. **Finance & Efficiency**: • Reduced A&E admissions
Resources to deliver	**Enablers**
• **Revenue funding**: (1) Potential licensing fee required for stratification tool: To be determine with future work (2) Extra capacity required by MDTs: To be determined with future work • **Capital funding:** (1) As required, estates: To be determined with future work	• **Workforce**: Train community staff, members of the MDT including social and community staff and practice staff on (1) the new standard risk stratification tool, (2) new published practice guide to MDTs and (3) culture change required for holistic care; Train and recruit more generalists vs. specialists. Create enough capacity for MDTs to expand coverage for rising risk. Use workforce modelling tool in managing needs • **Estate:** Co location of staff in MDTs improves the effectiveness of the approach, where possible co location of teams will be a priority in estates planning. • **IM&T:** Deploy the chosen stratification tool to all CCGs; Implement tools required for care planning by MDTs
Major milestones towards full implementation	**Main risks and mitigations**

• **Output 1**: By early 2017, determine the stratification tool that will be rolled out to the footprint and deploy at all CCGs. By mid to late 2017, ensure that the stratification method that is employed is standardised and all user comfortable with the new tool. • **Output 2:** By early 2017, map current coverage by existing MDTs and the referral processes to identify the gap to the target coverage. By mid-2017, publish a practice guide to MDTs to ensure focus end of life patients and standardise how GP staff engages with MDTs. Depending on the capacity gap to the target coverage, by end of 2018, increase MDT capacity to required level. Over two years, standardise for all CCGs the composition of MDTs and how social and mental health care plans are developed. By 2018, determine the path forward for estate planning for MDTs to be co-located. • **Output 3:** By early 2017, determine the current level of advance planning by MDTs (timeline dependent on output of that work). • **Output 4**: Nottinghamshire Observatory of Outcomes discussed more in detail in the Variation section	• **Risk**: Culture shift required for holistic care **Mitigation**: Move to an outcomes focus will support the culture shift to support holistic care. For example training to deliver a patient centred outcomes framework in Nottingham city will drive culture change. • **Risk**: Resistance to working in a uniform way on the ground **Mitigation**: Engage the GPs and demonstrate the important of uniform approach in scaling up

PID for Priority 2.4 – Improve self-care and management through information, education and use of technology

Priority leads: Dawn Jameson, Malik Arora, Rachel Jenkins	
Outputs	**Expected benefits (outcomes)**
1. Implement models of shared decision making; train staff suitably to consider patients and carers as part of their decision-making and offer alternative treatment options; quality control their discussions using performance measure tools (e.g., CollaboRATE measure, PAM) 2. Secondary prevention: incorporate healthy lifestyle support into care plans for patients with LTCs and mental health conditions 3. Technology enabled care: Empower patients and carers to be at the centre of their own care through access to their own records and test results, ability to add to their own records where relevant and new forms of interaction with professionals around their care plans. Set up a group to determine the best online sources of information and apps to promote healthy living and self-management of LTCs 4. Support self-care and carer support to enable people to be partners in care and confidently managing their health and well-being by increasing health literacy and activation levels and providing access to a range of appropriate support such as health coaching, peer support, self-management education and public awareness campaigns 5. Agree and share the content menu of services available for social prescribing for local people	**Health & Wellbeing:** • Quality of life measures (exact measures to be determined) • Increase healthy life expectancy **Finance & Efficiency:** • Reduced A&E admissions from care homes
Resources to deliver (and whether secured)	**Enablers**
• **Revenue funding:** (1) Maintenance of the patient online record system: To be determined with future work • **Capital funding:** (1) Set up the infrastructure: To be determined with future work	• **Workforce:** Training of GPs and MDTs on models of shared decision making • **Estate:** N/A • **IM&T:** Ensure the performance measure tool needs to interface the internal system of MDTs (e.g., SystemOne, EMIF); Infrastructure required to share patient records and test results
Major milestones towards full implementation	**Main risks and mitigations**

• **Output 1:** By end of first quarter 2017, develop training material for GPs and MDTs to utilise in implementing models of share decision making. By mid-2018, have trained all GPs and MDTs. By late 2018, reach targets set earlier on performance measure tools • **Output 2**: By mid-2017, publish guidance on care plans for "high" and "rising risk" patient groups to ensure healthy lifestyle support is captured. • **Output 3**: By end of 2017, develop the current pilot to set up the IT infrastructure required to safely house patient records and test results online and "go online" for a pilot CCG with select test results. By 2019, broaden the scope to all CCGs for patient access and all test results, as well as past medical records.	• **Risk**: Cybersecurity of patient information **Mitigation**: Staggered approach to "going live" with the

PID for Priority 2.5 – Enhance care to people in care homes through extended primary and community support

Priority leads: Sally Seeley	
Outputs	**Expected benefits (outcomes)**
1. Offer all residents enhanced primary care support from a consistent named GP who is linked to a multidisciplinary team 2. Offer Care homes Assistive Technology (telehealth, telemedicine and telecare) to function as a 'virtual MDT' with real-time access to good quality clinical data, increased clinical oversight and wraparound care for residents 3. Ensure programmes of education, training and development are available and accessible to all staff working in care homes (including managers, nurses, carers and support staff) which enhances their skills and competencies and confidence in caring for residents, particularly those with complex needs.	**Health & Wellbeing:** **Care & Quality:** • Increase in satisfaction rates of care home staff (range of questions can be asked) • Increase in recruitment and retention rates in care homes • Increase the number of residents who feel in control of their daily life • Improve health outcomes for care home residents, including reducing falls, Urinary Tract Infections, Respiratory Tract Infections, pressure ulcers • Improve the stability of the care home market **Finance & Efficiency:** • Reduced A&E attendances from care homes • Reduced non elective admissions from care homes • Reduced 999 calls / ambulance calls to care homes • Reduce excess bed days and Delayed Transfers of Care (DToC) • Reduced prescribing costs
Resources to deliver	**Enablers**
• Integrated assistive technology for care homes: £500K in 2017/18, £2.3M in 2018/19, £2.0M in 2019/2020 (Set up costs and non-recurrent costs in 2017/18) • Enhanced Primary Care Support (including multidisciplinary team input from pharmacists / nurses / specialist nursing into Care Homes): £600K in 2017/18, £750K in 2018/19, £800K in 2019/20	• **Workforce:** attracting qualified and non-qualified staff to work in this sector, programmes of education and training, skill mix and new ways of working • **Estate**: N/A • **IM&T:** Connectivity in care homes (secure high volume connection), access to IT infrastructure (hardware and software support) to enable telehealth and telemedicine • **Equipment:** Devices to support telehealth
Major milestones towards full implementation	**Main risks and mitigations**

• **Output 1:** By 2019 /20 , implement an enhanced primary care support model for each care home / care home resident in Nottingham and Nottinghamshire (staged approach in preceding years) • **Output 2**: By 2018/19 ensure all homes have the high volume connectivity in place to allow AT implementation • **Output 2:** By2019 /20, implement an assistive technology programme across all care homes (staged approach in preceding years) • **Output 3**: By 2017/18, develop the programmes of education, training and development for care home staff. By 2019/20, ensure that programmes are being offered and taken up by all care home staff.	• **Risk**: Low uptake of assistive technology offer **Mitigation**: Spread the deployment of the infrastructure over time • **Risk**: Unable to secure consistent enhanced primary care support. **Mitigation**: Involve key individuals and develop and implement skill mixing and new caring / professional roles • **Risk**: Low uptake of programmes of education and training. **Mitigation**: Spread the programmes over time and engage with staff in their development to ensure the relevance of them

PIDs for High Impact Area 3 – Simplify urgent & emergency care

Executive sponsor: Amanda Sullivan	
1. Priority projects within HIA and expected completion dates	**2. Main impacts on closing 3 gaps**

• Develop system leadership to enable a shared understanding of problems and coherence of actions
• Operate single front door at A&E with streaming to primary care and ambulatory care pathways, including redirecting ambulance to primary / urgent care centre
• Improve capability to discharge from A&E and hospital settings
  o Commence discharge planning from the point of admission and ensure that patients are discharged from EDs to their home or community beds (discharge to assess / transfer to assess) as soon as they are medically fit or diagnostic has been made
  o Ensure appropriate step-down provision to meet the care needs of the population
  o Enhance and scale up teams that provide specialist intermediate care in homes to reduce avoidable admission and readmissions by providing home-based support/rapid access to primary/community care centre for assessment
• Establish clinical hub for patient navigation, linking to 111, OOH, signposting and booking into local services, increase hear and treat and see and treat
	Care & Quality:
	▪ Support people to care for themselves and access the most appropriate urgent care services to meet their needs first time, making best use of resources
	  — Achieving national standard of treating 95% of patients attending A&E within 4 hours
	  — Demonstrated improvement in reliability and consistency of care in all care settings
	Finance & Efficiency:
	▪ Reduce avoidable activity in higher cost healthcare settings to:
	  — Contribute towards releasing up to 100-200 acute beds across NUH over the next 24 months
	  — Release a further 20 beds within Sherwood Forest over the next 12 months, in addition to 108 already removed
	  — Investment in capacity in community and social settings to ensure the right care is provided
	• Initiatives in this HIA will capture £16m in net savings in 2020/21

3. Key enablers	**4. Key decisions that still need to be made**

▪ Workforce:
  — Train specialist intermediate care and crisis response teams if not available in an area
  — Have mental health workers to patrol with police at night
  — Extend clinical roles to enable staff to operate at the top of their license
  — Train MDTs in 'Home First and pro-actively managing risks of independent living
▪ Estates:
	▪ Need to agree on the system issues, root causes and solutions needed and understand expected impact
	▪ All elements working together – understanding different sectors, recognising different perspectives (all legitimate) and incentives, transactional distractions / undermining of trust and coherence of action
	▪ Shifting to an organisationally agnostic approach, focusing on solving a difficult problem together

— Build and maintain primary care capability in the front door of A&E ▪ IM&T: — Put IT infrastructure in place to support increased usage of patient and healthcare professional navigation systems	
Main programme risks	**Mitigations**
Financial savings targets are not met	Continue to drive financial improvement plans through local transformation/service improvement plans at each organisation/locality level Include a joint strong oversight of implementation of projects, overseen by Finance Directors Group, and reporting to GNPB. Continue deep focus on identifying transformation funding to enable double running of key services whilst transformation is being implemented Implement alternative initiatives described in section 5.2.3 if the fixed cost (assumed 30%) cannot be taken out in its totally after 6-12 months of implementation
Beds capacity increase over next 3 years because providers efficiencies are not enough to keep them stable	Ensure alignment of commissioners and providers on this objective (keep beds increase as flat by delivering organisation efficiencies) Develop alternative care models in the community (as described) to manage demand of secondary care resources
Not enough supply of care professionals to deliver the added capability and capacity in the community	Continue intensive support from Local Workforce Action Board and on-going leadership and support from Health Education East Midlands Relentlessly implement the projects within section on workforce of this GN Strategy Plan
Insufficient non-recurrent funds available for the enabling/implementation costs during first 3 years of implementation	Identify preliminary transitional funding requirements and refine over the next 3-6 months Define a robust Strategy Plan to provide confidence to the regulator

