Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Nottinghamshire County Council**
Clinical Commissioning Groups	**Bassetlaw CCG**
	Mansfield and Ashfield CCG
	Newark and Sherwood CCG
	Nottingham North and East CCG
	Nottingham West CCG
	Rushcliffe CCG
Boundary Differences	**The map in the attached document 01 shows that the geographical boundary of Nottinghamshire County Council, and its Health and Wellbeing Board area, is largely aligned with the area covered by the six Nottinghamshire CCGs. We do not anticipate the small difference to impact significantly on the delivery of our Better Care Fund (BCF) plan.**
Date agreed at Health and Wellbeing Board:	**27/08/2014**
Date submitted:	**29/08/2014**

Minimum required value of BCF pooled budget: 2014/15	**£16,100,000**
2015/16	**£54,905,000**
Total agreed value of pooled budget: 2014/15	**£33,575,000**
2015/16	**£59,303,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Bassetlaw CCG
By	Phil Mettam
Position	Chief Officer
Date	26/08/2014

Signed on behalf of the Clinical Commissioning Group	Mansfield and Ashfield CCG
By	Amanda Sullivan
Position	Chief Officer
Date	26/08/2014

Signed on behalf of the Clinical Commissioning Group	Newark and Sherwood CCG
By	Amanda Sullivan
Position	Chief Officer
Date	26/08/2014

Signed on behalf of the Clinical Commissioning Group	Nottingham North and East CCG
By	Sam Walters
Position	Chief Operating Officer
Date	26/08/2014

Signed on behalf of the Clinical Commissioning Group	Nottingham West CCG
By	Oliver Newbould
Position	Chief Operating Officer
Date	26/08/2014

Signed on behalf of the Clinical Commissioning Group	Rushcliffe CCG
By	Vicky Bailey
Position	Chief Officer
Date	26/08/2014

Signed on behalf of the Council	Nottinghamshire County Council
By	Mick Burrows
Position	Chief Executive Officer
Date	26/08/2014

Signed on behalf of the Health and Wellbeing Board	Nottinghamshire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Joyce Bosnjak
Date	27/08/2014

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

Document or information title	Synopsis and links
01 Map of Nottinghamshire Boundaries	This map was produced by the Nottinghamshire County Council Public Health Intelligence Team to illustrate the named boundaries across the county, overlaying CCGs and District Councils.
02 Our strategy for Health and Wellbeing in Nottinghamshire 2014-2017	This Strategy sets out the priorities for the Health and Wellbeing Board for Nottinghamshire to improve the health and wellbeing of its residents.
03 Nottinghamshire Mental Health Strategy 2014-2017 (draft)	'No Health without Mental Health', developed by the Nottinghamshire Mental Health/Learning Disability/Autism and the CAMHS Integrated Commissioning Groups in partnership with the Nottinghamshire Health and Wellbeing Board.
04 Planned BCF Schemes and Themes	An outline of the specific schemes being implemented under each of the six main BCF themes in Nottinghamshire, along with timescales for delivery.
05 BCF Scheme Implementation Plans	Detailed action plans mapping out the key milestones associated with the delivery of each BCF scheme, alongside key interdependencies and financial implications.
06 Nottinghamshire BCF Reporting Template (draft)	Our locally developed and agreed format for internal BCF monitoring across the county by the BCF Finance and Performance Sub-group to report to the BCF Working Group.
07 Bassetlaw - A Community of Care and Support - Strategic Plan 2014-2019	Bassetlaw CCG Strategic Plan 2014-2019.
08 Mid-Nottinghamshire - Five Year Health and Social Care Strategy 2014-2019	Mansfield and Ashfield CCG and Newark and Sherwood CCG Strategic Plan 2014/15-2018/19.
09 South Nottinghamshire - 2014-2019 Strategy	Nottingham North and East CCG, Nottingham West CCG, and Rushcliffe CCG Strategic Plan 2014/15-2018/19.
10 Integrated Commissioning Carers' Strategy and Action Plan 2014-2015	County-wide Nottinghamshire Carers' Strategy, across all six CCGs and Nottinghamshire County Council.
11 7 Day Services Mapping and Aspirations	Details of Nottinghamshire's 7 day service current status and future ambitions.
12 Nottinghamshire Multi-agency Consent Form (draft)	Personal health record(s) sharing consent form, under development by the Nottinghamshire Records and Information Group.

13 Nottinghamshire Information Sharing Protocol (draft)	An overarching framework for partner organisations in Nottinghamshire to manage and share information on a lawful and 'need to know' basis with the purpose of enabling them to meet both their statutory obligations and the needs and expectations of the people they serve.
14 Derbyshire and Nottinghamshire Area Team Strategy for Primary Care Transformation	The primary care strategy for Derbyshire and Nottinghamshire for the period 2014-2019.

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS, and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20.

The Health and Wellbeing Board launched the public consultation for its strategy for Health and Wellbeing in Nottinghamshire (2014 – 2017) in June last year. The strategy took account of the local health and wellbeing needs identified through the JSNA – available via http://www.nottinghamshireinsight.org.uk/ – and proposed common ambitions and a range of priority actions to address these needs. The consultation invited views from members of the public, professionals, service providers, and members of the community and voluntary sector.

This was supported by a series of seven consultation events in each of the districts within the county. Feedback was also submitted through an online survey accessed via the Nottinghamshire County Council website, a freepost address, and an email address. The consultation events included presentations from members of the Health and Wellbeing Board, Public Health, the local district council, the local CCG, and Healthwatch. These were then followed by discussions focusing on the principles and priorities most important to people, and how the community and voluntary sector could be engaged to support delivery. The events also highlighted the close alignment between CCG and health and wellbeing priorities.

The consultation feedback confirmed strong support for a wide range of priority areas, illustrating the complex and diverse nature of Nottinghamshire. It also proved where local people felt the Board should direct its efforts, and how it should prioritise delivery. Four key ambitions were identified that reflect the vision of the Health and Wellbeing Board:

- For everyone to have a good start in life
- For people to live well, making healthier choices and living healthier lives
- That people cope well and that they are supported to improve their own health and wellbeing and maintain independence
- To get everyone to work together

This fourth ambition underpins all of the Board's work to improve efficiency, maximise value for money, and provide joined up services and care pathways. Our overall vision is that, through working together, we will enable people living in Nottinghamshire to live longer, be healthier, and have a better quality of life, especially in the communities with the poorest health. This is a shared vision, and steps have already been taken across Nottinghamshire to transition towards this person-centred model of health and social care. What matters most to local people, commissioners, and providers are the improvements we make together for the benefit of patients and service users by optimising choice, where possible.

Specific examples to improve integration of services were highlighted through the strategy consultation. These included services working together to improve access to primary care provision, promoting single assessment systems, and improving patient pathways so that they are easy to navigate, giving the best access to the range of services available.

The final strategy was agreed by the Health and Wellbeing Board in March 2014, and the

supporting delivery plan will be agreed by the Health and Wellbeing Board in September 2014. The strategy is attached in document 02. Ongoing engagement with partners and stakeholders continues to be undertaken through regular stakeholder events focusing on specific areas of the strategy, including mental and emotional health and wellbeing (February 2014) or the role of individual sectors, such as the voluntary and community sector (June 2014).

All of this work has taken into account the broader demographic and socioeconomic changes in Nottinghamshire. For instance, the JSNA for Nottinghamshire shows that the age structure of Nottinghamshire is slightly older than the national average, with 19% of the population aged 65 years and over in 2011 compared with 17% in England. The population is predicted to continue to age over time, with the number of people in Nottinghamshire aged over 65 years expected to rise from 154,100 in 2013 to 180,073 in 2021, an increase of 17%. There are even larger predicted increases in the number of people aged over 85 years (from 18,900 to 24,500, a 30% rise).

Health and wellbeing needs in older people are known to rise with age. Older people are more likely to experience disability and limiting long-term illnesses. Falls are also a common and serious problem for older people. Although the level of falls is average compared to national figures, the rate of hospital admissions caused by falls is increasing year-on-year across most districts within County, while Ashfield, Mansfield, and Rushcliffe rates are steady. More older people in Nottinghamshire are anticipated to live alone (increasing by 14% between 2014 and 2020). Older people living alone and without access to transport (notably Newark and Sherwood, and Bassetlaw) are particularly vulnerable. The local residents' survey confirms that the level of support within communities varies widely across Nottinghamshire, with the highest levels being in Ashfield and Broxtowe.

Accordingly, our local health and social care planning is tailored to the aging and increasingly isolated population by investing in better integration of services and providing more services closer to home to meet their health and wellbeing needs.

The increasing incidence of long-term illness is also a local issue for Nottinghamshire. 16% of Nottinghamshire's registered population aged 18 years and over is estimated to suffer from two or more chronic conditions at any one time. With more people developing long-term illnesses that affect their daily lives, and many people having multiple health and wellbeing problems, there is a clear need to join up assessments and care and ensure that treatment pathways are designed around the person, not the individual services.

Disability also affects a large proportion of the local population. Approximately one in ten adults in Nottinghamshire aged 18-64 years live with moderate or severe physical disabilities and approximately one in five people aged 65 years and over in Nottinghamshire are unable to manage their daily activities. For older people, these numbers are expected to increase from 28,000 in 2014 to 33,000 by 2020. With the rise in level of disability, improving support to maintain independence is becoming increasingly important.

The Nottinghamshire BCF plan and our wider work are well-aligned with all of these emerging population needs, allowing us to focus on specific schemes improving integration, supporting health and social care services through more streamlined working, and delivering person-centred care. The main feature of the schemes is to use new

approaches to build capacity in the system and respond to the short- to medium-term health and wellbeing needs of local people. The longer-term preventative aspects that will impact on future demand will continue to be the focus of the overarching Health and Wellbeing Strategy. Examples of these initiatives include delivering public health messages and services to school age children, lifestyle advice to adults before health problems arise, and promotion of healthy weight opportunities within communities, incorporating healthy diet and physical activity. The strategy will prioritise primary preventative actions to improve the general health and wellbeing of Nottinghamshire overall and reduce demand over time.

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

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

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

- People will only be in hospital if that is the best place – not because there is nowhere else to go
- Services in the community will allow patients to be rapidly discharged from hospital
- New technologies will help people to self-care
- Specialist workforce teams will be concentrated in one place
- The workforce will be trained to offer more flexible care
- Services from the NHS, social care, voluntary sector, care homes, and home care will deliver a continuum of care, working to a single set of processes
- People will understand and access the right services in the right place at the right time
- People will be living longer, more independent and better quality lives, remaining

at home for as long as possible

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

b) What difference will this make to patient and service user outcomes?

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

As part of this, we are committed to improving outcomes for service users and patients, and improving user experience of health and social care from the local authorities and the CCGs working together to shape sustainable health, social care, and housing requirements to deliver the national vision of fully integrated health and social care by 2018. Our joint objectives are:

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

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

1. **Satisfied patients**
   - Qualitative and quantitative analysis of patient experience

2. **Motivated and positive staff**
   - Staff questionnaires, training, and development
   - Proportion of whole time equivalent working in services

3. **Outcomes**
   - Mortality and morbidity rates
   - Case management of long-term conditions
   - Proportion of people entering long-term care

- Patients managed in community bed services
- End of Life plans in place/Preferred place of death
- Suitable housing options

4. **Financial Management**
   - A reduction in acute bed capacity through the increase in community bed/at home places
   - Information and advice to self-funders
   - Unplanned admissions
   - Delayed transfers of care
   - Re-admission rates

In addition, people across Nottinghamshire have told us they want to be supported to stay well and be independent for as long as possible. They want their care close to home, wherever possible, and to be treated with dignity and respect. We will help people to look after themselves and encourage the responsible use of services. We will inform them of the health and social care services available from statutory and voluntary sector organisations, linking in with the respective Health and Wellbeing Strategies. We will have an honest dialogue with our communities – so they fully appreciate the challenge facing health and social care and so they can help re-shape the system for the benefit of all.

In light of these ambitions, we aim to have made significant progress towards meeting the following aspirations by April 2016:

- People who are frail, who have escalating needs or who are at risk of deterioration will be identified proactively and assigned a case manager/key worker, who will develop a care plan with them and make sure that it is delivered. The same care plans will be used by their GP, and clinical teams based in the community and in hospital. Care will be delivered locally wherever possible by an integrated local team who works with their GP
- People will have a local point of contact to find out information and access local services in health, social care, and the voluntary sector (care co-ordination)
- People who need care urgently will be clearly signposted to where to access this care. More urgent care will be available closer to home, delivered by primary care, crisis response teams, and a new urgent care centre
- Patients admitted to hospital will be transferred home or to an appropriate community setting in a timely manner, where the focus will be on maximising their independence. Assessment of their ongoing needs will take place at home rather than in hospital. This will increase their chances of remaining in their home rather than going into long-term care
- People in care homes will receive the same level of proactive support and access to urgent care as those living in their own homes
- People with long term conditions will be empowered to monitor their own condition by texting ‘Flo’
- Carers will be supported through short breaks and respite services
- Local consultation with the public and registered patient list will shape and inform how access to primary care services will be delivered locally

- The development of 7 day services across primary, community and acute sectors will improve the ability for patients and service users to access services in a more timely manner

The most fundamental changes that patients will experience will result from the adoption of models of integration that make a person's journey through the system of care as simple as possible and encourage shared decision making. The patient's perspective will become the key organising principle of service delivery, and they will receive the care that they need, when they need it, driven by their requirements not the capacity/capability of the suppliers.

There will be an increasing focus on empowering people to be partners in their own care. For example, a self-care hub will be developed in Mid-Nottinghamshire to educate patients about their conditions and give them the knowledge, power, and confidence to play a key role in planning their own care.

Social marketing approaches will also be used, alongside existing communications and engagement channels, to help to educate patients about how to choose the most appropriate health service for their need. This should help them understand how to make informed choices about accessing a range of urgent care services, and remove barriers.

The ultimate vision in five years would be for care to be so well integrated that the patient has no visibility of the organisations and different parts of the system delivering it. Our services will all look radically different to patients and service users as outcomes will place them at the centre of seamlessly delivered well co-ordinated health and social care services. These outcomes will include a strong drive towards improving alternative forms of support to self-care and an integrated direct payment and health care budget to allow people to experience outcomes that are truly person-centred and flexible, improving their aspirations to maintain control, choice, and independence. This can only be achieved through a resolute focus on patients, services, and resources. A strengthened focus on prevention will help make these changes sustainable. Finally, by making changes to lifestyle and behaviours earlier in a person's life, we can help reduce the burden of ill-health in the future.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The BCF schemes prioritise short- to medium-term actions to build capacity in the health and social care system, and respond to patient and carer feedback to improve the quality and effectiveness of services. By focusing on supporting patients' post-acute illness (reablement, maintenance, and independence), mental health services, care home and specialist accommodation for older people, care for the elderly in the community, and the urgent care system, we aim to re-design intermediate care offered in the patient's own home to be more flexible, and consequently reduce the number of acute and mental health patient beds.