Activity *(X for years with active implementation work planned)*	**Year 1 – 2016/17**	**Year 2 – 2017/18**	**Year 3 – 2018/19**	**Year 4/5 – 2019/20 & 2020/21**
Enhance 111 (e.g. mental health 111) and increase people's awareness of how and when to use the right provider of urgent care (e.g. self-care v pharmacy v GP v walk-in centre v A&E) with 111 as the single point of access			X	X

Establish clinical hub for patient navigation, linking to 111, OOH, signposting and booking into local services, increase hear and treat and see and treat	Business as usual for what's currently in place	X	X	
Provide people with education and tools to support self-care, self-assessment and self-treatment			X	X
Provide easy access to online information and online booking service			X	X
Develop professional navigation services for physical 1and mental health (incorporating secondary care advice, social care and community / primary care)		X	X	X
Integrate crisis response support (for physical and mental health) with community services so as to assess and provide care at people's homes or to take people into primary/community care centre for assessment, including support for alcohol consumption cases			X	X
Operate single front door at A&E with streaming to primary care and ambulatory care pathways, including redirecting ambulance to primary / urgent care centre	X	X		
Make sure that A&E specialists have complete access to care records of patients			X	X
Make sure that there is access to senior specialist to make right decision	X	X		
Make sure that there is access to relevant specialist opinion, for e.g. mental health, where appropriate	X	X		
Make sure that there is optimised patient flow in A&E and the wards	X	X		
Commence discharge planning from the point of admission and ensure that patients are discharged from EDs to their home or community beds (discharge to assess / transfer to assess) as soon as they are medically fit	X	X		
Ensure appropriate step-down provision to meet the care needs of the population	X	X		
Enhance and scale up teams that provide specialist intermediate care in homes to reduce readmissions by providing home-based support/rapid access to primary/community care centre for assessment	X	X		

PID for Priority 3.1 – Develop system leadership to enable a shared understanding of problems and coherence of actions

Priority lead: A&E board chairs (Amanda Sullivan, Peter Homa)	
Outputs	**Expected benefits (outcomes)**
1. Develop governance and operational relationships that drive shared diagnosis of problems and co-design of actions 2. Collocate teams and develop cross-sector forums for operational bed / flow management 3. Instigate development programmes that develop a shared understanding and relationships across operational and leadership teams 4. Ensure shared messages are clear for operational teams about expectations of working together across organisational boundaries (organisationally agnostic, doing what is right for the population has precedence) 5. Differential organisational impacts (financial and operational) are transparent and mitigated collectively 6. Establish evaluation methodology and rapid learning as changes take place, so that remedial actions can be taken 7. Systematically share learning across the whole STP footprint	Care & Quality: • Achievement of 4 hour ED target • Reduced acute bed days / length of stay • Reduced ward moves / outliers Finance & Efficiency: • Coherence of action across the system and achievement of recovery plan impacts • Smoother operations with swifter decision making process
Resources to deliver (and whether secured)	**Enablers**
STP governance and delivery infrastructure for overall system leadership Development support through ECIP programme	• Workforce: N/A • Estate: N/A • IM&T: N/A • Equipment: N/A • Other: STP leadership support
Major milestones towards full implementation	**Main risks and mitigations**
• System leadership governance: initiate by Dec 2016 • All outputs: to be initiated during 2017/18	See main PID

PID for Priority 3.2 – Improve capability to discharge from A&E and hospital settings

Priority lead: Liz Cowley (Mid-Nottinghamshire), Mark Simmons, Vicky Bailey (Greater Nottinghamshire) and Andy Haynes (Sherwood Forest Hospitals Foundation Trust)	
Outputs	**Expected benefits (outcomes)**
1. Develop system metrics to give a shared and single understanding of bottle necks, problem diagnosis capacity and flow (single version of the truth for evidence-based action planning) 2. Identify out of hospital, social, and community capacity required in each setting of care based on fact base and learning from multidisciplinary cohort working. a. Immediate adjustments to capacity and flow should be made with a rapid learning loop flow across the system b. Identify medium and long term actions for transformation such as implementing specialist intermediate care and assessment in homes, improving capability to discharge to home, including mental health support 3. Establish a facilitated engagement and design process, based on patient cohorts a. Prioritise cohort of patients to be focused on (hypothesis: DST, non-weight bearing, bariatric, respiratory, dementia) b. Form a cross organisational team of clinicians to work together to solve for the best care for the cohorts to assess and standardise procedures to optimise flow from admission to discharge c. Take learning from the above process and work on the next cohort for service redesign 4. Implement priority interventions we agreed to prioritise a. Plan discharge process from moment of admission and consider home first b. Implement "improving discharge processes" key actions from NHS rapid implementation guidance	Care & Quality: • Achieve 95% of ED wait times below 4 hours • Achieve 75% Ambulance Category A wait times below 8 minutes • Reduce Emergency Admissions for Under 18 LoS =0 by 20% • Reduce Mental Health A&E attendances by 10% Finance & Efficiency: • Investment in capacity in community and social settings to ensure the right care is provided • Release 200 acute beds across NUH over the next 24 months and provide net saving of £8m by 2020/21 • Release a further 20 beds within Sherwood Forest over the next 12 months, in addition to 108 already removed
Resources to deliver (and whether secured)	**Enablers**
• Revenue funding: £10M (reprovision costs) • Capital funding: N/A	• Workforce: Train specialist intermediate care and crisis response teams if not available in an area Extend clinical roles to enable staff to operate at the top of their license Train MDTs in 'Home First and pro-actively managing risks of independent living • Estate: N/A • IM&T: N/A

	Consider use of systematic process (eg. Lean plus) • Equipment: • Other:
Major milestones towards full implementation	**Main risks and mitigations**
• Output 1: Working group to be decided and regular meetings to be scheduled by April 2017 • Output 2: Capacity requirements, short, medium, and long term transformation initiatives to be identified by April 2017 • Output 3: Prioritisation of the cohorts and first study into a pilot cohort to be completed by April 2017	See main PID

PID for Priority 3.3 – Operate single front door at A&E with streaming to primary care and ambulatory care pathways, including redirecting ambulance to primary / urgent care centre

Priority lead: Liz Cowley (Mid-Nottinghamshire), Guy Mansford, Ben Pope (Greater Nottinghamshire) and Andy Haynes (Sherwood Forest Hospitals Foundation Trust)	
Outputs	**Expected benefits (outcomes)**
1. Co-locate primary care with A&E / Newark Urgent Care Centre at all sites across the footprint to stream patients to the right care required given their conditions a. Ensure capacity matches demand patterns throughout the day. This will be in addition to urgent primary care access outside of hospital b. Develop alternative solutions where space is constrained (QMC site) 2. Further develop ED & GP relationships to develop agreed ways of working and trust to achieve optimum streaming and agreed risk thresholds. For example, Mid Notts joint triage pilot 3. Further develop current ambulatory care availability and model of care Ambulatory care as a default, rather than admitting to assess 4. Ensure timely access to mental health triage, assessment and specialist advice at the front door 5. Primary Care is the first point of contact for all patients accessing ED (including ambulance arrivals) with the exception of resus and majors. Patients are then streamed to ED as necessary.	Care & Quality: • Achieve 95% of ED wait times below 4 hours • Contribution to reduction in Emergency Admissions for Under 18 LoS =0 by 20% • Reduce Mental Health A&E attendances by 10% Finance & Efficiency: • Initiative will contribute to overall savings • Reduce NEL admission. No saving that this drives alone
Resources to deliver (and whether secured)	**Enablers**
• Revenue funding: to be agreed for QMC site. • Capital funding: to be agreed for QMC site.	• Workforce: Primary care workforce with the appropriate skills and experience at the front door to manage all ambulant users of A&E Extend clinical roles to enable staff to operate at the top of the license • Estate: Build and maintain primary care capability in the front door of A&E • IM&T: N/A • Equipment: N/A • Other: N/A
Major milestones towards full implementation	**Main risks and mitigations**
• All intervention to start this year and completed by 2017/18	See main PID

PID for Priority 3.4 – Establish clinical hub for patient navigation, linking to 111, OOH, signposting and booking into local services, increase hear and treat and see and treat

Priority lead: Nikki Pownall	
Outputs	**Expected benefits (outcomes)**
1. Build clinical hub operating 24x7, across the whole STP footprint: a. Improve DoS (Directory of Services) access across urgent care services to support better patient navigation b. Offer appointment bookings to appropriate services when treatment is required in and OOHs c. Offer additional clinical assessment of identified calls that would benefit from this (including 999 green calls) to reduce inappropriate referrals to services d. Care navigation is supported by care plans and patients notes are shared between providers who have access to the SCR 2. Increase the number of patients treated on the telephone 3. Resolve more calls to ambulance service through clinical assessment to reduce conveyance to emergency departments 4. Increase clinical assessment of NHS 111 A&E dispositions and NHS 111 Green Ambulance dispositions to re-direct patients to primary care services and reduce conveyance and attendance 5. Provide access to a range of clinical staff who have the necessary skills in specific areas of practice (eg. Mental health, pharmacy, dental, and independent prescribing) to more appropriately manage patient need 6. Share care planning with all NHS 111 services via a flagging mechanism to allow Call Handler to recognise Special Patient Need and transfer to clinician as appropriate 7. Reduce the number of patients going through the NHS pathways system where this does not add any benefit. E.g. Tag callers from Care Homes or those who are complex or frail and older and direct these numbers directly to a clinician 8. Use Interactive Voice Response (IVR) where appropriate to transfer Dental and/or Pharmacy Calls more speedily to an appropriate clinician 9. Assess current navigation systems (eg. call for care and mental health triage) to take the learnings and scale up if appropriate after year 1	Care & Quality: • Reduction in attendances from 111 ED dispositions by 75% • Reduction in green ambulance conveyance from 111 by 11% • 25% of green calls triaged by clinical hub by 2017/18 • 50% of patients triaged, dealt with on the phone. • 25% of patients who need to be seen have a booked appointment by 2017. • Patients journey time (average time to clinical encounter) is reduced by 10% by 2018 • 13% reduction in patients requiring face to face consultation by 2018 • Patient satisfaction increases by 10% based on current F&F rates across UEC services • Patient records accessed by each provider/professional across the healthcare system • No. serious incidents recorded by clinical hub/across UEC pathways • No. transfers from 111/green call classed as 'appropriate' • All professionals have access to patient records at time of consultation 100%. • Zero serious incidents and never events • 100% of transfers classed as appropriate by 2018. Finance & Efficiency: • Provide net savings of £7.5m by 2020/21 • Calls abandoned after at least 30 seconds • Average time to call answer • Average time to urgent clinical assessment

- Face-to-face primary medical care bookings
- Calls closed as self-care
- Re-contacts
- Directory of Services catch-all
- Compliance with advice
- Electronic transfer of referral information
- Average time to definitive clinical encounter
- Serious Incidents
- End to end reviews
- Helpfulness of advice
- Satisfaction
- If 111 was not available or not

Resources to deliver (and whether secured)

- Revenue funding:

	17/18	18/19	19/20	20/21
Clinical Hub Development (Warm transfer)	£133,196	£135,860	£133,196	£133,196
Green calls (Notts wide)	£243,320	£243,320	£243,320	£243,320
Additional Pharmacist Support	£11,829	£12,065	£12,306	£12,553
Mental health - 111	£77,200	£78,744	£80,319	£81,925
Mental health - 111 Direct booking				
Overheads	£74,487	£75,198	£75,063	£75,359
Programme management costs 50%				
Total recurrent costs	£540,032	£545,187	£544,204	£546,353

Vanguard funded costs				
Locall funded costs	£540,032	£545,187	£544,204	£546,353

Enablers

- Workforce: N/A
- Estate: N/A
- IM&T:
  Put IT infrastructure in place to support increased usage of patient and healthcare professional navigation systems
- Equipment: N/A
- Other: N/A

Grand Total investment	£540,032	£545,187	£544,204	£546,353

- Capital funding:

Major milestones towards full implementation	Main risks and mitigations
• All outputs: to start this year and completed by 2018 April • Output 9: Evidence base for current system to be shared and decision around scaling up to be made by 2018 April	See main PID

PID for High Impact Area 4 – Deliver technology-enabled care

Executive sponsor: Vicky Bailey	
1. Priority projects within HIA and expected completion dates	**2. Main impacts on closing 3 gaps**
▪ Workstream 1 – Information Sharing - (2017/19) o Digitise all providers o Implementation of the Community Portal o Medical Interoperability Gateway (MIG) phase 2 & 3 (enhanced datasets and end-point 2) o eHealthscope GP repository for clinical care (GPRCC) phase 2 & 3 o Data Quality Strategy o Summary Care Record (SCR) including Community Pharmacies o Midlands Accord (phase 1-3) o Standardised Nottinghamshire wide sharing principle o EPaCCS and Standardised electronic discharge summaries ▪ Workstream 2 – Infrastructure - (2017/19) o Improved infrastructure o Improved clinician to clinician communication (NHS Mail2, ITK/CDA structured messaging, multi-agency referrals) o End user device delivery o Networks o Cross-domain authentication o Wi-Fi o System integration including unified communications o VDI o Data centre strategies alignment and 'SMART offices' ▪ Workstream 3 – Citizen / Patient Access to Information - (2017/19) o Citizen access to own health data o Citizen access to self-care information and navigation ▪ Workstream 4 – Digital Maturity - (2017/19) o Digital maturity assessment test performed annually o Change Management Toolkit & Framework o Accelerated Change Management (increasing digital adoption) ▪ Workstream 5 – Assistive Technology - (2017/19) o Telehealth	▪ Care & Quality o All records available to share digitally across organisations o All staff accessing digital records at the point of need across organisations o All staff working in the community using mobile technologies to access digital records o All "known to social care" patients in acute settings having had their admission automatically notified/referred to social care ▪ Finance & Efficiency o Savings in 2020/21 of £3m o All organisations providing regular data for analytics use, risk stratification and supporting both clinical and business decisions e.g. commissioning o All staff with secure communications (NHS mail) access o All organisations using teleconferencing for care provision o All referrals to social care from acute settings being conducted electronically o All transfers of care done electronically (by organisation) ▪ Health & Wellbeing o All citizens/patients with access to their records o Patients receiving care at home to be supported by 'self-care' technologies o All clinical priority pathways with self-care information provision (to support self-care)

o Telecare o Tele-monitoring (Flo (text messaging) and MyGP24/7) o Advice and Guidance o Teledermatology o COVIRT - a "COPD Virtual Ward" o Video conferencing / Skype consultations o New technology and Wearables	
3. Key enablers	**4. Key decisions that still need to be made (and deadlines for resolution)**
▪ **Workforce**: o Clinical Leads o Programme Management o Project Management o Information Governance o Change Management o Administrative Support o Service Desk Support o Service Management o Third party suppliers ▪ **Estates**: o SMART Buildings ▪ IM&T: o Networks & Connectivity (COIN) o Communications o Data Centres o Wi-Fi o Licencing (e.g. SQL) o Business Intelligence environment ▪ **Equipment**: o End User Devices	▪ 2016/17 – LDR delivery of technology enablement initial fund decision. Deadline is pending and decision is with NHSE ▪ All organisations aligned and ready to initiate change activities (business, culture and technology change) ▪ Digital maturity status of all organisations approved prior to change activities commencing
Main programme risks	**Mitigations**
Funding delays from NHSE	We have been identified as a 'category B' site which delivers funds 16/17
Limitations in benefits realisation/change management	A new change management toolkit has been developed to capture these areas
Commercial partner readiness (including SNOMED readiness)	We will be monitoring via organisations digital maturity assessments
Limitations in capability to share across geographical boundaries (including requirements for Bassetlaw as a partner)	Engagement and alignment continues regularly with all parties working together

Activity *(X for years with active implementation work planned)*	**Year 1 – 2016/17**	**Year 2 – 2017/18**	**Year 3 – 2018/19**	**Year 4/5 – 2019/20 & 2020/21**
1. Digitise all providers	X	X	X	
2. Implementation of the Community Portal	X	X	X	
3. Medical Interoperability Gateway (MIG) phase 2 & 3 (enhanced datasets and end-point 2)	X	X	X	
4. eHealthscope GP repository for clinical care (GPRCC) phase 2 & 3	X	X	X	
5. Data Quality Strategy	X	X	X	
6. Summary Care Record (SCR) including Community Pharmacies	X	X		
7. Midlands Accord (phase 1-3)	X	X	X	
8. Standardised Nottinghamshire wide sharing principle	X	X		
9. EPaCCS and Standardised electronic discharge summaries	X	X		
10. Improved infrastructure cross organisations		X	X	
11. Improved clinician to clinician communication (NHS Mail2, ITK/CDA structured messaging, multi-agency referrals)	X	X	X	
12. End user device delivery		X	X	
13. Networks	X	X	X	
14. Cross-domain authentication	X	X	X	
15. Wi-Fi	X	X	X	
16. System integration including unified communications	X	X	X	
17. Virtual Desktop Infrastructure (VDI)	X	X	X	
18. Data centre strategies alignment and 'SMART offices'	X	X	X	
19. Citizen/patient access to own health data (POA 100% uptake, Self-care Apps, GPSoC API in place)	X	X	X	
20. Citizen/patient access to self-care information and navigation	X	X	X	
21. Digital maturity assessment test performed annually	X	X	X	X
22. Change Management Toolkit & Framework		X	X	X
23. Accelerated Change Management (increasing digital adoption)		X	X	X
24. Telehealth	X	X	X	X
25. Telecare	X	X	X	X
26. Tele-monitoring (Flo (text messaging) and MyGP24/7)	X	X	X	X
27. Advice and Guidance via (MIG)	X	X	X	X
28. Teledermatology	X	X	X	X
29. COVIRT - a "COPD Virtual Ward"	X	X	X	X

30. Video conferencing / Skype consultations	X	X	X	X
31. New technology and Wearables	X	X	X	X

PIDs for High Impact Area 5 – Ensure consistent and evidenced based pathways in planned care

Executive sponsor: Sam Walters	
1. Priority projects within HIA and expected completion dates	**2. Main impacts on closing 3 gaps**
▪ Standardise Care pathways: - Gastroenterology: July 2017 - Cardiology: September 2017 - Ophthalmology: April 2017 - Agree roll out of models for future specialties. ▪ Develop new models of follow-up care: April 2017 ▪ Delivering the Five Year Forward View for Cancer Care: March 2020 ▪ Develop Integrated Multidisciplinary Musculoskeletal Model: Phase 1: Feb 2017 (Mid Notts) Phase 2: April 2017(South Notts) ▪ Provide planned care in most appropriate setting: April 2017	Health & Wellbeing: ▪ Earlier diagnosis and secondary prevention support ▪ Extend life expectancy, and healthy life years Care & Quality: ▪ Improved patient experience ▪ Care closer to home ▪ Clinically evidenced consistent pathways and reduced unwarranted clinical variation Finance & Efficiency: ▪ Reduced costs with care provided in the most cost effective setting ▪ Earlier interventions reducing the cost of the subsequent care treatments ▪ Expected net saving of £21m by 2020/21
3. Key enablers	**4. Key decisions that still need to be made (and deadlines for resolution)**
• Workforce: Efficient use of specialist consultant/nurse staff skills development of new roles/skills in acute and community settings, optimally manage workforce with e-rostering • Estates: potential to reduce acute estate e.g. telephone clinics. Develop and pilot "one stop clinic" model, with GPs and specialists working together (incl. diagnostics, outpatient appointments) ▪ IM&T: infrastructure such as bespoke call and recall systems New technologies to support alternative methods of follow up care, such as tele-dermatology, near patient testing/monitoring and services such as Consultant Connect. ▪ Equipment: appropriate equipment to support revised pathways, and equipment for new technologies such as smart phones.	Agreement of proposals in operational plans and contracts Agreement of contractual mechanism for Integrated Multidisciplinary Musculoskeletal Model (Mid Notts)
Main programme risks	**Mitigations**
Change projects do not yield anticipated benefits	Monthly monitoring against outcomes

Award of contract for Integrated Multidisciplinary Musculoskeletal Model to meet service requirements (Mid Notts)	Revised approach to achieving benefits

Activity *(X for years with active implementation work planned)*	**Year 1**	**Year 2**	**Year 3**	**Year 4/5**
32. Standardised Pathways for Gastroenterology	X	X		
Standardised Pathways for Cardiology	X	X		
Standardised Pathways for Ophthalmology	X	X		
33. Develop new models of follow up care	X	X		
34. Delivering FYFV for Cancer	X	X	X	X
35. Integrated MSK Model	X	X		
36. Provide planned care in most appropriate setting	X	X		

PID for Priority 5.1 – Standardise care pathways in gastroenterology, cardiology and ophthalmology