Integration was a strong theme within the Health and Wellbeing Board strategy consultation, and underpins the BCF national conditions. Conclusions included the need to 'do things once', improving communication between agencies, avoiding multiple assessments, and making better use of the voluntary and community sector. The principle of integration is implemented through our BCF schemes, with particular reference to intermediate care teams (Mid-Nottinghamshire), personalised care for vulnerable and older people, and reablement services (North and South Nottinghamshire). In addition, the Mid-Nottinghamshire scheme around communications (social marketing) provides access to information on services across agencies as well as supporting independence.

The need to support people to retain independence was similarly highlighted to help empower individuals and also manage the demand on services. There is support for the work under the Disabled Facilities Grants that help keep people in their own homes and the need to 'support the carers and person at home properly'. The Telehealth (North and Mid-Nottinghamshire) and self-care schemes (Mid-Nottinghamshire) offer direct support to patients and carers requiring advice and support. Support for carers (South Nottinghamshire) also provides support with respite care and short breaks. While the schemes involving reablement, intermediate care teams, community models, supportive discharge, and home care all focus on building capacity in the health and social care system, the management of the patient and support for the carer also helps build independence. Furthermore, these schemes address the need to improve access to a health professional.

Another strong theme from the Health and Wellbeing Strategy was around improving access to primary care. In addition to the traditional approach to increased capacity (7 day working schemes), the various BCF intermediate care/community schemes also investigate innovative approaches to using health and social care services differently to better meet the needs of local people. The mental health liaison service (North Nottinghamshire), and memory assessment clinics and mental health intermediate care (all areas) address the important need to provide services for mental health patients. This was a prominent priority within the strategy consultation, where the Health and Wellbeing Board was asked to 'ensure mental health has parity with physical health'. In addition to dedicated mental health services, the draft Mental Health Strategy challenges all mainstream services to take action to identify issues early and deliver services that address the needs of vulnerable groups. This is attached in document 03.

The remaining priorities all received support through the consultation, indicating that no one health condition or behaviour should be prioritised. Our BCF schemes are designed

around the person, not the condition, and aim to address the multiple needs of individuals through better joined up work, communication, and integration. In this way, the BCF is a key component to delivering not just the health commissioners' integration plans, but also the overall Health and Wellbeing Strategy. We have accordingly structured all BCF schemes into six overarching themes:

7 Day Service Provision and Access

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

The success factors are:

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

Supporting Integration

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

The success factors are:

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

independent sector
- Clear leadership and vision
- Increased care closer to home

Transforming Patient Satisfaction

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

The success factors are:

- Decrease in avoidable admissions from care homes to hospital
- Decrease in safeguarding referrals from care homes
- Reduction in emergency call-outs
- Reduction in the use of carer support services and emergency respite care
- Increase in use of assistive technology units
- Increase in patients reporting satisfaction of care

Protecting Social Care Services

By aligning the commissioning intentions of each organisation highlighted in the JSNA, and closely aligning the key outcomes deliverable between health and social care, we will ensure that the range of schemes provided enable social care to deliver the key services requiring protection, and develop the integration agenda that will transform the way in which services are delivered. We will collectively be able to plan and re-shape services to deliver the required efficiencies being imposed upon social care nationally, and at the same time deliver improved outcomes that truly put people at the centre of services.

The success factors are:

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

Accelerating Discharge

Services will be re-designed to support ‘Transfer to Assess’ ensuring timely discharge from acute services to appropriate community or home based services. Health and social care will work together to provide good discharge planning and post-discharge support. This includes work around structured discharge planning and early supported discharge to enable people to return home earlier, remain at home in the long-term, and re-gain

their independence.

The success factors are:

- Integration of IT systems
- Reduction in delayed transfers of care
- Reduction in admissions and re-admissions to acute services
- Improvements in processes within and out-of-hospital

Infrastructure, Enablers, and Other Developments

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

The success factors are:

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

Other Schemes Additionally Supporting BCF Outcomes and Metrics

In addition to these, CCGs across Nottinghamshire are also working up further schemes to support the BCF outcomes and metrics that are not currently included in the pooled BCF arrangements. There will be a range of investments that will further contribute towards our vision of an integrated health and social care system centred on the patient.

In some planning units (e.g. Mid-Nottinghamshire), where detailed planning is well advanced, these form key planks of BCF planning. In other areas, where further work is required to firmly establish the evidence base to link investment to benefits, the schemes will continue, albeit not directly expressed within to the BCF plans. The range of schemes in the South Nottinghamshire CCGs is detailed at the end of the attached document 04. In future years, as the evidence base grows, more of these schemes will be delivered through the BCF pooled arrangements.

As an example, integrated health and social care is a key strategic priority for the South Nottinghamshire CCGs, which has resulted in the appointment of an Integrated Health and Social Care Programme Manager to lead this area of work, alongside the Local Authority.

Areas of work being targeted include, for example, intermediate care. This workstream is looking at the assessment process, deployment of staff, and resource allocation invested into the numerous services which interface to deliver rehabilitation services. This work has led to a review of current services, and opportunities are being explored to deliver

care closer to home through alternatives to residential provision.

The integration programme also now includes a short-term project to scope and review the Nottingham University Hospitals NHS Trust delayed discharge pressures. This work is focusing on four workstreams:

- Data analysis
- The Care Co-ordination Team
- The assessment process
- The discharge process

In the short-term, this work will deliver an effective process for accurate data recording and discharge management. In the longer term, this project will ensure a robust and financially viable process to effectively manage the discharge of patients from the acute setting in a timely manner. This work has a strong strategic interface with the wider developments outlined within the BCF plan to be delivered over the next five years.

An outline of the specific schemes being implemented under each of the six main BCF themes, along with timescales for delivery, can be found in the attached document 04.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

It is widely recognised that the current health and social care system in Nottinghamshire is unsustainable without transformational change. Our health and social care economy is facing a very clear set of challenges. Some of these are universal to commissioners and providers throughout England, and urgently need pioneers to develop solutions. Others are specific to Nottinghamshire, and take into account our local communities and organisations. Our most pressing challenges are:

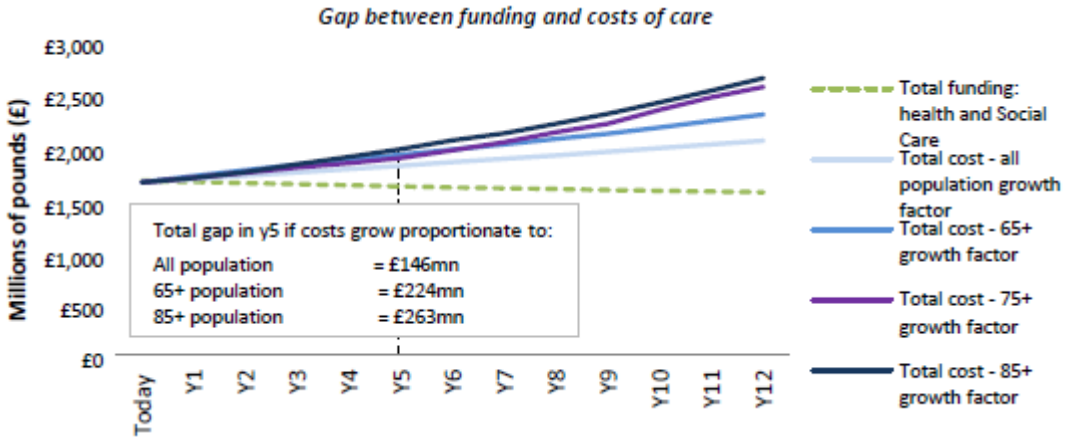
- An aging population, with more people needing more care. Over the next 20 years, the number of people in Nottinghamshire aged 66-84 and 85+ is expected to increase by around 36%-49%, with an average increase of 2,800 and 950 people per year, respectively
- A rising birth rate, placing increasing demand upon services
- Increasing numbers of young people with learning disabilities reaching adulthood: 128 in 2013/14 at a cost of £3.6m to the County Council
- Ongoing and increasing demand for acute hospital beds to deal with urgent care admissions, exacerbated in winter
- Rising citizen expectations around the quality and location of care
- Financial constraints as healthcare sees only small budget increases, while social care sees significant decreases
- Saving requirements for adult social care of approximately £80-90m over the next three years, requiring a fundamental review of the social care offering
- Challenging fixed points in the system, such as the PFI arrangements at King's Mill Hospital

Even without these changes in the health and social care landscape, we still face the challenge of providing better and more seamless care that is tailored to the individual, and is proactive and preventative. At the moment we are not achieving this. Our citizens have told us that our services are currently:

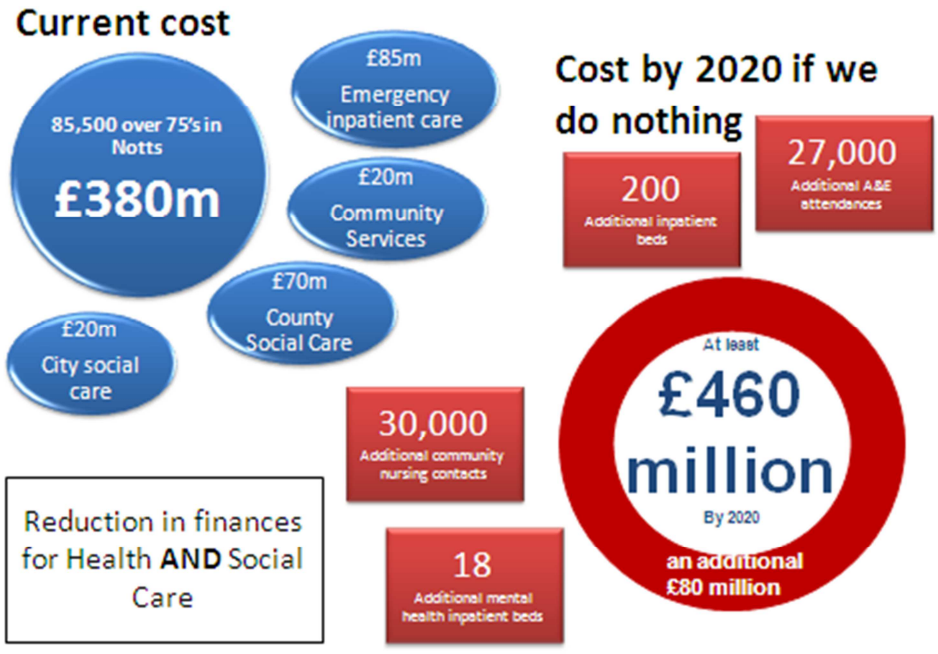
- **Disease-specific** – people are often under the care of three or more teams
- **Fragmented** – poor communication between teams means information is lost
- **Confusing** – it is not always clear what services are available
- **Limited** – long waiting times and lack of out-of-hours services mean that often there is no option but to call 999
- **Reactive** – services respond to crises rather than preventing them

There is also a growing gap between available funding and the costs of care across the county, as shown in the following graph. The scale of challenge is not under-estimated. Empirical analysis using proven modelling techniques has shown that, taking into account funding levels, population growth, and inflation, the financial gap for the county could increase to at least £146m in five years if services were to stay as they are. This gap could be even higher depending on the impact of demographics on healthcare costs. For example, if healthcare costs rise in line with the over 85 population, the gap in five

years exceeds £260m.



The schemes in our BCF plan have been identified to significantly close the gap, requiring significant integration of services at pace and scale. Because of the pressures arising from frail and elderly care, our population-level risk stratification and prioritisation exercises have provided a compelling case for us to focus primarily on the over 65s, shaping the majority of our BCF schemes. Moreover, Nottinghamshire County Council social care spend on all social care for the over 65s is high, being in the top quartile compared with statistical nearest neighbours. This means that doing nothing is simply not an option. A November 2012 analysis painted this stark picture of the increased demands on the Nottinghamshire system if we did nothing in the face of constrained health and social care budgets:



While the scale and pace of planned changes to make a real, sustainable difference will be doubtlessly challenging, examples already exist of integration of systems, processes, teams and budgets across Nottinghamshire in order to meet challenges and patient expectations, from which we have learned many lessons to apply in the BCF.

One such example is Productive Notts, a collaboration between the NHS organisations and local authorities in Nottinghamshire. Productive Notts had a focus on frail and elderly

people, and sought to provide an overall strategy and alignment for work in this area. Also of note, the North Nottinghamshire Care of the Elderly Network have developed a 'Frail and Elderly Pathway', with associated standards under consultation. Further work is to be carried out on mapping existing services to this pathway and to model required service changes.

Similarly, Nottinghamshire County Council's Living at Home Programme has been developed to reduce the number of people in care homes through changes to residential care referral thresholds and better support services available at home. A £40m housing scheme is being developed, offering a gated community of homes with flexible support services available. Further work to develop former Local Authority homes into respite centres is underway.

The case for change is further supported by risk stratification delivered by Nottingham's eHealthScope project and based on the Devon CPM (Care Plan Management) solution which uses information about admissions, outpatient attendances and A&E attendances to calculate the risk of future admissions. This information is then joined to care management information that GPs add information onto about the use of community services such as COPD matrons, heart failure matrons, and Crisis Intervention Services. This information is used in multidisciplinary team (MDT) meetings to make management decisions about who should be the care co-ordinator and which services should be offered to patients. MDTs concentrate on patients with a risk greater than 50% of admission, as this group has the greatest evidence for benefit (though the teams can view patients with lower risk).