Priority lead: Sarah Fleming / Jane Thornley	
Outputs	**Expected benefits (outcomes)**
1. Improved access to the relevant pathway 2. Earlier access to diagnostic testing 3. Improved patient experience 4. Reduced unnecessary outpatient attendances 5. Stable follow up activity delivered in community setting/ Reduction in unnecessary outpatient follow ups or provision locally nearer to home	**Health & Wellbeing:** • Improving overall health of population and primary and secondary prevention; ▪ earlier intervention **Care & Quality**: ▪ Faster patient access to the appropriate service ▪ Improved patient experience due to more streamlined pathway of care **Finance & Efficiency:** ▪ Reduced unnecessary outpatient and diagnostic activity ▪ Provide net saving of £1.8m by 2020/21
Resources to deliver (and whether secured) -	**Enablers**
• Revenue funding in 2020/21 when fully implemented: £220k Gastro £246k Cardiology £314k Ophthalmology to support redesigned pathway • Capital funding: N/A	**Workforce:** Develop clinical assessment service skills and roles. Reduce demand on specialties with workload and recruitment pressures reducing agency and locum staff. Develop skill set of community optometrists to support delivery in community setting. **Estate:** reduce need to build extra physical capacity in gastro, as reduction in demand will be offset by increased demand for 2ww modelled in cancer FYFV PID. **IM&T:** Improved access to data systems and ability to share patient information between providers and GP practices **Equipment:** shift of some diagnostics to community **Other:**
Major milestones towards full implementation	**Main risks and mitigations**
• Output 1: By 1.7.2017 reduce Gastro OPAs expected 23% reduction Output 2: By 1.9.2017 reduce Cardiology OPAs expected 23% reduction • Output 3: By 1.4.2017 reduce unnecessary ophthalmology referrals, ensuring patients have access to the most appropriate service, without delay. • Output 4: By 1.1.2018, reduce the growth rate of Ophthalmology OPAs, which have increased 30% over the last 5 years.	**Risk:** Some patients will not be physically assessed by a clinician, which is a new way of working that may not meet patient expectations. **Mitigation:** Communication with patients of the pre-assessment pathway Risk: That stakeholders do not engage with the process Mitigation: Targeted programme of stakeholder engagement Risk: Workforce is not available to deliver proposed models Mitigation: Targeted educational programme, allowing access to relevant training and accreditation

PID for Priority 5.2 – Develop new models of follow-up care

<table>
<tr><th colspan="2">Priority lead: Sarah Fleming / Jane Thornley</th></tr>
<tr><th>Outputs</th><th>Expected benefits (outcomes)</th></tr>
<tr><td>1. To improve the value of follow up care through:
a. Embedding an approach of risk stratification for follow up care in all specialties through greater integration between primary and secondary care to deliver optimum outcomes for patients.
b. Using technology to deliver and review follow up care, building on the work that has happened around telephone clinics at NUH, tele-dermatology at Circle and using new technology and information sharing to deliver a modern system of care, utilising the opportunity provided by the Advice and Guidance service
2. To reduce unwarranted clinical variation by:
a. Reduction in the variation in follow-up care delivered with the main providers of secondary care within the footprint.
3. To improve patient experience and provide care closer to home.</td><td>Health & Wellbeing:
• Support secondary prevention and independence
Care & Quality:
• Improved patients experience as patients are not required to go to hospital unnecessarily where either no follow up is required or the follow up can be undertake closer to home/via technology
Finance & Efficiency:
• Reduction in total secondary care outpatient follow-up appointments in region of 158,000 per year with a commissioner gross saving of £8.5m
• Reducing pressures to achieve waiting time targets and need for waiting list initiatives, and potentially estate costs
• Increased productivity through better use of resources</td></tr>
<tr><th>Resources to deliver (and whether secured) –</th><th>Enablers</th></tr>
<tr><td>• Revenue funding FYE:
£1.3m

• Capital Funding: N/A</td><td>• Workforce: new roles and skills required –reduced pressures for hard to recruit consultant specialties
• Estate: potential reduction in acute estate as small outpatient clinic footprint required.
• IM&T: infrastructure such as call and recall systems will be required to support the discharge of follow up care. This may require bespoke solutions that will need to be developed; opportunity for new technologies to support alternative methods.</td></tr>
<tr><th>Major milestones towards full implementation</th><th>Main risks and mitigations</th></tr>
<tr><td>• Issue Contracting Intentions: August 2016
• Work with specialties to agree risk stratification approach and confirm removal of provider costs: November 2016
• Implementation aligned with contractual intentions: 1st April 2017
• Evaluation is via monitoring of activity on a monthly basis. The Elective Care Oversight Group will obtain soft intelligence from the system on impact of work</td><td>Risk: Patient experience deteriorates as expectations of usual follow up care not met
Mitigation: Communication with patients regarding how follow up care will be managed. Systems in place to ensure ready access back into secondary care where clinically necessary.
Risk: Recovery from episodes of illness is negatively impacted on</td></tr>
</table>

	Mitigation: Systems to ensure ready access back to secondary care where clinically necessary.

PID for Priority 5.3 – Deliver the Five Year Forward View for Cancer

Priority lead: Simon Castle	
Outputs	**Expected benefits (outcomes)**
1. Implement NICE NG12 referral guidelines (Increase in referrals and access to diagnostics in primary care) 2. Non-specific symptoms pathway commissioned and operational 3. Increase cancer screening uptake rates 4. Implement all aspects of the Recovery Package	**Health & Wellbeing:** • Extend life expectancy, and healthy life years **Care & Quality**: • Improved patient and carer experience, less visits to acute hospital, improved outcomes **Finance & Efficiency:** • Reduce emergency admissions, A&E attendances, follow ups, earlier stage diagnosis leads to lower treatment costs. • Provides saving of £7m in 2020/21
Resources to deliver (and whether secured)	**Enablers**
Revenue funding: Required investment of £2.2m in 2020/21 includes: • 10-15% pa increase in referrals (£637k-£955k pa) and subsequent diagnostics (£557k-£834k pa). • Recovery package / stratified pathways of care - £0.75m pa • Capital funding: N/A	• **Workforce:** Pilot community Cancer Service. Radiographers and Cancer Nurse specialists expanded roles. • **IM&T:** Cancer risk tools embedded within GP systems, Mind Map referral tools, Electronic Health Needs Assessments (eHNA)
Major milestones towards full implementation	**Main risks and mitigations**
Output 1a GP Direct Access to diagnostics operational as per NICE guidelines by April 2017 Output 1b NICE guidelines implemented – education sessions to GP through PLTs, roll out Mind Map Referral Tool, GPs to utilise Qcancer Risk tool with GP systems – April 2017	**Risk:** Workforce – particularly in diagnostics (imaging) **Mitigation:** Upskill radiographers to undertake reporting. Pooling for workforce across East Midlands. Greater use of private sector. East Midlands Cancer Network developing Workforce Strategy

Output 2 Pilot non-specific symptoms pathway in South and Mid Notts by April 2017. Evaluation and roll out to all practices by April 2018 Output 3 Improve pockets of low cancer screening uptake rates – identify areas, understand reasons (deprivation, %BME) agree interventions (April 2017). Implement actions through 2017 Output 4 Full roll out of recovery package across South and Mid Notts – eHNAs, Treatment Summary, Health and Wellbeing Event, Cancer Care Review by April 2018	

PID for Priority 5.4 – Develop Integrated Multidisciplinary MSK Model

Priority lead: Sarah Fleming/Jane Thornley	
Outputs	**Expected benefits (outcomes)**
Design and delivery of a multidisciplinary integrated MSK service for patients across the STP footprint. This combines orthopaedics, rheumatology (exc DMARD), MSK pain management, podiatry, physiotherapy and diagnostic services. The service will co-ordinate and manage the healthcare pathways of patients to deliver high-quality care/clinical outcomes and excellent patient experience. The vision for a new model of Musculoskeletal (MSK) care that will deliver: 1. Service innovation, through a new clinical model of care designed by the MSK clinicians that focuses on the delivery of an integrated MSK system 2. Improved value for money with better outcomes and improved quality of care by incentivising a shift of resources from the acute setting to the community	Health & Wellbeing: • Earlier diagnosis and preventative support Care & Quality: • Improved patient experience • Care provided closer to home Finance & Efficiency: • Provide gross saving £6.6m in 2020/21 • In line with the elective care plans, it is estimated that a 9% reduction to out patient referrals could be achieved • System-wide model, which will take 10% cost out of MSK and ensure costs within the programme budget of £34.6m (Mid Notts)
Resources to deliver (and whether secured)	**Enablers**
▪ Revenue funding: The contractual model assumes redesign and efficiency within the programme budget that will support internal transition whilst releasing savings. Value of transitional funding required still to be projected/evaluated. (Mid Notts) • Capital funding: N/A	**Workforce**: Efficient use of specialist consultant/nurse staff skills development of new roles/skills in acute and community settings, Optimally manage workforce with e-rostering
Major milestones towards full implementation	**Main risks and mitigations**

Baseline Activity Analysis Engagement with relevant stakeholders Set up Mid Notts/South Notts MSK Network through extension of existing MSK Clinical Group Develop draft MSK model and financial assumptions Agree procurement and contracting approach Communications and Engagement Plan Agree procurement Process Issue of invitation Evaluation Service Commencement 1.2.17 Phase 1 (Mid Notts) Service Commencement 1.4.17 Phase 2 (South Notts)	**Risk:** stakeholders do not engage with the process **Mitigation**: Targeted programme of stakeholder engagement **Risk:** CCG are unable to define/agree outcomes based payment mechanism **Mitigation:** Work with other areas to learn from successes **Risk:** Internal capacity to deliver implementation is stretched delaying timescales. **Mitigation:** Re-assign work portfolio of team and assign key tasks to individual CCG officers within remit of project (ie Finance, Contracting, Transformation, Primary Care) **Risk:** that clinical lead capacity to lead project forward is not available **Mitigation:** Seek alternative clinical lead resources - including MSK Network **Risk:** that providers do not have workforce capacity to provide MSK model Mitigation: Providers to pursue alternative approach (ie AQP, training, different ways of working)

PID for Priority Project 5.5 – Provide planned care services in the most appropriate setting

<table>
<tr><td colspan="2">Priority lead: Mel Sims</td></tr>
<tr><td>Outputs</td><td>Expected benefits (outcomes)</td></tr>
<tr><td>1. Complete the clinical reviews of services that are currently provided at NUH.
a. Review national and international evidence and practice, as well the information on current provision and develop new specifications for the services which are provided in the most clinically appropriate setting as close to home as possible, or identify where services can be de-commissioned
b. Identify the most appropriate delivery mechanism for the new/revised specifications (e.g. transfer services to the community to deliver more integrated care closer to home; re-design the service within existing provider)
2. Clinically review services to identify opportunities to redesign pathways to ensure procedures are undertaken in an outpatient setting if clinically appropriate rather than as a day case.
a. Complete clinical reviews to identify redesign opportunities
b. Review national benchmarking to identify practice elsewhere in order to develop service specifications for local services going forward</td><td>Health & Wellbeing:
• Focus on procedures being undertaken as an outpatient rather than as a daycase.
• Focus on self-help and self-care
• Focus on reducing admission and attendance at hospital
• Care closer to home and integrated services are consistently identified by patients and the public as key design principles in new models of care – where this is delivered it reduces stress on patients, their families and other informal carers thereby improving their health and well being

Care & Quality:
• Patients will receive care in the most appropriate setting
• Specifications for each service including the evidence base, KPIs and expected outcomes to be delivered
• Progression of more integrated care pathways with reduced hand offs between services

Finance & Efficiency:
▪ Improved value for money. Reduced cost at NUH and QIPP savings for commissioners as the specifications will be for delivery of safe effective services but will not look to commission standard in excess of this requirement
▪ Provides net savings of £1.3m in 2020/21</td></tr>
<tr><td>Resources to deliver (and whether secured)</td><td>Enablers</td></tr>
</table>

▪ Revenue funding: £11.7m (reprovision costs) • Capital funding: N/A	**Workforce**: Efficient use of staffing and estate by treating patients in least acute setting of outpatient clinic rather than daycase – one-stop shop where clinically appropriate **Estate:** N/A **IMT:** N/A
Major milestones towards full implementation	**Main risks and mitigations**
By end January 2017: Complete clinical review of existing provision and complete national and international best practice and evidence review – identifying areas for further work By April 2017: Agree and contract for revised specifications and patient pathways	**Risk:** Stakeholders do not engage with process and agreement cannot be reached on way forward **Mitigation**: Targeted programme of stakeholder engagement with independent clinical support if required **Risk:** Internal capacity within CCGs and providers to deliver implementation is stretched delaying timescales. **Mitigation:** Re-assign work portfolio of team and assign key tasks to individual CCG officers within remit of project (ie Finance, Contracting, Transformation, Primary Care)

PIDs for Supporting Workstream – Improve housing and environment

Executive sponsor: Bev Smith	
1. Priority projects within HIA and expected completion dates	**2. Main impacts on closing 3 gaps**
▪ Provide timely, safe and supported home environments for people who are medically fit to leave hospital through a common discharge scheme ▪ Expand the Nottinghamshire 'Warm Homes on Prescription' scheme which will improve the thermal efficiency of homes inhabited by people with health conditions that are made worse by the cold	Finance & Efficiency: ▪ Anticipated reduction of (c)2000 excess bed days across the STP footprint with a total system gross saving of £4m in 2020/21 ▪ Anticipated reduction in non-elective inpatient long stays in hospital with total saving of £741k in 2020/21 ▪ In total, gross saving will be £4.7m and a net risk-adjusted saving of £2m in 2020/21
3. Key enablers	**4. Key decisions that still need to be made (and deadlines for resolution)**
▪ **Urgent and Emergency Care** – Need to ensure a clear and joined up approach is adopted by all parties involved in hospital discharge arrangements ▪ **Workforce**: MECC and embed housing professionals in MDT's ▪ **IM&T**: - Support for a redesigned assistive technology referral pathway action	▪ Project management structure needs to be identified and put in place to deliver the two priority projects
Main programme risks	**Mitigations**
Lack of political buy in and engagement	• Ensure portfolio holders on HWB are briefed on process and high level principles • Involve members in principles of STP approach and governance • Appropriate reporting and political approval of key actions
Lack of Chief Executive buy in and alignment	• Effective communication strategy in place via theme sponsor • Involve CEX 's in developing approach and governance arrangements
Lack of Buy in and alignment of third party housing providers	• Effective communication and involvement throughout the process. Regular feedback and two way communication to address concerns. • Full commitment to be obtained from Housing providers within Nottingham and Nottinghamshire
Lack of staff buy in	• Effective staff communication and involvement throughout the process. Regular feedback and two way communication to address concerns. • Full commitment from middle managers and senior management • Change management training/coaching to be provided as appropriate
Lack of buy-in from stakeholders	• Stakeholder consultation to be undertaken at appropriate stage • Communication strategy on STP at appropriate time prior to implementation

Lack of resource capacity from specialist areas to support and facilitate project management	• Detailed planning of each project and the programme of work • Consider the secondment of external resource particularly in the absence specialist skills and expertise • Shared knowledge of the workloads and projects currently planned or underway at each organisation that might impact on the development of STP projects
Lack of strong and effective programme management arrangement	• Utilise Prince 2 methodology as reflected in the PID with all process stages followed using templates and tools as agreed. • Prepare a detailed programme plan including dependencies and details of key tasks and milestones for future phases • Set out clearly project roles and responsibilities.

Activity *(X for years with active implementation work planned)*	**Year 1 – 2016/17**	**Year 2 – 2017/18**	**Year 3 – 2018/19**	**Year 4/5 – 2019/20/21**
1. Provide timely, safe and supported home environment (PID)	X	X		
2. Delivering a common approach to adaptations which create suitable and safe home environments	X	X		
3. Work with key partners to identify and implement a common referral pathway which supports people who would benefit from Assistive Technology in their home environment	X	X		
4. Develop a Nottinghamshire 'Health and Housing Profile' which will allow better targeting of interventions towards those with long term health conditions and who live in the poorest housing	X	X		
5. Implement a programme to remove the most serious hazards from the home environment through a combination of advice, support for repairs and enforcement		X	X	
6. Expand the Nottinghamshire 'Warm Homes on Prescription' scheme which will improve the thermal efficiency of homes inhabited by people with health conditions that are made worse by the cold. (PID) *Funding in place for year 2016/17	X*	X	X	X
7. Support health professional's by establishing a single point of access for housing related referrals which will facilitate the delivery of timely and appropriate housing advice and assistance	X	X		
8. Ensure fast food takeaways implement healthier methods of cooking and offer healthier food options on their menu by increasing the number of premises participating in the Healthier Option Takeaway (HOT) Campaign	X	X		
9. Implement the 'Spatial Planning for the Health and Wellbeing of Nottinghamshire and Nottingham Framework including embedding the Health Impact Assessment model within Local Plan Development and working on the development of supplementary planning guidance to ensure that large developments are subject to a Health Impact assessment at the planning stage		X		
10. Develop and implement an Air Quality Strategy for Greater Nottingham and Nottinghamshire which will drive positive action to reduce the impact and cost of air pollution on the populations health	X	X		

11. Develop and deliver a communications and engagement strategy to encourage positive behavioural change in a range of diverse groups with varying priorities and differing health/economic consequences from air pollution	X	X		
12. Prepare for proposed Nottingham Clean Air Zone (planned implementation 2019) which will identify a range of actions to reduce emissions of nitrogen dioxide and particulates from road transport and other sources		X	X	X

PID for Supporting Workstream Priority 1 – Supporting people to live independently at home

Priority lead: Dave Banks, Rushcliffe Borough Council	
Outputs	**Expected benefits (outcomes)**
Hospital discharge schemes developed across the footprint to minimise the pressures on acute health care services and build on existing schemes in operation, which have evidenced significant savings to the health service. The identified savings are based on the evaluation of the Mansfield Hospital Discharge scheme and pilots in Ashfield and Nottingham City. To roll out a common hospital discharge framework across the STP footprint, it is estimated that system wide savings of around £4m per annum can be achieved, along with improving the health outcomes for the individual. The proposal links directly with the UEC priority of "Improve capability to discharge at home" and the actions to achieve this through: 1) Commencing discharge planning from the point of admission and ensuring patients are discharged from EDs to their home or community beds as soon as they are medically fit. 2) Ensuring appropriate step down provision to meet the care needs of the population. 3) Enhance and scale up teams that provide specialist intermediate care in homes to reduce readmissions by providing home based support/ rapid access to primary/ community care centre for assessment. 4) Early housing interventions to reduce readmissions	Finance and efficiency gross savings of £4m in 2020/21 Development of a common hospital discharge framework across the footprint will ensure that patients are discharged from hospital efficiently, safely and with the appropriate support provided. This will deliver additional capacity within the health service; significant system wide savings and improved health outcomes for patients Effective and safe discharge procedures will release hospital beds and deliver improved health outcomes for the patient by being able to return home (or to appropriate accommodation) with the appropriate support in a timely manner. In addition to generating additional capacity within the health service. Specifically, the measures contained within the business case contribute to the following metrics and STP-wide targets: **Prevention and Promoting Independence** • Increase healthy life expectancy by three years by 2020 **Primary and Community care** • Top 25% for older people remaining at home 91 days after discharge • 573 per 100,000 care home admissions for over-65s • Reduction in avoidable deaths **Urgent and emergency care** • 6% reduction in A&E attendances • Reduction in non-elective admissions to 8,909 (city) and 9,695 (county) per 100,000 (in 2016-17) • 30.5% reduction in non-elective acute bed days Indicator BCF4 (Delayed transfers of care (delayed days) from hospital per 100,000 population) shows that in 2015/16 there were 5,370 delayed transfers per 100,000 population in Nottingham City and 3,367 per 100,000 population in

	the county. Data provided by Nottinghamshire Public Health team shows that there were a total of 17,048 delayed days during 2015/16 from Nottingham University Hospitals Trust. Evidence from the evaluation of the Mansfield Hospital Discharge scheme identified that the average cost of a hospital bed stay is £225 per day. The Mansfield Scheme has an annual cost of £233,000. Evidence gained from an evaluation by Nottingham Trent University identified the cost savings to the NHS brought about by this pilot were £1,371,060 per annum and, over a period of July 2015 – April 2016 reduced the number of excess bed days by 576 (c 700 annually). Estimating the cost of providing a County and City wide hospital discharge scheme is particularly difficult at this stage of the business case as running costs are heavily dependent on each district council, local hospital provision and size, the model of discharge chosen and the level of service offered. Indicative costs from the Mansfield scheme have been included within this business case as a reference point. It is anticipated that similar results could be achieved at QMC and Nottingham City Hospital, thereby resulting in cost savings to the NHS of £4 million per annum and reducing the number of excess bed days by around 2000 across the footprint. The set up costs of the 9 month Nottingham City Hospital to Home (HHC) pilot were £66,000 with identified savings of £500,000 when compared to the alternative scenario in the absence of the HHC project. A key focus of this scheme has also been to look at early housing interventions which reduce hospital admissions and readmissions. Indicative evaluation of the scheme shows a saving to the NHS of £6.55 for every £1 invested in the project. The project has also demonstrated significant savings to Social Care budgets through its early intervention approach. The scheme has focussed on older people but the evaluation lends to recommendations for expansion to supporting people with mental health support needs and homeless people. The expanded scheme will be rolled out later this year. The Hospital Discharge Scheme at Ashfield District Council utilises an initial 2 fully furnished properties with a further 2 units being handed over early 2017. Adult Social Care lease adapted, level access properties from the Council to provide interim accommodation to patients who are ready to leave hospital but may not have suitable housing to return to or may be waiting for adaptations to be carried