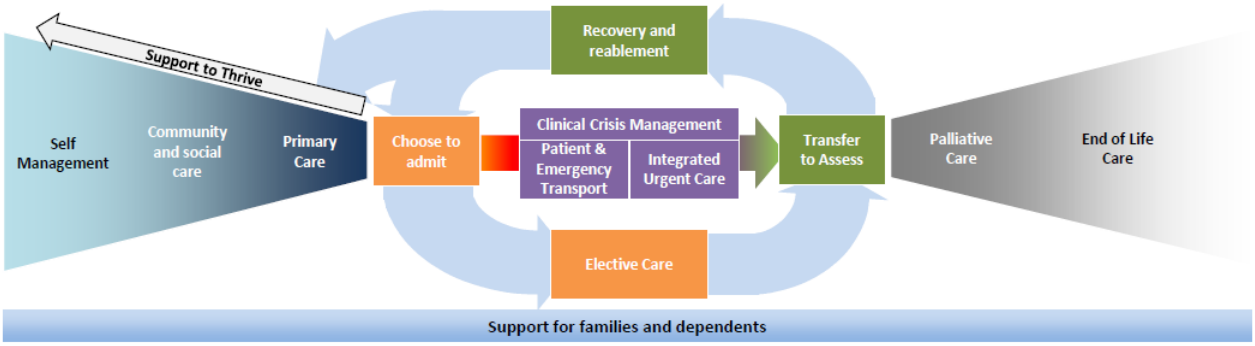
2% of patients at risk will be handled by general practices, approximately 1% of which will be informed by disease registers covering end-of-life, serious mental illness, long-term conditions such as COPD and heart failure, while the other 1% comes from those patients risk stratified as having a greater than 50% risk of admission. Of the 2% of patients, approximately 50% require multidisciplinary team involvement.

Citizens of Nottinghamshire have told us that they want to be supported to stay well and be independent for as long as possible, to receive care close to home and to be treated with dignity and respect. They want better co-ordination between health and social care services to support the whole person rather than just one element of their needs.

Accordingly, we have an overarching model of care built around the principles of 'Support to Thrive', 'Choose to Admit', 'Transfer to Assess', and 'End of Life Care' that we use to drive our county-wide and locality-based interventions. This approach is being taken to move towards more co-ordinated care for adults, including older people:

- **Support to Thrive** – enabling citizens to remain independent in their own homes for as long as possible through a focus on prevention, early identification of need, timely and appropriate co-ordinated and planned delivery of advice, information, support, and care, via a fully integrated community care team with general practice and primary care as the driving force
- **Choose to Admit** – the co-ordination and delivery of services in the community and at the hospital front door interface to prevent unnecessary admissions into hospital, co-ordinated through community hubs (a single point of access) and delivered by MDTs
- **Transfer to Assess** – the co-ordination and delivery of services in the community

and at the hospital back door interface to facilitate early transfer as soon as the citizen is medically safe for transfer, co-ordinated through community hubs (a single point of access) and delivered by MDTs



Layered on this are locality-specific approaches designed to respond to local system pressures, and based on rigorous analytical modelling, as described below.

North Nottinghamshire

What matter most to commissioners and providers in North Nottinghamshire are the improvements that we make together for the benefit of our citizens. The five key areas identified in the five-year strategic plan will all benefit from a more integrated approach:

<u>Supporting people out-of-hospital after acute illness</u>

- We know that 11% of admissions are inappropriate, and that significant numbers of patients stay in hospital too long (EMPACT)
- Ward managers can discharge up to 80% of patients, IDT should focus on the other 20% (ECIST)
- Integrated working will ensure that transfer and discharge from hospital will be improved, e.g. introducing the trusted assessor's role will ensure that only one standardised assessment will need to take place rather than several thereby improving the patient experience and pathway efficiency

<u>Mental health</u>

- Patients that experience a mental health crisis who present into A&E after 5pm have a higher chance of being admitted onto a mental health inpatient ward. Over a six month period between November 2012 and March 2013, 78% of all admissions to the ward happened after 5pm or at a weekend
- Working together to deliver improved assessment, treatment, and community based services on par with services for physical health and delivered 7 days a week

<u>Improving the quality of care homes</u>

- Using a sample of all Nottinghamshire County Council, 49% of long-term care admissions in Bassetlaw were directly from hospital in 2012/13. ~24% of emergency hospital admissions for the over 65s were care home residents, with the majority of these from residential care homes where there is limited clinical support
- Integration and partnership working with the care home owners and managers will result in improved processes for clinical support, and a reduction in avoidable emergency admissions to hospital and A&E

Care of the elderly and frail in the community

- We know that 11% of admissions are inappropriate, and that significant numbers of patients stay in hospital too long (EMPACT)
- Integrated working could lead to a reduction in the numbers of people admitted to hospital, and would support the new approaches we are developing to respond to the increased prevalence of dementia

Urgent same-day care

- Difficulty in accessing primary care – research suggests that optimising primary care could reduce out-of-hospital demand by up to 11%, and reduce pressures on other parts of the health and social care system
- Integrating intermediate care with health and social care is a key part of the supporting people out-of-hospital and the care of the elderly strategic programmes
- There will be opportunities to collaborate and/or partner to deliver improved access for patients

Risk profiling of Bassetlaw's population is underway using a locally-developed approach. The tool was developed in partnership with the South Yorkshire and Bassetlaw Commissioning Support Unit and is also being used by Sheffield CCG. All practices in Bassetlaw are using the tool to identify vulnerable patients at risk of hospital admission, and working with Bassetlaw Health Partnerships to establish regular MDT meetings to jointly agree care plans and ongoing management of patients.

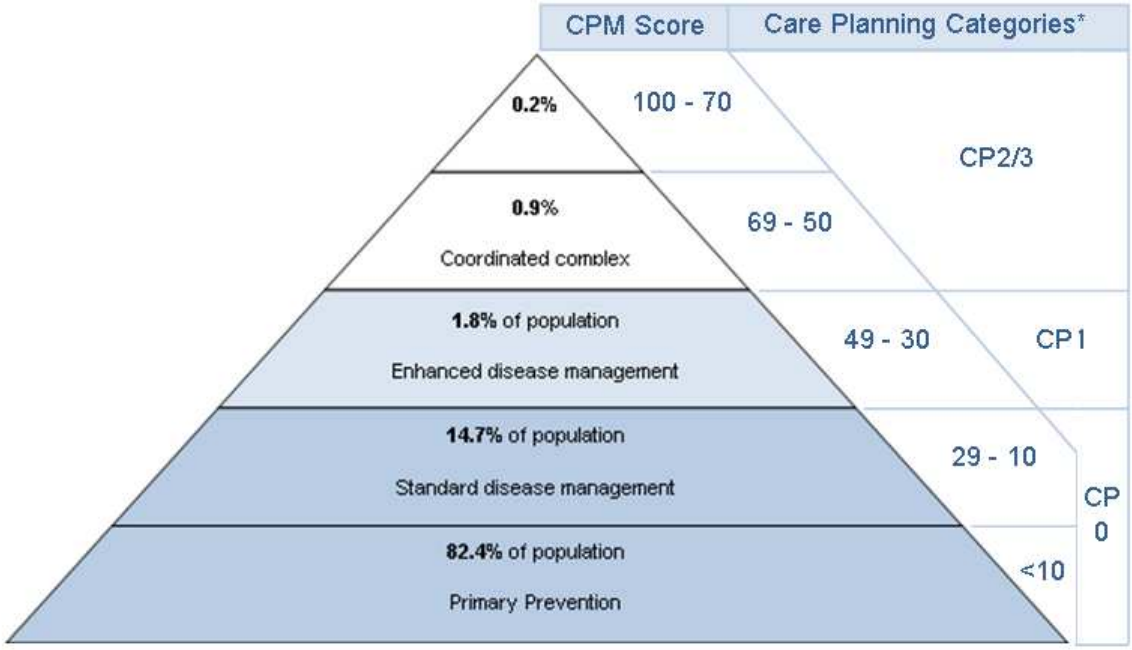
The tool ranks patients in order of Care Plan Management (CPM) score – the higher the score, the greater the risk of an admission into hospital. Initial results for Bassetlaw show the following:

		Care Plan Management Score				
		100-70	*69-50*	*49-30*	*29-10*	*<10*
GP Practice	Registered Population *1 July 2013*	**Proportion of population**				
		0.2%	*0.9%*	*1.8%*	*14.7%*	*82.4%*
Total Bassetlaw CCG	112,200	**231**	**1,015**	**2,025**	**16,498**	**92,460**

These sets of patients will be managed with a named accountable professional to provide an enhanced patient experience, which will improve the quality of care and reduce the burden on other services (thereby reducing costs):

- Co-ordinated complex – Planned Case Management/Social Work Active Case – 0.9% of the population
- Enhanced disease management – Proactive Case Management/Social Work Active Case – 1.8% of the population

Self-management support is available to individuals within both the standard disease management, and primary prevention categories.



Care Planning Categories*

CP0 None required or patient declines planned review

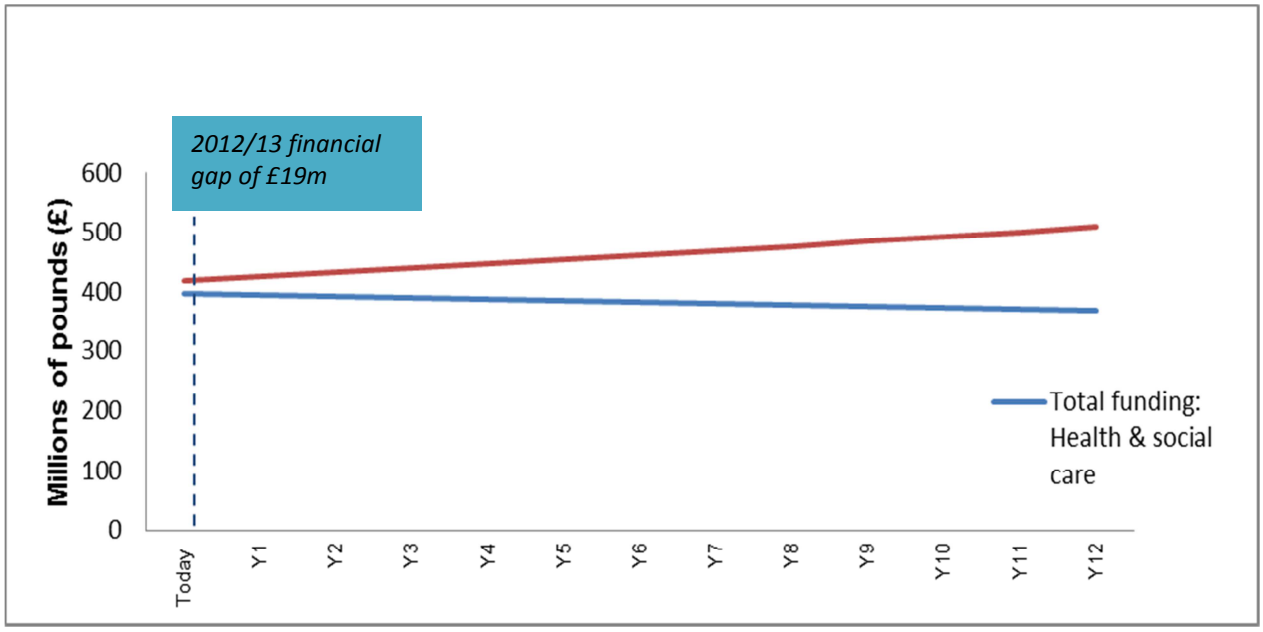
CP1 GP (or other single discipline) annual review

CP2 Planned health & social care review (annual or more frequent)

CP3 Proactive case management/social work active case

Mid-Nottinghamshire

The health and social care system in the Mansfield, Ashfield, Newark, and Sherwood CCG localities faces some very significant challenges; namely, how care is to be delivered to the quality and outcomes required with the limited (but still very substantial) funds available. The current models of care are not delivering best health outcomes, and are not affordable if scaled up to address growth in population demand. Using 2012/13 as a baseline, £398m is spent on the population of Mansfield, Ashfield, Newark, and Sherwood at a cost of £418m (excluding specialised services commissioning). If services were simply delivered in the same way, given an increase in the population and a simultaneous reduction in social care funding, there would be a gap of at least £70m (and possibly more than £100m) by 2018.



In developing the required interventions to address the challenge in Mid-Nottinghamshire, a number of pieces of analysis were undertaken to contextualise and prioritise the required interventions. The approach taken was to provide an indication of the expected impacts of proposed interventions on the financial challenges facing the care economy by constructing a series of tactical models and calculations based on the best available data. The findings have shaped the service transformation plans, and are continuously revisited and tested in detail to develop a clear evidence base for the efficacy of the proposed changes.

From the baseline information, comparative analyses were developed to identify potential causes of the current gap, which included:

- Higher than average length of stay for non-elective care (particularly frail elderly)
- Outliers in referrals and admissions to secondary care (emergency and elective services)

The combination of an aging population, the shifting expectations among citizens around the time and type of care they receive, an emerging evidence base of the benefits of care closer to home, and a predicted increase in demand will all place additional pressures on the health and social care economy.

To support the empirical analysis, deliberative engagement events with clinicians and service users established the following as key challenges to how care is delivered to the public in Mid-Nottinghamshire:

- Poor communication across organisations and a lack of integration of services
- A lack of understanding of the services available and how to access these services
- A lack of focus on prevention and treatment of patients in out-of-hospital community settings
- A significant increase in the number of frail and elderly people in the population who require higher levels of care
- A significant increase in the number of births, putting an increased demand on

services

- The relatively low proportion of local people accessing the local acute hospitals for elective services (low market share)

The holistic review of current state and projected future state, taking into account the changing population health demand, together with care re-design bounded by quantitative modelling, enables prioritisation of resources to address highest risk populations and deliver maximum overall health benefit within available joint health and social care resources.