	out in their homes. It is anticipated that this will result in reductions in both further health problems and future re-admissions.
Resources to deliver (and whether secured)	**Enablers**
Indicative costs can be used based on the Mansfield scheme, however actual costs will be dependent on local need and hospital demand etc. Based on the evaluation of the Mansfield scheme, **total indicative costs are £699,000 per annum**. Costs have not been secured. Staffing resources need to be quantified on a local basis.	Project management group to be established – this will require broad input from a range of partners including CCGs; Public Health; District, City and County Councils; Nottingham University Healthcare Trust; Registered Providers. A common framework will be developed utilising learning from the Mansfield, City and Ashfield pilot. Further enablers will be identified through this process. As stated, the proposal links directly with the UEC priority of "Improve capability to discharge at home" and the project management group will link closely to the UEC priority to ensure joint priorities are achieved.
Major milestones towards full implementation	**Main risks and mitigations**
• Establishment of a project group which looks at housing interventions which speeds up hospital discharge and prevents readmission. To include a range of partners from housing, health, social care and the voluntary sector by 31 December 2016 • Detailed proposals in place to establish locally appropriate hospital discharge schemes by 31 March 2017 • It is intended that delivery would commence from 1 April 2017, but specific timescales relating to full establishment of hospital discharge schemes are to be agreed through the Project Management Group and local consultation. It is to be noted that a successful bid has been put to the NHS Pioneer Fund to employ a Nottinghamshire Health and Housing Programme Manager for an initial one year period, hosted by the County's Public Health team. Once in post, the Programme Manager will be tasked with assisting in the delivery of this project.	• **Risk**: Cannot agree details of discharge scheme **Mitigation**: Strong commitment to establish hospital discharge schemes throughout Nottinghamshire. Political support will be gained across the footprint and strong governance arrangements will be in place • **Risk**: Funding request is insufficient to establish discharge schemes **Mitigation**: A strong Project Management Group will ensure that a budget is strictly considered and worked to in order to deliver. • **Risk**: Lack of need means returns lower than expected **Mitigation**: There is strong evidence of significant unmet need relating to hospital discharge. Strong partnerships with housing and health will be formed from the outset to maximise delivery • **Risk**: Lack of suitable properties to discharge patients to **Mitigation**: There are strong partnership arrangements in place with housing providers across the STP footprint who manage several thousand General Needs and Supported Housing dwellings across the footprint. Housing providers manage several thousand dwellings and will be integral to enable delivery of the project.

	• **Risk**: Lack of engagement with appropriate partners across the housing, health and voluntary sector to deliver the stated outcomes **Mitigation**: The full involvement of partners will be a key priority from the outset. There is already very strong support from a range of partners to ensure that the proposal is successful and stated outcomes are achieved. Strong local choice based lettings partnerships will support this process

PID for Supporting Workstream Priority 2 – Improving private sector housing conditions: expansion of Warm Homes on Prescription Programme

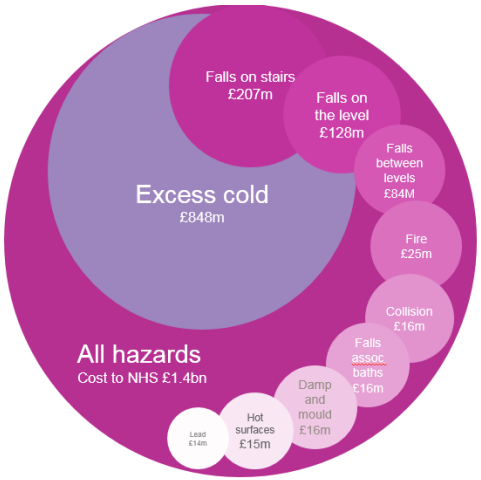
Priority lead: Dave Banks	
Outputs	**Expected benefits (outcomes)**
1. **Expand the Nottinghamshire 'Warm Homes on Prescription'** programme across the County and City, targeting residents with existing cold-sensitive, long term health conditions who cannot afford to keep warm at home. Key deliverables include: • Identifying and targeting high risk individuals in partnership with health, social care, voluntary organisations, district and City councils. • Provision of tailored home energy assessments, • Support with tariff switching, • Benefit maximisation advice, • Provision of financial assistance for replacement boilers, heating systems/controls, draught-proofing. • Financial assistance for enabling works and minor repairs to residents Each of the 7 Nottinghamshire district councils have launched the LAEP* Boiler on Prescription Pilot within their localities to date. This project proposal looks to expand the scheme in each district with extension into the City. *Local Authority Energy Partnership	▪ **Health & Wellbeing:** There are proven links between poor housing standards (energy efficiency, disrepair, trip hazards, damp and mould, excess cold) and health which in turn brings about increased demand upon health and social care services; worsened outcomes for the individual and increased costs to key partners (health, social care etc). Relatively low cost interventions to improve housing standards can lead to significant improvements in health and cost savings. Expansion and roll-out of the LAEP 'Warm Homes on Prescription' programme will deliver significant positive outcomes for those high risk patients who frequently depend on and use NHS services. Key outcomes will include: ▪ improvement in long term health conditions exacerbated by the cold and damp leading to fewer hospital admissions and reduced GP access. ▪ warmer homes due to more efficient heating and/or lower energy costs will result in improved levels of comfort and physical and mental wellbeing. ▪ reduced health inequalities. Ensuring patients are able to keep warm and well at home reduces the risk of falls, heart attack, stroke, respiratory problems and the exacerbation of other serious, cold-sensitive health conditions. Strategic benefits of expanding the programme include: • Positive contribution to meeting CCG targets to reduce emergency admissions, readmissions, visits to A&E and GP appointments. • Demonstrates that GP Practices are "Being responsive to people's needs" as recommended by the Care Quality Commission, Inspection Regulation Compliance Section, Regulation 9. • NICE Guideline on 'Excess Winter Deaths and Morbidity': identify people at risk of ill health from living in a cold home and provide tailored solutions via a health and housing referral service.

	• Level 0 of the Public Health England 'Cold Weather Plan' to provide all year round, preventative work to ensure that people who are vulnerable to the cold don't get caught out in winter. • 'Cutting the Cost of Keeping Warm' Fuel Poverty Strategy for England (2015), Department of Energy and Climate Change; includes case study of £2m LAEP affordable warmth project. ▪ **Care & Quality:** The LAEP Warm Homes programme targets 'hard to reach', low income residents with long term cold-sensitive health conditions in vulnerable groups including young children, families, and older people. **Targeting this high risk group** will have a **significant and immediate effect** on their chances of being admitted/re-admitted to hospital, needing access to GPs and care homes, resulting in a reduction in excess winter deaths thus contributing to the following Nottinghamshire and Nottingham City targets/metrics: • Reduction in excess winter deaths index (3 years, all ages) to 14.5 (city) and 12.9 (county); • Reduce fuel poverty to 12.2 (city) and 8 (county); • Reduction in non-elective admissions to 8,909 (city) and 9,695 (county) per 100,000 (in 2016-17) • 6% reduction in A&E attendances ▪ **Finance & Efficiency:** Finance and efficiency gross savings of £741k in 2020/21 Expansion of the LAEP programme will require new capital investment to facilitate provision of capital energy efficiency measures. An additional investment of circa £550,000 for County-wide expansion (with the exception of Bassetlaw) would almost double the existing capital resources of the existing pilot for actual measures including the City. Additional minimum investment of circa £65,000 would be required to facilitate the ongoing coordination of the programme and completion of home energy assessment visits should the pilot be expanded. Currently limited in-house district council/City resources are available to provide such assessments.

The pilot has attracted DECC investment to date however this funding will end imminently. The County Council are currently contributing £54,900 Public Health grant to support the existing LAEP pilot.

Savings to the NHS

Hazards to health associated with poor housing costs the NHS £1.4bn per year (Buildings Research Establishment, *The cost of poor housing to health, 2015*). Excess cold is the biggest single cost (£848m), followed by falls (£419m). By treating these hazards the Healthy Home programme reduces the risk of accidents and deterioration of long term health conditions made worse by the cold and the treatment costs to the NHS. According to the King's Fund, each avoided unplanned hospital admission saves the NHS around £3,283 per stay.



Savings to Adult Care

Investing in the Healthy Home programme can result **in savings to the Adult Care budget** by avoiding :

a) Residential care costs - keeping vulnerable residents warm and well at home enables them to continue to live independently for longer and reduces the risk of hospital admissions which in turn reduces the need for residential care for those who are unable to return home to an unsuitable property. This also helps to reduce delayed transfer of care costs due to patients being unable to return home to a warm property. Residential Care costs are around £600 per week*.

b) In-house social care – being cold at home increases the risk of deterioration of pre-existing cold-sensitive long term conditions, decreases mobility and

increases the risk of trips and falls, all scenarios likely to lead to an increase in social care needs. Costs around £200 per week*.