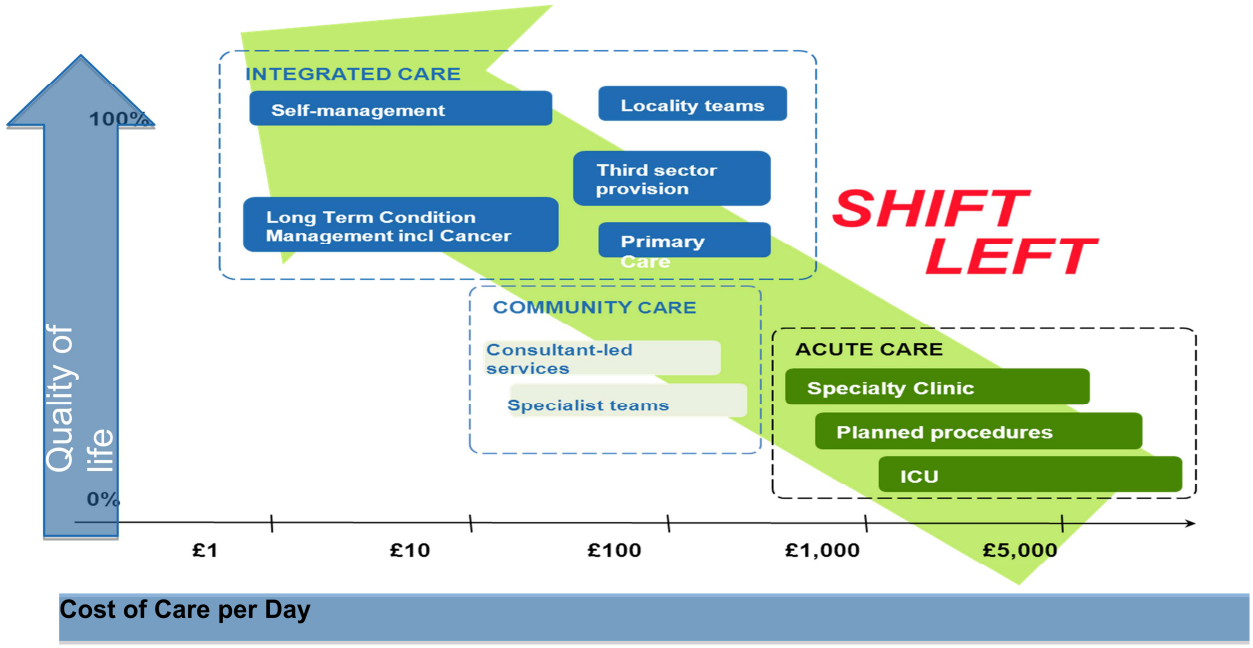
The resultant integrated model of care, supported by the BCF, will enable CCGs to mitigate the associated risks, providing better quality care while reducing cost. If services were to continue as they currently are, taking into account funding levels, population growth, and inflation, the financial gap would widen between health and social care funding and the total cost of delivering care in Mid-Nottinghamshire. Social care budgets are expected to continue to come under significant pressure due to the austerity in the public sector, further exacerbating the situation. In addition, the costs of delivering care will increase as a result of population growth and aging and as a result of price inflation.

The identified interventions in Mid-Nottinghamshire's Future Model of Care, many of which are integral to our BCF implementation, will reduce the potential five-year financial gap of £70m to £35.1m by dealing with such challenges as aging and growing populations while integrating services. The impacts on the five Mid-Nottinghamshire organisations involved have been modelled, but it is anticipated that there will also be further benefits for neighbouring organisations.

A truly integrated health and social care service for Mid-Nottinghamshire will help to achieve the following outcomes:

- Maintaining personal independence and increasing community care
- An Integrated Urgent Care Service
- "Right People, Right Place" Elective Care
- Reabling people to go home

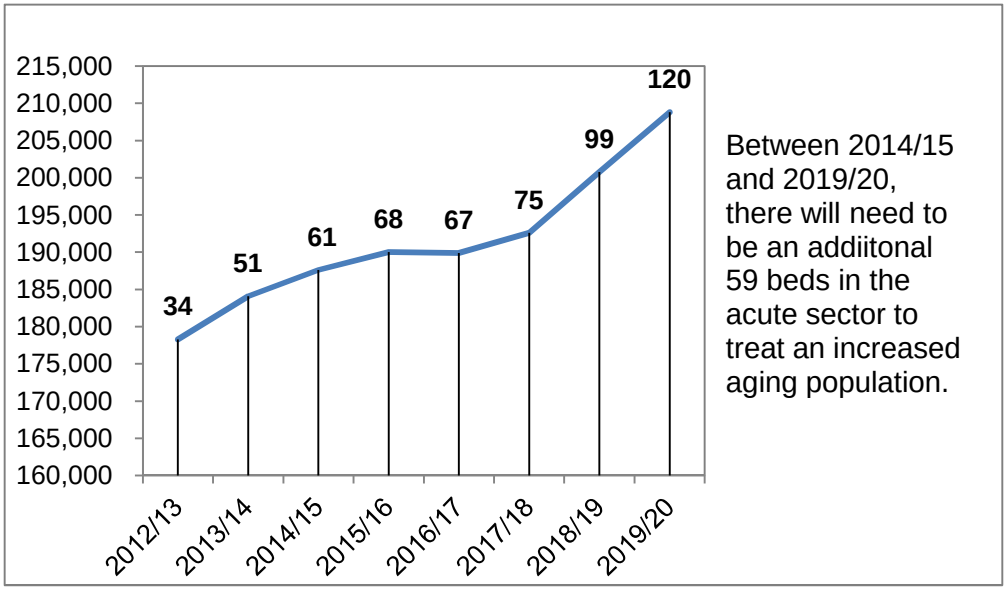
The over-arching model of the new system envisaged is shown on the next page, demonstrating a "shift left" from complex and high cost specialist hospital care to better value, lower unit cost, and preventative interventions in the community.



South Nottinghamshire

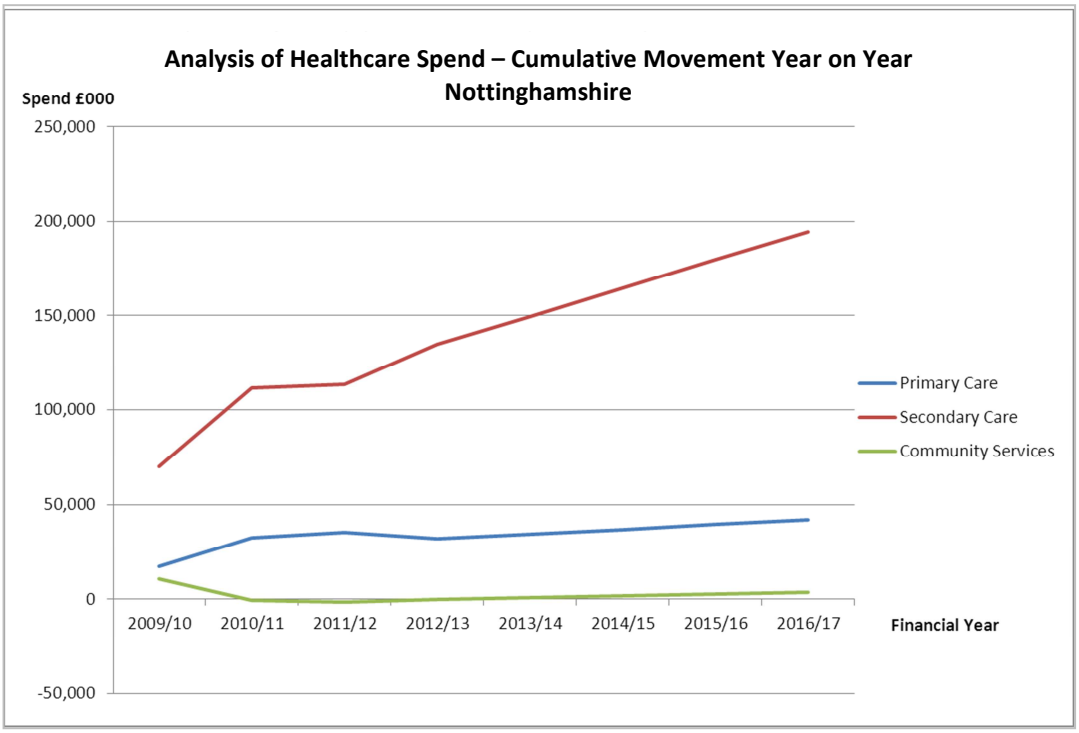
A key challenge for South Nottinghamshire CCGs is supporting and delivering care to the increasing numbers of older people in an environment in which health funding will not increase in line with demographic growth, and social care funding will reduce. The number of people over 75 will increase between 2014/15 and 2019/20 by 12% within the south of the county and, unless we change the way in which we deliver care, there will be increases in demands placed on all those who provide care.

The following graph shows the impact on the demand for beds in Nottingham University Hospital. It is estimated that an additional 59 beds would be needed to meet increasing demand if we do not work together to improve the way we care for older people.



Between 2014/15 and 2019/20, there will need to be an addiitonal 59 beds in the acute sector to treat an increased aging population.

Demand has historically been met by increasing expenditure on the acute sector, while spend on community and primary care has remained static. For Nottinghamshire, modelling from 2009/10 projected an increasing trend, as shown in the following graph:



Analysis of activity at NUH indicates:

- There has been a slight upward trend in A&E attendance volume to NUH (+4% overall) since 2010/11
- That non-elective admission volumes to NUH have declined slightly since 2010/11, but there was a sudden (~3%) rise at the start of 2014/15
- That, of all drivers of emergency pathway pressure, length of stay for over 65s appears most challenging given the three-year trend
- That the emergency care challenge appears to be less a challenge of “front-door demand”, and more a challenge of length of stay and rapid discharge for more complex patients
- Non-elective General Medicine is the largest single specialty value within the acute Trust, which reflects the increasing demand and complexity of care of the elderly activity
- Re-admissions performance is recognised as a major potential improvement driver for the Trust. At any time, 300 beds at NUH will be occupied by patients who have been re-admitted to hospital within 28 days. In 2013/14, there were 17,500 patients re-admitted, which equates to 48 per day
- That a 32% reduction in bed occupancy by re-admitted patients could imply 90 freed beds (i.e. 32% of 300 beds ~ 90 beds)
- That 61% of admitted patients come through the emergency department highlighting a need to address opportunities as part of the Choose to Admit approach

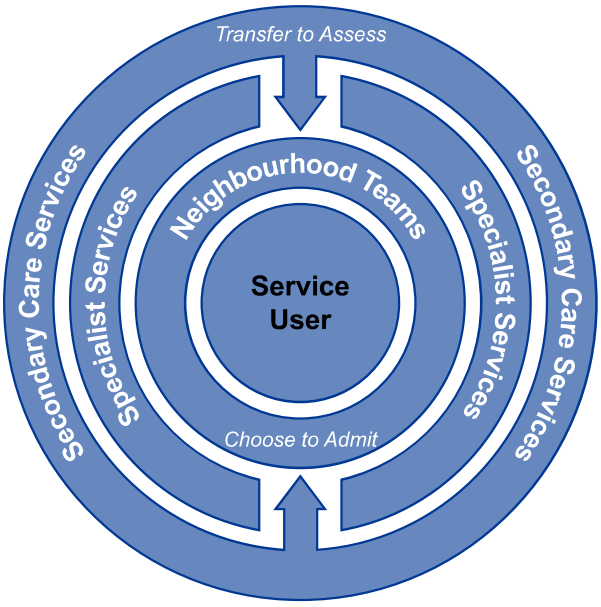
Using this predictive analysis, components of the delivery of integrated care in South Nottinghamshire will be:

- Establish locality facing multi-disciplinary and multi-agency integrated care teams (working across traditional boundaries) aligned with groups of GP practices

serving a patient population circa 25-30k seven days-a-week (see the below diagram)

- Simplify and improve access to all local care services through the development of an integrated multi-agency community hub
- Using validated predictive modelling tools and regular locality multi-disciplinary team meetings, systematically identify those with frailty, escalating needs, and risk of deterioration
- All those identified at risk or in need of a proactive care approach will be assigned an appropriate case manager, key worker, or advocate who will:
    - Develop advice and information prescription
    - Develop a holistic goal-orientated care plan in partnership with the individual
    - Co-ordinate and oversee care delivery
    - Monitor and review
- Actively build resilience and support people to self-care through the provision of information, advice, and signposting to appropriate self-help support
- Provide a systematic proactive planned approach to facilitating safe and timely transfer from hospital for those with ongoing needs requiring further assessment
- Establish a comprehensive range of rehabilitation and reablement support services that are easily, and – where necessary – rapidly, accessed via the community hub to:
    - Provide comprehensive assessment and rehabilitation/reablement to prevent crisis
    - Support individuals to recover after illness or injury
    - Provide a rapid response to deterioration or crisis and “Choose to Admit”
    - Support timely transfer from hospital and “Transfer to Assess”

Neighbourhood/local care teams:
- GP
- Practice nurse
- Community matron
- Community nurse
- Social worker
- OT
- Physio
- Mental health nurse
- Care co-ordinator
- Voluntary sector



Community-facing specialist services, such as:
- Geriatrician
- Psychiatrist
- Respiratory and oxygen assessment
- Diabetes
- Heart failure
- Palliative care
- Continence
- Tissue viability

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies.

Our detailed BCF implementation plans can be found in the attached document 05. These set out the timing and phasing for all individual schemes, as well as the associated milestones and activity changes anticipated. This document is intended to augment the scheme details provided in Annex 1 and the Part 2 spreadsheets, so it should be treated as a supplement to this BCF plan rather than a standalone document in its own right.

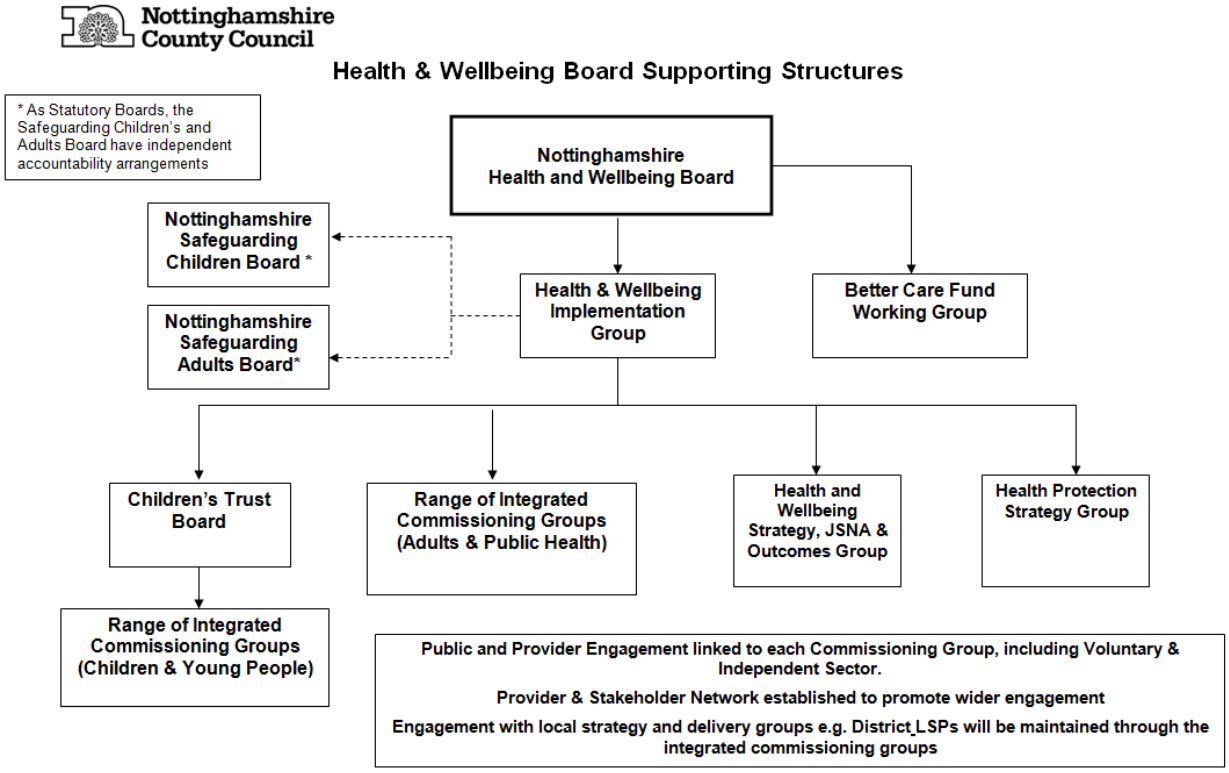
b) Please articulate the overarching governance arrangements for integrated care locally

At a county-wide level, the Health and Wellbeing Board is ultimately responsible for maintaining oversight of the health and social care system. In its role, it receives information on a range of initiatives and provides the forum to explore interdependencies. Through its governance system, the Board allows partners to engage in developments and explore joint solutions to the range of health and social care issues.

The Board's work programme includes regular reports on the BCF progress and delivery, as the BCF forms an important subsection of the Health and Wellbeing Strategy, so its reporting and performance management is combined and monitored through the Health and Wellbeing Implementation Group.

The Health and Wellbeing Implementation Group has executive oversight of the work of the Board, with specific responsibility over the development of the JSNA and delivery of the Health and Wellbeing Strategy. A delivery plan has been developed that supports the implementation of the strategy. This is approved by all partners, a named executive, and Health and Wellbeing Board member leads are identified to help support each integrated commissioning group/planning unit, and champion the work for each priority.

The supporting governance structure of the Health and Wellbeing Board is as follows:



Operationally, each locality already has an established board or group to oversee the development and implementation of integrated care plans: the Integrated Care Board in the North, the Transformation Board in Mid-Nottinghamshire, and the BCF Planning Group in South Nottinghamshire.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

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

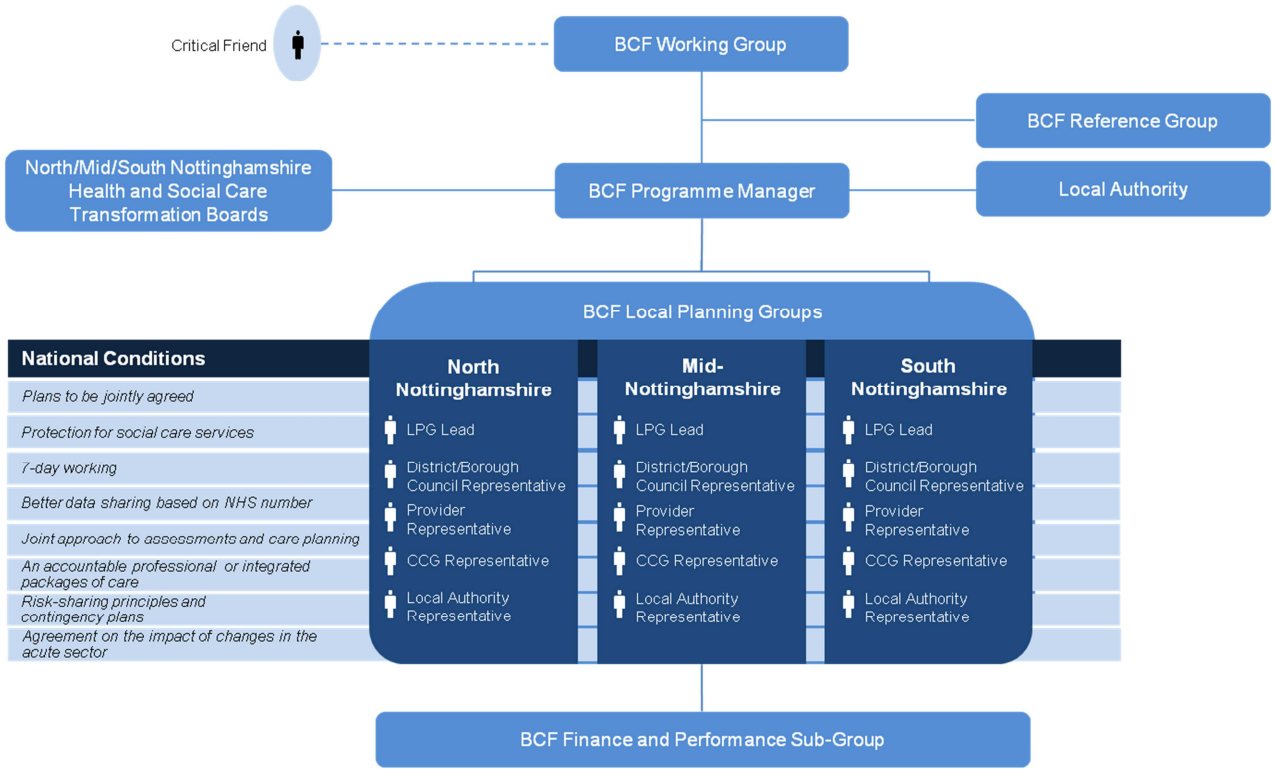
The Working Group co-ordinates to identify and commission required resources to deliver the plan and agree necessary milestones and timescales. As well as ensuring that the plan conforms to the national conditions and is consistent in meeting required performance targets, this steering group will maintain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

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

A Finance and Performance Sub-group has been established to monitor and report to the Working Group on the targets set in the BCF's nationally-determined and locally-agreed performance metrics. This Sub-group receives finance and performance information from each statutory body, and collates reports for discussion. It then reports monthly up to the BCF Working Group. The Working Group will then, in turn, provide quarterly reporting directly to the Health and Wellbeing Board, with exception reports and recommendations for appropriate remedial actions.

A dedicated BCF Programme Manager has also been appointed, and will have dual accountability to the Local Authority and CCGs. This post is hosted by the Mid-Nottinghamshire CCGs.

Our county-wide BCF governance structure is shown on the following page:



Our finance and performance monitoring and reporting format, as agreed by the BCF Working Group, is attached in document 06 (please note that the finance and performance data included in the report are fictitious, and included only for illustrative purposes).

The principles of joint working are already embedded in much of the work being delivered across all localities and the Health and Wellbeing Board. We very much intend to build on this momentum as the BCF plan enters implementation.

As an overarching principle, accountability for performance, mitigation of risks, and any remedial action will be managed wherever possible at unit of planning level and will be monitored and overseen through the aforementioned BCF governance process. A partnership agreement will be drawn up to formalise the BCF management arrangements. The principles agreed by the CCG and Local Authority Chief Financial Officers are described below.

Hosting arrangements

The County Council will be the host. Prior to the financial year, funds will transfer into the pool.

Commissioning and contracting

Responsibility for commissioning a service will remain with the relevant accountable body – joint commissioning processes are being developed locally (e.g. Mid-Nottinghamshire). Providers will be paid from the pool and must invoice the pool for the related services. Monies within the fund are set out in the approved submission. These must be spent on the schemes documented. If resources are diverted elsewhere, this must be agreed by all parties in the unit of planning.

Overspends

Where an area of spend is over budget, this must be identified early and remedial action should be agreed between the provider and commissioner, and then reported to the Finance and Performance Sub-group. Responsibility for the overspend is the commissioner's. If the commissioner feels that another party should carry some of the financial burden, then this must be discussed. However, no responsibility will be carried across the unit of planning boundaries.

Underspends

Funds may be unspent in one year. In these circumstances, the unspent balance will be ring fenced to fund a related service (for example to support backfilling another service before the new integrated teams are fully operational) or carried forward into the following year. If funds are diverted to a service outside the descriptor, then this must be agreed by all parties within the unit of planning.

Contingency funds

The contingency fund will be held with the risk pool/contingency funds of each body. The contingency fund will operate on a unit of planning basis, and monies will be ring-fenced accordingly. Any draw on additional monies due to lower performance will be from the unit of planning contingency fund nominally allocated. The use of any contingency will be at the discretion of the planning unit. However, if the remedial action plan is failing to deliver, through the BCF governance process, the planning unit may have to consider further mitigations which will have an impact on contingency funds.

BCF scheme delivery will be operationally managed at locality level by the Integrated Care Board in the North, the Transformation Board in Mid-Nottinghamshire, and the BCF Planning Group in South Nottinghamshire, who all oversee local implementation of integrated care plans.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme	Locality
A	Seven day working	South Nottinghamshire
B	GP Access	South Nottinghamshire
C	Proactive and personalised care	South Nottinghamshire
D	Community Care Co-ordination	South Nottinghamshire
E	Support to Carers	South Nottinghamshire
F	Protecting Social Care Services	County-wide across Nottinghamshire
G	Rehabilitation/reablement services – at home and community bed based	South Nottinghamshire
H	Additional support to social care (home care/OT)	South Nottinghamshire
I	Transformation programme management	South Nottinghamshire
J	Disabled Facilities Grants	County-wide across Nottinghamshire
K	Locality intermediate care teams	Mid-Nottinghamshire
L	Self-care service	Mid-Nottinghamshire
M	Specialist intermediate care team	Mid-Nottinghamshire
N	Improved primary care access and support closer to home	Mid-Nottinghamshire
O	Better Together implementation support	Mid-Nottinghamshire
P	Communications and social marketing	Mid-Nottinghamshire
Q	7 day access to services	North Nottinghamshire
R	Mental health liaison	North Nottinghamshire
S	Personalised care	North Nottinghamshire
T	Reablement services	North Nottinghamshire
U	Discharge/assessment including intermediate care	North Nottinghamshire
V	Respite services	North Nottinghamshire
W	Improving care home quality	North Nottinghamshire
X	Telehealth	North Nottinghamshire
Y	Social care capital	County-wide across Nottinghamshire
Z	Care Act implementation	County-wide across Nottinghamshire

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
NORTH NOTTINGHAMSHIRE RISKS				
Financial pressures for the Local Authority impact on the ability of the CCG to fund schemes within the BCF	HIGH likelihood (4)	HIGH impact (5) Financial impact (exact impact on health and social care not ascertainable at this point) Risk falls on CCG commissioners and Local Authority. It is not possible to scale this until the full extent of the budget pressure within the LA is known at District level	20	Ongoing leadership from the BCF Working Group to ensure that there are sufficient resources to realise our BCF vision and meet targets - reallocation of BCF resources where necessary/appropriate
The assumed reduction in residential and nursing home placements does not	MEDIUM likelihood (3)	MEDIUM impact (3) The impact will fall on Social Care Commissioners through increased	9	Activity modelling informed by evidence and local clinical opinion; model to include impact of best,

materialise		costs. The impact will also fall on the social care sector providers where there may not be enough capacity to meet demand This will potentially impact on CCG commissioners around additional CHC packages (a 10% in low-level packages costing potentially up to £300k) and the LA for residential home placements		base and worst case scenarios
Information Governance: local arrangements contingent upon national agreement	HIGH likelihood (4)	HIGH impact (4) Difficulties in sharing patient / service user information between health and social care professionals No anticipated financial impact	16	Monthly monitoring of situation at a senior level through the System Resilience Group and Integrated Care Board Informal local systems in place for MDTs and community staff Develop and maintain links to Connected Nottinghamshire Programme
Acute activity reductions do not materialise at the required rate due to delays in implementation impacting on developments, or unanticipated cost pressures slow down implementation	HIGH likelihood (4)	VERY HIGH impact (5) Overall activity reductions are forecast at £669k in 2015/16. A 20% impact would therefore increase the cost base for commissioners by c£134k In addition funding for unanticipated cost pressures would be required. If this impacted on the overall North Nottinghamshire BCF at 10% this	20	Monthly monitoring at a senior level through the System Resilience Group and Integrated Care Board, and the BCF Working Group and BCF Finance and Performance sub-group Ongoing monitoring of Clinical Decision Unit (CDU), Assessment and Treatment Centre (ATC), IDT and A&E MDT to maximise capacity

		would require an addition c£900k funding		Ongoing monitoring of all Reablement Services (beds and community) ICB to refresh system-wide modelling of impact (annual) BCF schemes phased towards 15/16
Performance-related funding reliant on outcomes that may not be evidenced in the short to medium term, and contingent upon activity from patients registered to other CCGs not within or part of Nottinghamshire's BCF plans	MEDIUM likelihood (3)	HIGH impact (4) Financial impact (see section 5b below) Risk falls on CCG commissioners, with a similar impact to the risk above, around non-delivery of savings which will require non-recurrent funding to maintain the programme	12	Monthly monitoring of outcomes at a senior level through the System Resilience Group and Integrated Care Board and early identification of slippage Monthly monitoring and evaluation of the five programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers
Quality of care and financial stability of providers across all sectors is adversely affected due to the changes proposed	MEDIUM likelihood (3)	HIGH impact (4) Impact on outcomes in Domains 4&5 of NHS Outcomes Framework, and Domains 3&4 of the Social Care Outcomes Framework Impact on service providers which is at this stage not quantifiable	12	Ongoing leadership from the System Resilience Group and Integrated Care Board Early engagement of partners with work programmes agreed in partnership at a senior level

Agreement for whole scale change from all partners, including changes to ways of working is not forthcoming	MEDIUM likelihood (3)	HIGH impact (4) Change does not happen at the required scale and pace which will impact on achievement of performance metrics. This will then require additional non-recurrent support from commissioners	12	Ongoing leadership from the System Resilience Group and Integrated Care Board Early engagement of partners with work programmes agreed in partnership at a senior level Planned change management approach for all organisations involved to communicate these changes to the front line
National changes to Urgent and Emergency Care (primary care, A&E and OOH) and changes to the primary care contract impact on the design of schemes	MEDIUM likelihood (3)	HIGH impact (4) Potential impact on commissioners in relation to the value for money that is ascertainable from contracts, and additionally, impact on providers implementing the requirements of the contracts (including the potential for financial impact where requirements are not met). This is not quantifiable at this stage	12	NHS England Area Team representation on the System Resilience Group and Integrated Care Board
Insufficient recruitment of qualified and skilled preventive staff	MEDIUM likelihood (3)	VERY HIGH impact (5) Staffing and skill shortages for new key front-line staff. While not all new schemes require significant additional staffing, the impact will be on additional costs (locum staff) or non-delivery of savings. This will have to be assessed in due course at individual scheme level	15	Monthly monitoring at a senior level through the System Resilience Group and Integrated Care Board Workforce development plan in place, including a succession plan Review recruitment and retention plans (annual)