*Source: The state of health care and adult social care in England, Technical Annex 2: Adult social care funding data collection **2012/13**

Resources to deliver (and whether secured)

		YR1: 2017/18 £000s	YR2: 2018/19 £000s	YR3: 2019/20 £000s
COSTS	Revenue – Recurrent	65*	115	**115**
	Revenue – Non-Recurrent			
	*Estimated Cost – Procurement (Non-Rec)	0**	0	0
	*Estimated Cost – Mgmt Resource (Non-Rec)			
	Capital	550	550	550
	TOTAL COST	**615**	**655**	**655**
	Notes: *£50k of Public Health funding in place for year 2017-18 ** Procurement undertaken during year 2016-17			

Revenue funding:

Revenue non-recurrent Year 1 2017/18 - £65,000
Revenue recurrent Year 2 & 3 (2018/19 & 2019/20) - £115,000

Capital funding:

-£350k (6 District Councils, excludes Bassetlaw)

Enablers

- Workforce: N/A
- Estate: N/A
- IM&T: N/A
- Equipment: N/A
- Other: N/A

-£200k Nottingham City **Potential Funding:** In years 2017-2020 additional funding (circa £100,000 per year) to support the most vulnerable in society will be available via the Energy Company Obligation: Help to Heat policy. This policy is currently being consulted but it is anticipated that any measures installed will not be fully funded and will need blending with an alternative source of funding.	
Major milestones towards full implementation	**Main risks and mitigations**
The project is established and has been delivering during year 2016/17. It is envisaged the same model will continue throughout years 2017/18, 2018/19 and 2019/20. <u>Output 1</u>: REFERRAL ROUTES and REFERRAL VOLUME By Sept 2017 (6 months into 3 year programme) - Main referral routes established with key partners including Adult Care, hospital discharge teams and other key NHS and social care teams (by Sept 2017) - Referral routes are effective and providing 12 clients per month countywide by Sept 2017 (half capacity) and 25 per month by March 2019 (full capacity) <u>Output 2</u>: CASE LOAD - 100 residents assessed and heating measures commission by Sept 2017 - 250 residents assessed and measures commissioned in 2017/18 - 300 residents assessed and measures commissioned in 2018/19 - 300 residents assessed and measures commissioned in 2019/20 Warm Homes on Prescription project evaluation: •Customer feedback questionnaire – job by job basis •Case studies when required •Year 1 Project evaluation – Summer 2018 •Year 2 Project evaluation – Summer 2019	• **Risk:** Project unaccountable **Mitigation:** Project Board in place that consists of a representative of each authority and a member of public health Terms of Reference for the Board in place • **Risk:** Uncoordinated approach to delivery and budget management **Mitigation:** Programme Manager in post to coordinate and be accountable for delivery • **Risk:** Limited or non-qualifying referrals received **Mitigation:** Work closely with front line staff who visit people in the own home to be able to identify the patients at risk from living in a cold home and allow them to make direct referrals Seek further strategic support from CCG Refresh/bried key NHS and social care team • **Risk:** Officer capacity **Mitigation:** Revenue funding requested within this PID to allow the recruitment of additional staff, including shared energy advisors to complete home visits. • **Risk:** Poor quality installation **Mitigation:** All contractors procured hold necessary insurances and quality management systems. • **Risk:** Customer service **Mitigation:** Local authority sign-off on completion of works with certification as required.

•Final Evaluation – Summer 2019 Final completion date March 2020	Each authority has a robust customer complaints protocol. • **Risk:** Unable to determine the projects' effectiveness **Mitigation:** Seek assistance from University to complete independent evaluation Agree evaluation requirements with all partners, including health, at the outset.

PIDs for Enabler – Future proof Workforce and organisational development

<table>
<tr><th colspan="2">Executive sponsor: Lyn Bacon</th></tr>
<tr><th>1. Priority projects within HIA and expected completion dates</th><th>2. Main impacts on closing 3 gaps</th></tr>
<tr><td>• Develop a population/place based approach to workforce re-design using systems dynamics modelling tools and techniques to enable testing of new roles, new team structures, new ways of working
• Developing collaborative HR solutions to address workforce capacity and capability issues and ensure workforce sustainability and resilience
• Organisational Development to support system effectiveness
• Embedding a systematic approach to prevention and lifestyle behaviour change by rolling out prevention and early intervention skills across the workforce
• Building capacity and capability in primary care through implementation of the GP Forward View and Pharmacy workforce action plan</td><td>Health & Wellbeing:
▪ Improve health and wellbeing of the population through enhanced self-care and lifestyle behaviour change
▪ Improve health and wellbeing of the workforce
Finance & Efficiency:
▪ Contribution to finance and efficiency through collective approach to efficiency and productivity: reduced reliance on agency staff, streamlining HR processes and shared back office functions
▪ Contribution to finance and efficiency through optimisation of skill mix across the system
▪ Contribution to finance and efficiency through flexible deployment of skills across the system
All:
▪ This workstream will support other STP priority workstreams to deliver their objectives & benefits</td></tr>
<tr><th>3. Key enablers</th><th>4. Key decisions that still need to be made (and deadlines for resolution)</th></tr>
<tr><td>▪ Workforce: Local Workforce Action Board & supporting infrastructure provides governance structure accountable to STP Programme Board. HEE-EM support & expertise, D2N2 LEP H&SC Skills Action Plan;
▪ Training Hubs (Nottm City, Rushcliffe, Urgent Care, PCDC); development of community practice-based education centre of excellence;
▪ Estates:
▪ IM&T: Change management plan in IMT will equip the workforce with skills to use new technology
▪ Equipment:</td><td>▪ Refined costing model for workforce elements and integration of workforce into system financial and activity modelling
▪ Level of collaboration between CCGs on delivering GPFV – potential to pool resource</td></tr>
<tr><th>Main programme risks</th><th>Mitigations</th></tr>
<tr><td>Failure to collaborate due to organisational regulatory and financial pressures</td><td>Strong partnership and relationship building via LWAB and OD plan. Demonstrating added value of collaborative working</td></tr>
</table>

Good practice difficult to replicate across the geography due to variation in demographics and available resource	Refine modelling approach to accommodate different circumstances and provide range of bespoke scenarios
Affordability and availability of optimum workforce particularly in less popular locations and areas	Maximising technology to enable access across wider geography. Innovative job plans and career pathways through shared approaches to recruitment
Capacity and capability to focus on developing and leading workforce change	Release capacity through investment in network of workforce champions under the umbrella of LWAB (clinical and non clinical)

Activity *(X for years with active implementation work planned)*	**Year 1**	**Year 2**	**Year 3**	**Year 4/5**
1. Establish robust workforce baseline and financial analysis for all workforce groups required to deliver STP ambitions (review annually). Develop robust workforce costing model	X	X	X	X
2. Complete thematic review of all workstreams and services to identify cross cutting workforce implications, challenges and good practice as evidence base for forward planning & investment	X	X		
3. Cross system engagement on prioritisation of high impact interventions and developments to refine five year strategy and plans	X	X		
4. Identify and agree pooling of financial and other resources for delivery via LWAB mechanisms	X	X	X	
5. Health check on alignment of system and organisational workforce plans and opportunities for efficiencies and productivity (focus on LTP NUH & SFH)	X	X		
6. OD Diagnostic and agreement on five year vision and implementation of OD interventions	X	X	X	X
7. Clinical engagement in development of scenario based workforce skill mix options appraisals using systems dynamic modelling. Urgent and Proactive Care initially then other areas to be prioritised	X	X	X	
8. Develop collaborative action plan to implement Carter Review recommendations that add value to be delivered collectively	X	X		
9. Develop and deliver medical workforce development strategy across primary and secondary care including introduction of new support roles	X	X		

10. Engagement with education providers and general practice training hubs to develop innovative and responsive programmes	X	X	X	X

PID for Enabler Priority 1 – Embedding a systematic approach to prevention & promoting independence across the whole workforce

<table>
<tr><th colspan="2">Priority lead: Lindsay Price</th></tr>
<tr><th>Outputs</th><th>Expected benefits (outcomes)</th></tr>
<tr><td>1. Workforce development and investment plan to provide the workforce with the skills to deliver brief interventions, motivational interviewing, IAG and other techniques to support people to change lifestyle behaviours and remain independent for longer (physical & mental wellbeing/resilience)
2. Programme to give staff skills to support people to self-care and mind-set change for staff to reduce reliance of people on services
3. Self-care skills for citizens and skills development plan for carers
4. Investment plan to build resilience in the voluntary sector to sustain prevention, self-care and independence in the community</td><td>Health & Wellbeing:
• Increase healthy life expectancy by three years
• Improve mental wellbeing of the population
• Reducing NHS staff sickness and absence

Care & Quality:
• Consistent and systematic approach and prioritisation across the whole system

Finance & Efficiency:
• Reduction in secondary care activity
▪ Reducing NHS staff sickness and absence</td></tr>
<tr><th>Resources to deliver (and whether secured)</th><th>Enablers</th></tr>
<tr><td>Estimated costs and ROI are outlined in the Prevention Workstream PID
• Revenue funding:
75K identified via Local Workforce Action Board (LWAB)

• Capital funding: N/A</td><td>• Workforce: Local Authority PH teams, PHE, MECC framework, LWAB and sub groups – education investment plan; building on and sustaining delivery of current programmes on physical and mental wellbeing
• Education: providers/commissioners to build into all health and social care programmes, organisations to build into induction and mandatory training delivery, innovative models of education delivery including e-learning
• Estate: N/A
• IM&T: Appropriate e-learning platform for MECC delivery
• Equipment: N/A
• Other: Communication strategy to raise awareness of MECC across the wider workforce</td></tr>
<tr><th>Major milestones towards full implementation</th><th>Main risks and mitigations</th></tr>
<tr><td>Output 1: By Early 2017, Agree MECC framework for Nottinghamshire based on evidence base (PHE)

Output 2: By Late 2016, Demonstrate partner commitment through identification of Board level champion</td><td>• Risk: There is a risk that coverage will be patchy with hard to reach groups not benefitting from the MECC approach
Mitigation: By having a menu of options, and maximising the voluntary sector contribution it will make the training more accessible

• Risk: Commissioners do not include MECC in service specifications</td></tr>
</table>

Output 3: By Spring 2017, Develop model of who will need skills and to what level (what qualifications needed) – prioritise over the five year timescale Output 4: By Spring 2017 Carry out baseline assessment of who has received relevant training in the last three years – gap analysis Output 5: By Spring 2017 Develop menu of options, providers and implementation plan to deliver skills to relevant groups (e.g. e-learning, train the trainer, action learning sets, PLT) Output 6: By Summer 2017, Develop innovative delivery models working with education providers Output 7: By Late 2017, Embed & evaluate through commissioning models (CQUIN, contracts, induction programmes, appraisal) and evidence collection	Mitigation: We will educate commissioners on the ROI of the MECC approach • Risk: Baseline intelligence data not available Mitigation: Agree MDS with all providers including the voluntary sector • Risk: Inability to measure impact as ROI is long term Mitigation: Seek qualitative case studies to demonstrate benefit. Develop proxy indicators for example, health checks, staff wellbeing, sickness rates, staff turnover (Staff survey)

PID for Enabler Priority 2 – Developing a population/place based approach to workforce re-design using system dynamics modelling

Priority lead: Jackie Hewlett-Davies	
Outputs	**Expected benefits (outcomes)**
1. Bespoke, integrated tool to enable scenario based workforce and skill mix modelling to vision and test future workforce requirements & costs 2. Clinical engagement in designing and testing future workforce options 3. Capacity and capability across the system to use modelling tools and techniques 4. Good quality workforce intelligence across health and social care 5. Workforce development/investment strategy and plans to transition from current to future shape including new roles, new ways of working, new integrated teams and voluntary sector contribution	Health & Wellbeing: ▪ Optimum skill mix = improved health and wellbeing of the workforce Care & Quality: ▪ Optimum skill mix = improved care, reduced variation in clinical practice, improved patient experience Finance & Efficiency: ▪ Optimum skill mix = effective use of resources
Resources to deliver (and whether secured)	**Enablers**
• Revenue funding: £100K secured via Local Workforce Action Board (LWAB) • Capital funding: N/A	• Workforce: Engagement of clinical workforce in designing the model • LWAB & sub groups, HEE-EM workforce data & analysis • Estate: N/A • IM&T: Modelling software & expertise from Whole Systems Partnership • Equipment: • Other: N/A
Major milestones towards full implementation	**Main risks and mitigations**