MID-NOTTINGHAMSHIRE RISKS				
Assumed change in residential and nursing home placements does not materialise	MEDIUM likelihood (3)	MEDIUM impact (3) Social care budgets become stretched to fund high cost residential/nursing care, which reduces the opportunity to divert scarce Local Authority resources to interventions that sustain independence in patients' homes, and deliver more and better integrated community based care. Could be some collateral implications for continuing health care budgets and also increase the number of patients required to self-fund If this risk materialises and cannot be fully mitigated the financial impact is estimated as circa 6% of existing costs (£1.4m) as follows: - CCG's to bear costs of a 10% increase in continuing care placements - CCG's/LA to fund 10% more residential and nursing home placements	9	Activity modelling informed by evidence and local clinical opinion; model to include impact of best, base, and worst case scenarios
Insufficient qualified staff can be recruited in time to meet required increase in community service staffing levels and new services	HIGH likelihood (4)	MEDIUM impact (3) Either delay to implementation, or phased implementation leading to profiling of benefits realisation being delayed. CCGs may be asked to consider transitional funding for premium costs to smooth	12	Reduce scale of services and/or phase delivery to accommodate extended recruitment timescales. Use of agency staff to bridge gaps. Early discussions with regional workforce development teams to facilitate long-term recruitment and

		implementation where existing staff cannot easily be transferred from within the existing workforce system to new roles. This could increase pay costs in year 1 of implementation by up to 20%, but may offer VFM if benefits of new system are accelerated On the basis of current local CCG investment plans for workforce transformation it is anticipated that if current system wide OD and workforce plans do not operationalise in accordance with current implementation timescales, then the cost pressure that providers would approach CCGs to fund to maintain pace of transformation to delivery of new service models is circa £1.5 m		development planning. Workforce Workstream mobilised with dedicated resource focussed on delivering workforce transformation, with links in to wider county and regional workforce change plans
Staff moving from existing services within Mid-Nottinghamshire or from neighbouring HCEs will destabilise existing services, leading to overall loss of performance	MEDIUM likelihood (3)	MEDIUM impact (3) Impact would be felt in other health economies as services suffer from failure to retain and recruit staff. Could give rise to delays in addressing the need to reduce reliance on hospital care in these areas, with consequent financial impacts	9	Reduce scale of services and/or phase delivery to accommodate extended recruitment timescales. Use of agency staff to bridge gaps. Early discussions with regional workforce development teams to facilitate long-term recruitment and development planning
There could be public resistance to proposed changes that could delay implementation through	LOW likelihood (2)	VERY HIGH impact (5) Could give rise to delays in implementation and consequent delays in deriving benefits. Worst	10	Engagement plan in place; citizens' champions recruited, and now actively supporting the programme and part of an ongoing extensive

formal challenge		case would be programme stopped through legal challenge over consultation (judicial review). CCG to manage reputational damage and potential costs to defend legal challenge While the over-arching transformation programme may be delayed/stopped, it is anticipated that many of the interventions that are required to deliver integration benefits will continue as "business as usual". Therefore the financial impact relates specifically to the costs to defend a legal challenge of the transformation process, not the nature of the new service changes. While dependent upon the nature and scale of the legal challenge, the CCGs estimate a likely cost of circa £250k which would be funded from reserves		deliberative engagement process. Legal advisors appointed to ensure requirement for consultation considered at all stages. Significant engagement already undertaken, including formal evaluation. Equality impact assessment and health impact assessments undertaken and being continuously reviewed. Outline Business Case to be produced for sign-off by all organisations setting out any particular requirements for public consultation. Health and Wellbeing Board and Health Scrutiny Committees have been fully briefed on the integration transformation proposals from the outset and influenced the approaches taken to public engagement
IT suppliers do not have capacity to respond to requirements of Mid-Nottinghamshire within required timescales	MEDIUM likelihood (3)	HIGH impact (4) Could give rise to delays in full implementation, and may require additional cost to secure new suppliers/design new systems. Impact would fall upon commissioners as full system benefits realisation would be delayed, and providers as market forces would drive up IT solutions costs If the required pace of IT change	12	Requirements are similar to those of other Nottinghamshire CCGs, giving greater leverage with suppliers

		cannot be delivered through existing supply chains and collaborative arrangements, then the CCG would look to increase its current level of investment factored in to transformation plans (£2.75m) by a further £1m (non-recurrently)		
Insufficient non-recurrent monies available for the enabling/implementation costs	VERY LOW likelihood (1)	HIGH impact (4) CCGs required to divert funds from other core priorities. As implementation of integrated service models and out-of-hospital care is the highest priority for the commissioner, then this risk is unlikely to materialise unless there are un-expected pressures on current funding models The CCGs have very robust triangulation of transformation investment, commissioner QIPP and provider CIP plans. The worst case scenario for this risk materialising is therefore £1.125m, which would be funded from reserves	4	Requirements included in CCGs' annual planning assumptions
Notwithstanding effective management of all of the specific risks identified above, the projected admissions to acute hospitals do not fall as projected e.g. un-forecast and exceptional circumstances – flu	VERY LOW likelihood (1)	MEDIUM impact (3) Acute providers required to support beds planned for de-commissioning and are therefore unable to support workforce transformation from acute to community settings If this risk materialises and cannot be mitigated by improved efficiency in	3	Integral to the CCG's planning assumptions, and investment in strong reporting and management of risks across the range of transformation projects Strong links between emergency planning and urgent care management ensures that contingency arrangements are

pandemic etc.		community and self-care services, then the CCGs would be required to continue to fund acute activity at higher than forecast levels, while continuing to invest in community solutions The anticipated additional cost is circa £950,000 based on assessment of likelihood (25% of full cost impact)		continuously reviewed and updated
SOUTH NOTTINGHAMSHIRE				
Implementation of the schemes / programme may result in unintended consequences on the quality of care	LOW likelihood (2)	LOW impact (2) User experience and / or outcomes worsen Financial impact – as described in the risk of increased non elective admissions £280,000. This impact will fall on CCGs	4	Ongoing leadership from the BCF Working Group/South Planning Group Lead: CCG Accountable Officer Sponsor Timeline: Ongoing Ongoing engagement of partners with work programmes at all levels Lead: CCG Accountable Officer Sponsor Timeline: Ongoing Application of robust care quality monitoring arrangements to the BCF schemes in keeping with the arrangements that are in place with all main health and social care providers, with stretch targets such as CQUINs also agreed annually. NB: There are strong relationships established between the respective

				health and social care quality teams and formal as well as informal arrangements in place e.g. MASH (multi-agency safeguarding hub). Lead: BCF Programme Manager Timeline: In readiness for April 2015 Processes in place to monitor and evaluate the BCF schemes on an ongoing basis ensuring evidence of quality improvement and benefits for service users, as well as financial benefits. Lead: Scheme Leads/BCF Programme Manager Timeline: In readiness for April 2015
'Sign up' and cultural change from all partner organisations is not achieved resulting in failure to deliver the schemes/programme	LOW likelihood (2)	MEDIUM impact (3) User experience and outcomes remain unchanged / worsen Staff satisfaction remains unchanged / worsens Organisation (health and social care, commissioner and provider) failure / system failure. Financial impact – as described in the risk of increased non elective admissions £280,000 This impact will fall on CCGs	6	Ongoing leadership from the BCF Working Group/South Planning Group Lead: CCG Accountable Officer Sponsor Timeline: Ongoing Partner organisation 'sign up' to a Compact Agreement for system-wide transformational change. Lead: Transformation Director Timeline: a) Compact developed September 2014; b) Endorsed by 12 partner governing bodies in October 2014; c) Monitored through the

				South Notts Transformation Board (SNTB) on an ongoing basis Programme of organisational development in place for the South Notts Transformation Board (SNTB) at senior executive level led by an external Critical Friend and addressing issues such as agreeing a core purpose, shared mechanisms for managing financial risk and benefit, and building strong interpersonal relationships. Lead: Director of Transformation Timeline: Monthly sessions commenced June 2014 and commissioned until March 2015, when assessment of needs for 2015/16 will be undertaken. Develop, agree and implement a system wide OD plan for all levels of the system, which builds on culture change initiatives that have been ongoing for the last year, such as walking the emergency pathway and shadowing colleagues. Lead: Director of Transformation Timeline: a) Development of plan Oct-Nov 2014; b) Approval by SNTB Nov 2014; c) Implementation commences Dec 2014; d) oversight of delivery by SNTB throughout 2015

				and beyond.
The current workforce profile coupled with recruitment/retention difficulties impact negatively on the timely delivery of the schemes/whole programme	HIGH likelihood (4)	VERY HIGH impact (5) User experience and outcomes remain unchanged / worsen Staff satisfaction remains unchanged / worsens Workforce numbers decrease with increased use of temporary staff Organisation: Provider failure to deliver new models of care/increased cost of delivering new models of care Commissioner / system failure to realise benefits Financial impact – a 20% increase in community service costs - £1,500,000 This impact will fall on CCGs who commission community services	20	Ongoing leadership from the BCF Working Group/South Planning Group Lead: CCG Accountable Officer Sponsor Timeline: Ongoing System wide review of the current workforce including gap analysis and development of five year workforce plan across all organisations (inc. training and development needs). Executive leadership in place Lead: Director of Transformation Timeline: Ongoing Models of service change developed and implemented on realistic assumptions about workforce. Lead: Director of Transformation Timeline: April 2015 Strengthened links to the Health Education East Midlands and the Nottinghamshire Local Education and Training Committee to secure advice and support and gain links to wider initiatives Lead: Director of Transformation Timelines: ongoing

The existing contractual arrangements with providers are not conducive to the commissioning of new models of care resulting in the failure to realise the service and financial benefits expected for the BCF schemes	LOW likelihood (2)	LOW impact (2) Commissioner failure to realise financial benefits System failure to achieve benefits of schemes / programme Financial impact – as described in the risk of increased non elective admissions £280,000 This impact will fall on CCGs	4	Ongoing leadership from the BCF Working Group/South Planning Group Lead: CCG Accountable Officer Sponsor Timeline: Ongoing Early and ongoing engagement of partners with work programmes agreed in partnership at a senior level to enable readiness for contractual changes Lead: CCG Accountable Officer Sponsor Timeline: Ongoing throughout 2014/15 Collaborative commissioning arrangements in place between the CCGs together with developing integrated and joint commissioning arrangements focused on giving strength, breadth and depth to negotiating positions. Lead: Provider Contracting Lead Timescales: Ongoing during 2014/15 contracting round Health and social care community commitment to the development of accountable care systems which will encompass the BCF schemes in

				time. Lead: Director of Transformation Timeline: a) population focus agreed August 2014; b) Project Initiation Document agreed September 2014; c) project progressed through design, modelling, contracting phases etc. October 2014 to March 2016.
Citizen resistance to schemes requiring behavioural change will result in failure to achieve reductions in health and social care activity	LOW likelihood (2)	MEDIUM impact (3) Decreased user satisfaction Organisations: Provider activity levels remain unchanged or potentially increase (with potential impact on the delivery of access standards) Commissioners unable to realise financial benefits and potentially have increased cost of additional activity. Financial impact – as described in the risk of increased non elective admissions £330,000 This impact will fall across the health and social care community with CCGs bearing the cost impact of increased activity in the Acute Sector	6	Implementation of citizen engagement strategy. (NB: citizens have already been broadly engaged in the development of strategic and local plans and have a strong voice from structural i.e. committee level and local/neighbourhood/client group/GP practice level. Lead: Citizen engagement lead Timescales: a) Strategy approved at SNTB in August 2014; b) Oversight of strategy implementation by SNTB on an ongoing basis.
Schemes/the programme does not result in the expected level of activity	MEDIUM likelihood (3)	HIGH impact (4) User satisfaction remains unchanged or potentially decreases	12	Ongoing leadership from the BCF Working Group/South Planning Group

reduction in provider organisations		Organisations: Providers are unable to meet demand resulting in failure of quality standards. Commissioner failure to achieve the expected benefits System unsustainability Financial impact – as described in the risk of increased non elective admissions £450,000 This impact will fall across the health and social care community with CCGs bearing the cost impact of increased activity in the Acute Sector		Lead: CCG Accountable Officer Sponsor Timeline: Ongoing Robust analysis and modelling to ensure assumptions on activity reductions are realistic for the individual schemes and overall programme. Lead: BCF information/analytics lead Timeline: Work undertaken but to be refreshed for each contracting round Implementation of robust programme management arrangements including identification, assessment, management and escalation of risks to delivery Lead: BCF programme manager Timeline: a) arrangements developed and agreed by March 2015; b) Implementation from April 2015; c) Ongoing review and improvement thereafter
The successful implementation of the schemes/programme including planned reduction in activity to providers results in provider financial instability	LOW likelihood (2)	MEDIUM impact (3) Provider loss of income / financial instability Financial impact –£427,000 This impact will fall across the health and social care community with CCGs bearing the cost impact of	6	Early and ongoing engagement of provider partners with the BCF; programme agreed in partnership at a senior level with provider organisations to gain alignment of provider plans Lead: CCG Accountable Officer

		supporting the Acute Sector		Sponsor Timeline: Ongoing Individual schemes and overall programme subject to ongoing robust analysis and modelling to ensure any financial impact on providers is clear Lead: BCF information/analytics lead Timeline: Work undertaken but to be refreshed for each contracting round
Implementation of the schemes will result in an undesired increase in admissions to care homes	MEDIUM likelihood (3)	MEDIUM IMPACT (3) Measures of independence / outcomes for users worsen Organisation: Increased cost to Social Care Commissioners Social care sector providers are unable to meet increase in demand with a potential 'knock on' effect to health providers Financial impact – 10% increase in continuing care spend – £1,000,000 This impact will fall on CCGs bearing the cost impact of increased activity in CHC 10% increase in long term care costs - £70,000 This impact will fall on Local Authority social care with a cost impact of increased admission into long term	9	Ongoing leadership from the BCF Working Group/South Planning Group Lead: CCG Accountable Officer Sponsor Timeline: Ongoing Systems in place to monitor bed availably in care home sector Lead: Local Authority Service Director Lead Timeline: Ongoing Plans in place to use Intermediate Care / Assessment Beds flexibly as required to support transfer of patients out-of-hospital Lead: Local Authority Service Director Lead Timeline: Ongoing

		care		Rollout of the South Notts strategic intent on the 'Transfer to Assess' model which has been shown to reduce the number of new admissions to long term care. Lead: Local Authority Service Director Lead Timeline: Ongoing Implementation of recommendations arising from a review of community capacity plans to support Transfer to Assess approaches Lead: Local Authority Service Director Lead Timeline: Ongoing
There is a risk that the assumed reduction in residential and nursing home placements does not materialise	MEDIUM likelihood (3)	MEDIUM impact (3) The impact will fall on Social Care Commissioners through increased admission to long term care The impact will also fall on the social care sector providers where there may not be enough capacity to meet demand Financial impact – increase in long term care admissions £90,000	9	Activity modelling informed by evidence and local clinical opinion; model to include impact of best, base and worst case scenarios Lead: Local Authority Service Director Lead Timeline: Ongoing
Social care funding challenges result in a reduction of available care packages to support long-	LOW likelihood (2)	HIGH impact (4) Potential for health commissioners to have to redirect resources to support the plan	12	Mechanisms in place to ensure individual schemes and overall programme are subject to robust analysis and modelling to ensure

term care resulting in a shift in cost of long-term care to health		10% increase in social care packages of £780,000. This cost impact will fall on Local Authority Social Care		that the impact of funding cuts is identified and included Lead: BCF Programme Management Lead Timeline: Ongoing Social care engage/consult health before finalising their cost reduction proposals. Lead: Local Authority Service Director Lead Timeline: a) Ongoing during development and finalisation of plans March 2015; b) Ongoing as plans are refreshed thereafter. Development of whole health and social care system financial plan for 2015/16 to 2018/19 Lead: Director of Transformation Timeline: a) Initial plan December 2014 b) Plan further developed and refreshed on an ongoing basis thereafter
Improved outcomes/performance (KPIs not achieved) may not be evidenced in the short-term resulting in a lack of performance related funding	MEDIUM likelihood (3)	VERY HIGH impact (5) System failure (commissioner and provider, health and social care) due to a lack of funding. Financial impact of £1,900,000 as CCGs would be required to divert funds from other core priorities to	12	Profiling of outcome/performance improvement to take account of timescales to mobilise and see impact of schemes/programme Lead: CCG Accountable Officer Sponsor Timeline: Ongoing

		enable schemes to be delivered.		Ongoing monitoring of outcomes at a senior level through the BCF Working Group/South Planning Group with a robust approach to performance management Lead: BCF Programme Manager Timeline: a) Systems in place for April 2015; b) Ongoing from April onwards Ongoing monitoring and evaluation of programmes to ensure that services/projects within the programmes are fit for purpose and meeting expected outcomes within timescales Lead: Scheme Leads Timeline: a) Systems in place for April 2015; b) Ongoing from April onwards Services to be procured on an outcomes basis with funding linked to outcomes therefore a shared risk between commissioners and providers Lead: CCG/NCC Contracting Lead Timeline: Ongoing
Individual organisations develop strategies that could adversely impact on the successful development	LOW likelihood (2)	LOW impact (2) System failure Financial impact – as described in the	4	Accountability and Governance Framework for Transformational Programme to be implemented from September 2014. Framework

of the schemes/ programmes		risk of increased non elective admissions £280,000 This impact will fall across the health and social care community with CCGs bearing the cost impact of increased activity in the Acute Sector		recognises the right and need for individual organisations to pursue own objectives but in a manner that minimises unintended consequences to system change Lead: Director of Transformation Timeline: a) Framework approved by SNTB in September 2014; b) SNTB ongoing oversight of Framework from October 2014. Assurance process in place to ensure ongoing alignment of partner plans with the BCF Lead: BCF programme manager Timeline: December 2014 and annually thereafter
Identification of Care Act resources from existing BCF resources results in the inability to fully implement schemes and achieve KPIs	HIGH likelihood (4)	HIGH impact (4) Impact – Cost pressure on Local Authority and CCGs. Individual schemes will be at risk as delivery will need to impact with reduced resources Financial impact - £863,000 will fall across Local Authority and CCGs	16	Review of delivery and impact of schemes within identified budget Lead: Scheme Leads/BCF Programme Manager Timeline: Ongoing Review of implementation requirements of Care Bill Lead: Local Authority Service Director Lead Timeline: Ongoing

COUNTY-WIDE RISKS – 7 DAY SERVICES				
Recruitment of qualified and skilled preventive staff	MEDIUM likelihood (3)	VERY HIGH impact (5)	15	Ongoing leadership from Transformation Boards Workforce development plan in place, including a succession plan Review recruitment and retention plans (annual)
Insufficient support and leadership from senior health and social care managers	VERY LOW likelihood (1)	VERY HIGH impact (5)	5	Ongoing leadership from Transformation Boards Early engagement of partners at a senior level
Workforce culture and managing changing working practices	MEDUIM likelihood (3)	VERY HIGH impact (5)	15	Ongoing leadership from Transformation Boards Develop changes to working practices with teams Test changes to working arrangements so that staff can see the benefits
Scale and pace of implementation across providers does not align	MEDUIM likelihood (3)	VERY HIGH impact (5)	15	Ongoing leadership from Transformation Boards to ensure that patient / service user pathways meet requirements
Availability of IT and infrastructure resources	HIGH likelihood (4)	VERY HIGH impact (5)	20	Ongoing leadership from Transformation Boards to ensure that resources are available Develop and maintain links to Connected Nottinghamshire Programme

Diluting Monday- Friday provision to cover additional hours	MEDUIM likelihood (3)	HIGH impact (4)	12	Ongoing leadership from Transformation Boards Monitoring of situation at senior level to ensure sufficient resource and capacity
Increased demand for services due to the increased availability	MEDUIM likelihood (3)	VERY HIGH impact (5)	15	Ongoing leadership from Transformation Boards Monitoring of situation at senior level to ensure sufficient resource and capacity
COUNTY-WIDE RISKS – DATA SHARING				
Organisational systems won't be able to support the use of the NHS Number as the key identifier now or in the future	VERY LOW likelihood (1)	MEDIUM impact (3)	3	All identified systems across Nottinghamshire are now able to support the NHS number. Future systems would be specified with this as a requirement. Where an legacy system needs to provide information that may not have the ability the integration software would provide a mechanism to hold multiple indexes to allow matching externally to the system
NHS Number matching may not be possible in a timely manner impacting early identification of Primary Key Identifier	LOW likelihood (2)	MEDIUM impact (3)	6	Plans are in place across all organisations to ensure NHS number is populated manually via process or automated
Staff may not use the NHS number early enough or at all in communicating/identification	LOW likelihood (2)	MEDIUM impact (3)	6	Organisational change management plans (including training and communication) will be closely monitored

The integration technology required to support electronic communication of information (and later workflow) may not be delivered in the required timescales due to affordability. This would prevent elements of the business process changes	LOW likelihood (2)	MEDIUM impact (3)	6	Interim solutions are being put in place that could be further expanded should this occur. Delays could be managed but efficiency/ease of access to information would be impacted
Key systems may not have published API's (and supplier unable to provide) preventing the sharing of information in a timely way	LOW likelihood (2)	LOW impact (2)	4	Although this risk is difficult to militate against the ability to provide alternative mechanisms to data will ensure that this does not impact on progress
Required standards may not have been specified	HIGH likelihood (4)	LOW impact (2)	8	This risk is very likely to occur but with the Nottinghamshire IT Managers working group and the Data Advisory Group it is felt that there is a suitable operation body to define local standards. In addition any required standards not in place would be identified to the appropriate body (health or social care) to lobby for the creation of an appropriate Information Standard Bulletin (ISB) via the Health and Social Care Information Centre
Systems may not be able to manage the approved/chosen consent model	MEDIUM likelihood (3)	MEDIUM impact (3)	9	While it is recognised that not all systems will support an advanced or even basic consent capture and management it is felt that there are

				alternate methods to support this work should this be the cases limiting the impact
Staff may be risk-adverse to sharing information via electronic systems	LOW likelihood (2)	MEDIUM impact (3)	6	There will be some staff and some elements of data that it will be difficult to get staff to share routinely. This is why the communication and clinical leadership built into this work is vitally important and is considered good mitigation
One or more organisation may not accept the strategic direction for IG preventing the data required for care to be shared	LOW likelihood (2)	3	6	Connected Nottinghamshire has very senior level engagement and with the positive impact of the Records and Information Sharing Group the likelihood of this is considered low

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners.

The county-wide Pay for Performance (P4P) aspect of funding equates to 30% of the CCG revenue funding potentially subject to P4P measures. Total non-elective savings are as follows:

Financial Value of Non Elective Saving/ Performance Fund (as per Nottinghamshire Plan)	**£4,490,281**
Combined total of Performance and Ring-fenced Funds (as per allocation)	**£14,374,855**

As previously set out, Nottinghamshire is a complex health economy, comprising six CCGs working as three units of planning, and a two-tier local government structure, consisting of a County Council and seven District Councils. There is a wide range of voluntary sector providers, some with a very local focus, and some that are able to operate effectively across the county. The three major acute Trusts relate primarily to the three units of planning, although there are some cross-boundary flows and referrals in and out of county for tertiary services. Relationships between CCGs and providers, across CCGs, and with aligned health and social care commissioning with the Local Authority are strong, both collectively and individually. The Health and Wellbeing Board has been actively engaged in supporting and driving the BCF plan for Nottinghamshire, and considers the risk sharing approach to be appropriate for the complex environment described.

Our county-wide BCF governance arrangements have created a forum for discussing local and shared risks impacting upon integration transformation. These discussions enable shared learning and dissemination of best practice in terms of effectiveness of required interventions, and approaches to managing and mitigating delivery risks. While addressing local health and social care needs, the Transformation Boards in each of the three Units of Planning take a similarly robust approach to identifying, monitoring, reporting, and mitigating risks within individual schemes. Through development of analytical toolkits, a greater focus is being placed upon empirical measurements of risks and benefits.

At unit of planning and CCG levels, we have carried out modelling, taking into consideration the project status, timeliness of key milestones, and the Local Authority's budget challenge to establish the 'at risk' proportion of this. We have assessed that, due to the challenging nature of our non-elective reductions target, £1.53m is 'at risk'.

It is important that mitigation and contingency are enacted where, and at the level at which, the risk is incurred. This enables the risk to be effectively managed, ensures that the most appropriate mitigation is implemented, and crucially embeds accountability at the relevant point within the health and social care system. Some county-wide risk sharing arrangements are already in place, for example around continuing care. However, much risk sharing (particularly for non-elective admissions) is most appropriately administered at unit of planning level because of the provider geography

across the county. Therefore, all issues concerning risk and contingency will be managed at a unit of planning level. We consider this approach to be best suited to management of risk in a complex constitutional arrangement, wherein formal risk sharing across a number of statutory commissioning bodies cannot be practically enacted.

Any variation from plan at local CCG or unit of planning level will be analysed and investigated at this level, and the accountable unit of planning concerned will take corrective action and implement appropriate recovery plans. P4P 'at risk' funding will be paid proportionately in line with the split of contribution to the reduction in non-elective admissions, as per Part 2 of the template based on resident population.

The BCF Finance and Performance Sub-group reporting will ensure a clear line of sight across unit of planning mitigations and use of contingency and significant matters will be escalated up to the BCF Working Group.

CCGs have historically managed activity variances, and have a number of process and governance structures in place to identify these early and mitigate. CCGs hold both contingency and specific risk reserves based on calculated risk at plan stage, so these resources will be utilised should investment be needed for any mitigation or corrective action.

Mechanisms also exist and are built into provider contracts to manage and minimise the impact of any variation to the system. Furthermore, the whole focus of the schemes in the BCF plan is geared towards admissions avoidance, and the implementation of these (and therefore the investment) will be done in a planned and managed to way to allow flexibility to transfer resource should there be slippage within the schemes.

In addition, it is important to note that the schemes currently being implemented focusing on admissions avoidance have been developed across the health and social care community with full engagement. Therefore, each scheme has its own set of potential risks identified, mitigations, and contingency. At this level, this means accountability is clear and each organisation is clear on the risks to them and their planned response.

There are numerous precedents for cross-organisational risk sharing in Nottinghamshire. For instance, a financial risk pooling agreement for 2014/15 has been agreed by the Nottinghamshire County and Nottingham City CCGs that covers acute and critical care high cost patients, as well as 'one-off' major incidents. Furthermore, health and social care have an established history of managing risk through large elements of joint section 256 spending on reablement and other mutual priorities.

There also exists a precedent for budget pooling to achieve considerable savings and promote joint working. The Integrated Community Equipment Service (ICES) was formed in Nottinghamshire in April 2004 as a result of national government requirements. Nottinghamshire quickly established a partnership between the local authorities and health organisations, and the current ICES contract was jointly commissioned from 1 April 2011 as a county-wide service. The ICES budget is managed via a partnership arrangement by Nottinghamshire County Council, while the service is currently operated by British Red Cross and is jointly commissioned by:

- Nottinghamshire County Council (lead commissioner)
- Nottingham City Council

- All Nottinghamshire CCGs
- Nottingham City CCG

There are numerous formal and informal risk sharing arrangements with providers in place. For example, the Mid-Nottinghamshire CCGs' contract with County Health Partnerships, a community health services provider, sets out risk sharing arrangements on any shortfalls to QIPP delivery. One recent example of informal arrangements arose from Local Authority budget cuts having a significant impact on community health providers when intermediate care expenditure was scaled back – commissioners have since stepped in to jointly fund intermediate care facilities in care homes. Integrated commissioning boards further help to facilitate informal relationships that realise Nottinghamshire's collaborative commissioning intensions.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area.

The CCG operational and strategic plans outline priority areas for each local planning unit to deliver better integration and improved care to local people. The BCF plan is a cross-cutting subset of the entirety of this work already underway to deliver health and social care services locally. Likewise, the Health and Wellbeing Strategy concentrates on priorities where the Board can make the greatest difference, which the BCF schemes can now work to realise. As with any large-scale transformation, the total sum of all schemes, both within and outside the BCF, will act synergistically to deliver the mutual outcomes.

The BCF is therefore our catalyst to enhance the focus and speed of service integration to respond to increasing demand for services and funding pressures. The challenge we face is to maintain service delivery and development of nationally-defined initiatives, such as the implementation of personal budgets, while exploring new local approaches to put the person at the centre of their care and maximise efficiencies.

As a two-tier Local Authority area, housing plans are held within each of the seven districts; therefore plans are designed to respond to district-specific issues. Through engagement with the local CCG, joint priorities are identified for action. The Health and Wellbeing Strategy aims to promote a common goal for Nottinghamshire by ensuring we have sufficient and suitable housing, including housing related support, particularly for vulnerable people – an example of how the BCF will help realise this can be seen in the BCF plans for the North Nottinghamshire. Such common priorities will be monitored through the Board's governance process.