Output 1: By Late 2016, Engagement workshops to agree population cohorts and demographic, activity, transformation & financial assumptions (priorities identified as Urgent Care and Proactive Care systems) Output 2: By late 2016, Agree care functions, intensity and frequency of care delivery in future system & build the model Output 3: BY Late 2016, Vision future skill mix to deliver care functions & establish baseline of current workforce including costings Output 4: By 2017/18, Develop strategies to achieve modelled future skill mix – develop investment plan to deliver Output 5: By Late 2016, Prioritise other pathways/systems to continue to build the model Output 6: By Autumn 2017, Review, evaluate and adapt model against delivery	• **Risk**: Optimum skill mix not affordable within financial constraints **Mitigation**: Model alternative scenarios • **Risk**: Investment in workforce development & new roles is not affordable in the timescale required **Mitigation**: Maximise opportunities to access external funding sources • **Risk**: Geographical differences compromise ability to deliver the agreed workforce development strategies **Mitigation**: Explore opportunities to incentivise people to work in less popular areas through redesign of job plans and flexibility to work across the patch • **Risk**: Lack of clinical engagement in the redesign **Mitigation**: Communication and engagement strategy

PID for Enabler Priority 3 – Building capacity, capability and resilience in the primary care workforce (general practice & pharmacy)

Priority lead: Charlotte Lawson	
Outputs	**Expected benefits (outcomes)**
1. Develop recruitment & retention strategies for example, portfolio working, incentives, rotational opportunities, collaborative campaigns, sharing specialist staff 2. Establish a responsive and sustainable pharmacy workforce to fulfil the profession's potential contribution through new ways of working & enhanced skills 3. Review impact of wellbeing initiatives targeting general practice and roll out in a sustainable model (supported appraisals, coaching and mentorship) 4. Primary care workforce development strategy & plan (new ways of working, new types of worker for example Physician Associates , Personal Assistants, Nurse Associates, Care Navigator, Pharmacists) 5. Local implementation plan to deliver relevant high impact actions from realising capacity in general practice report 6. Evaluate the various models of federation across the geography identifying the variation of impact on the workforce to establish good practice examples 7. Develop high quality primary care baseline workforce data, and create bespoke data collection to evidence investment decisions 8. Support structured deployment of the initiatives described in the General Practice Forward View across the STP footprint 9. Undertake workforce modelling to understand capacity utilisation and options for alternative skill mix and alignment of roles in Primary Care & opportunities for shared roles with secondary care	Health & Wellbeing: ▪ Improved HWB & resilience of the primary care workforce Care & Quality: ▪ Optimum skill mix in primary care, reduced variation in clinical practice, improved patient experience Finance & Efficiency: ▪ Optimum skill mix = effective use of resources and potential cost savings through reduced reliance on agency/locum staff
Resources to deliver (and whether secured)	**Enablers**
• Revenue funding: Potential to pool available CCG funding (vulnerable practice, GPFV) Training hubs, Rushcliffe and Nottingham City Urgent care training hub (£100k) • Capital funding: N/A	• Workforce: HEE general practice workforce data tool, bespoke general practice workforce modelling, Primary Care Workforce Group (PCSET) for delivery City & Rushcliffe Training Hubs, Urgent Care Training Hub • Estate: N/A • IM&T: N/A • Equipment: N/A • Other: N/A

Major milestones towards full implementation	Main risks and mitigations
Output 1: By Spring 2017, Further develop clinically-led Primary Care Workforce Group (PCSET) bringing CCGs and primary care providers together to support delivery of GP Forward View and Pharmacy Forward View Output 2: By Late 2016, Model optimum skill mix of pharmacy teams in all settings and invest in skills development to deliver and sustain Output 3: By Late 2016, Further develop Pharmacy Workforce task & finish group to shape vision of future workforce across primary and secondary care and develop action plan to deliver Output 4: By Spring 2017, Establish robust baseline data on general practice and pharmacy workforce building on national data set Output 5: By Spring 2017, Pilot a range of bespoke workforce modelling tools to vision future shape of the workforce and develop skill mix options, new role potential & new ways of working across different geographic areas according to local circumstances Output 6: BY Spring 2017, Develop delivery options based on GPFV high impact changes including potential for new support roles, increasing capacity in advanced practice roles, opportunities for sharing resources between practices & with secondary care and using technology Output 7: By Late 2017, Deliver pharmacy workforce development plan to enhance clinical skills of community pharmacists to work in general practice and hospital (building on current national and local pilots)	• Risk: GP workforce data tool via HEE may not be available in required timescale Mitigation: Develop local data collection • Risk: Optimum future skill mix may not be affordable Mitigation: Modelling of alternative scenarios • Risk: Investment required to deliver workforce development strategy may not be affordable in the required timescale Mitigation: Look for innovative education models working with the training hubs Develop the network of training hubs, to get full geographical cover

PID for Enabler Priority 4 – Supporting system effectiveness through organisational development

<table>
<tr><th colspan="2">Priority lead: Julian Eve</th></tr>
<tr><th>Outputs</th><th>Expected benefits (outcomes)</th></tr>
<tr><td>1. Facilitating strategic alignment between agencies, organisations and disciplines
2. Supporting decision making based on shared principles
3. Reviewing system wide skill and capacity (leading and delivering change)
4. Facilitating reviews of pathways of care: (designed by stakeholders)
5. Facilitating implementation of new roles and embedding new ways of working across boundaries</td><td>Care & Quality
▪ Bringing the culture of health care (including primary care) and social care together
▪ Facilitating multi agency conversations as ‘the way’ of getting things done
Finance & Efficiency
▪ Facilitating opportunities for cross organisation groups to come together to discuss and recommend changes
▪ Ensuring that leadership development is leadership systems training and learning</td></tr>
<tr><th>Resources to deliver (and whether secured)</th><th>Enablers</th></tr>
<tr><td>• Internal OD Capability and Capacity Review
• Mid – Nottinghamshire Vanguard OD resource allocation 2016/17 - £100K (secured)
• Health Education England allocation for 2016/17 - £75K (secured)
• East Midlands Leadership Academy (EMLA) notional allocation of support for OD and Leadership support 2016/17 - £20K (secured)
• Development work, facilitation and resources required for 2017/18 - £250K (not secured)</td><td>• Support of the Local Workforce Action Board and Health Education England
• NHS Improvement and the work on culture and leadership
• Effective working relationships between members of the Nottinghamshire OD Collaborative
• Senior Leaders across the Nottinghamshire STP footprint modelling collaborative behaviours
• National support from Do OD and the National Leadership Academy
• Successful system wide bid to deliver Mary Seacole program</td></tr>
<tr><th>Major milestones towards full implementation</th><th>Main risks and mitigations</th></tr>
<tr><td>▪ Completion of the first stage OD delivery plan for Mid Nottinghamshire by March 2017
▪ Full Organisational Development (OD) plan for Nottinghamshire March 2017
▪ Agreement and adoption of an appropriate diagnostic tool for the Nottinghamshire STP footprint (recommendation to pursue the NHS Improvement Culture and Leadership tool) to undertake:
▪ Phase 1- Diagnosis of Nottinghamshire STP cultural Issues (end March 2017)
▪ Phase 2: Design and development of Nottinghamshire's collective leadership strategy to address the issues (end August 2017)</td><td>• Risk: OD Principles not adhered to / diagnostic not undertaken
Mitigation: Creation of a an OD project board and delivery team from the present OD Collaborative

• Risk: Whilst developing and capitalising on internal OD capacity; and capability; acknowledgement of limitations on individual capacity to deliver
Mitigation: The use of short-term priming money as investment to backfill consultancy support

• Risk : Lack of full buy-in to the agenda from all senior leaders including reinforcement of organisational sovereignty</td></tr>
</table>

▪ Phase 3: Deliver - implement any necessary changes (Sept 2017 to September 2020)	Mitigation: Advice and assistance from national OD and leadership connections

PID for Enabler Priority 5 – Developing collaborative HR solutions

<table>
<tr><th colspan="2">Priority lead: Clare Teeney</th></tr>
<tr><th>Outputs</th><th>Expected benefits (outcomes)</th></tr>
<tr><td>1. Facilitating strategic HR alignment between STP organisations to deliver efficiencies and productivity improvements
2. Supporting shared decision making around collective workforce priorities
3. Reviewing and agreeing approaches towards system wide workforce capacity, capability and resilience (workforce planning)
4. Developing policies, protocols and procedures to better enable the flexible deployment of our workforce including rotations, talent management
5. Developing collaborative approaches towards recruitment to bring capacity into Nottinghamshire and benefit from efficiencies
6. Work collectively to reduce the reliance on agency staff through demand & supply side initiatives
7. Support the implementation of the Carter review recommendations including shared back office functions, e-rostering, streamlining processes, reducing bureaucracy</td><td>Health & Wellbeing:
▪ Improving staff experience and wellbeing

Care & Quality:
▪ Improving career opportunities, recruitment & retention

Finance & Efficiency:
▪ Reducing waste and inefficiency and reduce costs
▪ Improving the flexibility of our workforce to maximise access to right skills
▪ Streamlining the employment opportunities and experience opportunities and experience</td></tr>
<tr><th>Resources to deliver (and whether secured)</th><th>Enablers</th></tr>
<tr><td>• Agency spend diagnostic exercise (resources to support secured)
• £75k to support the HR collaborative until 31 March 2017 (secured)</td><td>• Support of the Local Workforce Action Board and Health Education England
• NHS Improvement and the work on culture and leadership
• Effective working relationships between members of the HR collaborative
• Support through other agencies for example NHS Improvement, the Leadership Academy, CIPD
• The STP Executive Group</td></tr>
<tr><th>Major milestones towards full implementation</th><th>Main risks and mitigations</th></tr>
<tr><td>Output 1: By Late 2016, Agency activity and spend diagnostic undertaken

Output 2: By Spring 2017, Review of the workforce challenges and identify priorities

Output 3: By Spring 2017, Read across to OD collaborative work programme

Output 4: By Late 2016, Review and evaluation of nurse rotation pilot

Output 5: BY Spring 2017, Review of Carter and actions for local implementation</td><td>• Risk: Resources to support initiatives
Mitigation: The use of short-term funding to support up to 2017

• Risk: Duplication and lack of alignment across workstreams
Mitigation: Endorsement of priorities and work via WTDG and LWAB</td></tr>
</table>