North Nottinghamshire

In North Nottinghamshire, the five-year plan sets out the collective vision for the health and social care economy – with which the BCF plan is fully aligned. Other initiatives include the following (with partners represented at the Bassetlaw Integrated Care Board):

- A joint approach to personal budgets and personal health budgets – this is interdependent with the schemes within the BCF plan
- The development of Bassetlaw District Council Regeneration & Growth Strategy (2014 – 2028, draft) - Bassetlaw District Council's plan is interdependent in relation to developing the skills and availability of an appropriate workforce. This will be achieved by working with partners to ensure the current and future workforce education and skills reflect the aspirations of high skilled employment, increased wage levels and a general increase in the Gross Valued Added metric within the district. This will impact on the recruitment and retention of suitably qualified staff to deliver schemes within the BCF plan
- The Invest in North Nottinghamshire project with the private sector to develop and promote the area regionally, nationally, and internationally as a place to live, visit, and do business. This new brand will be used to position the area of North Nottinghamshire as an attractive place to work, invest, visit, and live, thereby increasing new business investment, increased visitor numbers, and residents' appreciation of the locale's distinctiveness

Mid-Nottinghamshire

The schemes identified in the BCF form a key part of the Mid-Nottinghamshire CCGs' Better Together programme referenced in their five-year strategic plans. These strategic plans have been endorsed by local providers, including Nottinghamshire County Council and local District Councils. The CCGs are further developing partnerships with District Councils to ensure links are in place with local plans in relation to housing. This is important to ensure that the CCGs can advise and influence the NHS England Local Area Team on the primary care requirements of any housing developments. In turn, this facilitates planning for additional or changing population demographics on a locality level. The partnership also allows joint working on the wider determinants of health, and how combined CCG and District Council resources can offer more cohesive and comprehensive strategies and better commissioned services. Other innovations around prevention and increasing wellbeing to reduce health needs are in development at locality level.

The development of primary care is key to the success of Mid-Nottinghamshire's strategic plans and the specific schemes in the BCF. The Mid Nottinghamshire CCGs have expressed an interest in co-commissioning, and await a decision expected in October 2014 on what part they can play in working with the NHS England Local Area Team in improving the access and quality of care, along with the range of services that ensure patients receive care close to home. As part of the CCGs' approach to developing primary care, local strategic plans have been developed, forming the overarching strategy of NHS England in Derbyshire and Nottinghamshire.

Mid-Nottinghamshire's plans are based on JSNA findings and are aligned to the Health and Wellbeing Strategy for the county. Specifically, schemes have been developed to provide service users, carers and families with:

- Access to information and services that empower all, and meet a number of the priorities and, more specifically, the wider determinants of health such as welfare, housing, and safety
- The self-care strategy and implementation of the hub also seek to support carers and provide access and training facilities which, along with the co-ordination of respite care, provides an environment for carers. This aligned to the Primary Care Strategy, and the improvement of access allows carers to be looked after, as well as the patients
- Supporting people with long-term conditions through the additional specialist team and its interfaces with other services to avoid exacerbations of their conditions
- Supporting older people to be independent, safe, and well through risk stratification, early intervention support, and signposting services to maintain independence in their home or usual place of residence
- Providing services that work together to support individuals with dementia and their carers through the interface of locality teams with specialist intermediate care teams ,and changed ways of working to keep the patient at the centre of care planning
- The creation of a navigation hub allows patients, carers, and professionals to access services to support in times of difficulty, and to avert crisis and the need for hospital care. The hub also offers access to wider services that support delivery of other priorities across supporting victims of domestic abuse and co-ordination of

care for people with mental ill-health

In delivering these schemes, the use of technology is a critical success factor. The cross-cutting theme of Information Management and Technology (IM&T) is pivotal to getting information sharing within providers and across organisations. Technology approaches are also available to assist patients, such as the use of Skype as an alternative to appointments for those who find it difficult to get out of their homes, or the use of assisted technology such as 'Flo', which allows patients to self-manage and access health professionals when needed. Technologies also support people safely maintaining their independence in their own home with remote monitoring and call alerts. These options will all inform self-care strategy and delivery.

The co-ordination of the schemes and communication to ensure all initiatives are aligned will be managed by the senior management team within the CCGs, through the Transformation Board. The CCGs are also mindful while developing new and innovative services that there is a need to ensure the usual services are maintained and remain of a high quality as expected in the national constitution. To this end, the CCGs have developed an Operational Resilience and Capacity Plan.

All commissioners and providers in Mid-Nottinghamshire are part of the Transformation Board, whose role is to oversee the design and implementation of schemes, and also serves as a steering board to ensure that interdependencies and risks with other strategies and initiatives is monitored. In addition, the Mid-Nottinghamshire strategic plans have been endorsed by the Health and Wellbeing Board, who are updated on the developments of the programme. The CCGs are also working closely with Nottinghamshire County Council colleagues in understanding the changes required as a result of current and future cost reviews and the potential impact on the schemes included in the BCF.

South Nottinghamshire

There is good alignment between the BCF plan and other initiatives:

- As a health and social care community, it is acknowledged that there are significant financial challenges over the next five years. The CCGs and Nottinghamshire County Council are working to understand how changes required following cost reviews may impact on BCF schemes. Schemes within the BCF have been developed to meet best practice and optimum use of resources to ensure high quality and cost efficiencies, to best meet the needs of patient care
- Personal health budgets are offered to continuing health care patients in South Nottinghamshire through the Greater East Midlands Commissioning Support Unit. National evidence suggests that patients in receipt of a personal health budget are less likely to access unplanned care services and have more control over their own care. As such, this initiative supports the achievement of the BCF outcomes
- The South Nottinghamshire System Resilience Group (SRG) is the forum where all partners across the health and social care system in Greater Nottinghamshire come together to undertake the regular planning and review of service delivery across both planned and unplanned care. The overarching goals for the SRG are two-fold: to bring together both urgent and planned care, and to enable systems to determine appropriate arrangements for delivering high quality services

The SRG works across boundaries to improve patient experience and clinical outcomes,

through establishing partnerships and better working relationships between all health and social care organisations in the Greater Nottinghamshire area and health community. Specifically, it:

- Determines local service needs
- Initiates the local changes needed
- Addresses the issues that have previously hindered whole system improvements

There is a system resilience plan that aligns fully to the BCF plan, and will contribute significantly to the delivery of the BCF outcomes, particularly around urgent care. There are interdependencies between system resilience and BCF planning through the sharing of plans and KPIs, and collaboration of partners working across the system and the shared focus of integration of services across health and social care.

Ongoing communication between the related initiatives sits well with the South Nottinghamshire Transformation Board and associated five-year strategy, and provides the overall governance for delivery of improved outcomes for patients.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents.

North Nottinghamshire

For North Nottinghamshire, due to the partnership approach adopted for developing CCG plans with the local health and social care economy, schemes described in the Nottinghamshire BCF plan are all included within the two-year operating plans for 2014-2016 and aligned with the five-year strategic plans.

The Bassetlaw CCG Strategic Plan 2014-2019 can be found in the attached document 07.

Mid-Nottinghamshire

The schemes identified in the BCF form a key part of the Mid-Nottinghamshire CCGs' Better Together programme referenced in their five-year strategic plans. All of the schemes are included in two-year operating plans.

The Mansfield and Ashfield CCG and Newark and Sherwood CCG Strategic Plan 2014/15-2018/19 can be found in the attached document 08.

South Nottinghamshire

In September 2013, the three South Nottinghamshire CCGs and Nottingham City CCG came together in a unit of planning engaging citizens and partner organisations (NHS England, local government, and provider organisations) in the development of a unifying vision together with a two-year operating plan and five-year strategy, ensuring alignment with other local plans – including the BCF. The plans are based on:

- Re-shaping health and social care – care organised around patients, not institutions
- Organisational barriers coming down with teams working together
- GPs/primary care at the fulcrum
- Care predominantly in the home/community
- Hospitals for people who need to be in hospital
- Resources shifting from hospitals to primary and community care
- Changes based on clinical needs of patients, with patient safety paramount
- High quality, accessible, sustainable services based on real needs of the population

The BCF schemes are all included in the two-year operating plans and integral to the achievement of five-year strategy and South Nottinghamshire's ambition for an integrated, sustainable and accountable health and social care system that delivers excellent outcomes for the population served.

The Nottingham North and East CCG, Nottingham West CCG, and Rushcliffe CCG Strategic Plan 2014/15-2018/19 can be found in the attached document 09.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

North Nottinghamshire

Bassetlaw CCG has submitted an expression of interest to NHS England to co-commission primary care. This expression has been developed with the full support of the CCG Governing Body and involved regular engagement with member practices, including a number of discussions at the Members' Committee. Additionally, the CCG is working with other CCGs in South Yorkshire to explore areas of mutual benefit via collaboration.

Primary care is at the heart of delivering the strategic plan that the CCG has developed on behalf of the wider NHS and social care community. Integrating the delivery of care in the community with general practice co-ordinating the 'wraparound' of bespoke services for the patient is our aim. In particular, this applies to the frail and elderly, and to patients with multiple chronic conditions. It is in these areas where there is the greatest potential for deployment of the BCF to support our overall aims.

The Integrated Care Board will oversee the development of plans, explore the potential for synergies, and – if/where required – develop risk mitigation strategies. No risks are anticipated at this stage as the planning framework and assurance process for co-commissioning have yet to be released by NHS England.

Mid-Nottinghamshire

Mid-Nottinghamshire's five-year Better Together service strategy has focused on CCG directly commissioned services, although primary care will play a pivotal role in achieving plans for the future.

Whole-system commissioning is required if disease prevention, early intervention, and self-care are to become part of joined-up services. Co-commissioning between NHS England, social care, and CCGs will require strong collaborative relationships.

Mid-Nottinghamshire have sought views in defining the scope and nature of co-commissioning to be undertaken. A comprehensive scope is proposed, as this gives greater potential to develop and incentivise whole-system solutions. The extent of CCG involvement in co-commissioning can range from influencing NHS England decisions to joint commissioning to full delegated responsibility from the Area Team. A joint commissioning approach to also include social care is proposed because this helps to broaden involvement in decision making, while also enabling integrated care. This may also include pooled budget arrangements.

In order to manage GP conflicts of interest in a fair and transparent manner, it is proposed that a Committee in Common is established to make decisions regarding general practice, with close links to the Better Together Programme. This does not preclude clinical involvement in the design phase of commissioning.

It is clear that co-commissioning arrangements would need to robustly separate commissioner and provider interests, and would need to focus on better services rather than GP income. Primary care investment would not be about GPs taking more resource.

Instead, general practice would be at the centre of resources – the place where community, primary, and secondary care integrate around the needs of the population or patient.

South Nottinghamshire

In South Nottinghamshire, it is recognised that general practice has a pivotal role in the delivery of service ambitions as detailed in both the BCF plan and the five-year strategy. Consequently, the CCGs have already developed a close working relationship with the Derbyshire and Nottinghamshire Local Area Team in respect of the development and implementation of a local Primary Care Strategy. Specifically, General Practices have worked with their CCGs and the Area Team to produce an ambitious response to the Prime Minister's Challenge Fund. The Challenge Fund is being used locally to develop and test a range of innovative pilot projects during 2014/15 and, following evaluation, will be extended as part of the BCF plans in 2015/16.

In addition, in response to 'Transforming Primary Care' 2014, CCGs have commissioned GP practices to deliver a range of services that will support delivery of the BCF objectives, complementary to BCF schemes. These specifically aim to:

- Support GP practices in transforming the care of patients aged 75 or older
- Support the accountable GP in improving quality of care for older people
- Reduce avoidable admissions and re-admissions
- Reduce Emergency Department attendances and unplanned hospital admissions for people with chronic ambulatory sensitive conditions
- Reduce length of stay
- Improve patient health indicators, such as blood pressure, diabetes monitoring, and spirometry
- Improve integrated working between primary, community, and social care
- Improve sharing of information between providers
- Increase care provided closer to home
- Improve patient satisfaction

To further strengthen and clarify the collaborative co-commissioning arrangements between the CCGs and the Area Team, and in response to the letter from NHS England on 09 May 2014, the South Nottinghamshire CCGs submitted a joint expression of interest to develop new arrangements for co-commissioning primary care services, specifically those provided by general practice.

The submission confirmed the commitment from the CCGs to continue working in partnership with the Derbyshire and Nottinghamshire Area Team to agree how the CCGs might effectively contribute to the development of primary care services, and have a greater influence in commissioning decisions in respect of GP services. The CCGs have expressed a desire to work collaboratively with the Area Team to identify which elements of primary care would be most appropriate and beneficial for the CCGs to co-commission, in order to support delivery against the commissioning intentions detailed in the five-year strategy, the two-year operating plans, the BCF plan, and those which might impact most on the sustainability of primary care.

The South Nottinghamshire CCGs acknowledge that the development and transformation of primary care is an essential element in the NHS plans for transformation, including

delivery of schemes identified in the BCF plan. The CCGs have therefore welcomed the opportunity to have greater involvement in primary care commissioning, where to do so would:

- Support the development and delivery of integrated health and social care services, to enable patients to be cared for in their own homes where possible, and to reduce the requirement for acute hospital admissions
- Make primary care commissioning more responsive and locally sensitive
- Enable primary care commissioning to be undertaken in a more coherent fashion around the Health and Social Care Integration agenda and BCF work
- Provide greater potential to develop and incentivise whole-system solutions
- Support improvement in the quality of primary care
- Enable CCGs to flex local GP contracts (PMS) in order to support delivery against BCF plan objectives
- Support delivery of a whole-system commissioning strategy in order to prevent disease, and promote early intervention and self-care

The CCGs will continue to work with the Area Team over the next few months to explore and agree a model for co-commissioning of primary care in South Nottinghamshire, and to identify associated risks.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending).

In accordance with the current Fair Access to Care Services (FACS) eligibility criteria, the agreed local definition of protecting adult social care services is:

- Those care and support services for people who would otherwise have critical or substantial risk to their independence

The Care Act introduces new regulations and statutory guidance that set the new national framework for eligibility. The new criteria require local authorities to consider the physical, mental, and emotional wellbeing of individuals in need of care. The regulations place emphasis on undertaking combined assessments where service users have health as well as social care needs. There is also a strong emphasis on taking into account people's fluctuating needs and their overall wellbeing.

In Nottinghamshire, it is anticipated that the new eligibility framework will mean that higher numbers of people will require an assessment of need for social care services, and more people are likely to be eligible for social care services. In order to meet these anticipated pressures, an element of the BCF allocation is being directed at preventative services that seek to reduce and/or delay people's need for long-term care.

The BCF allocation for protecting social care services is being targeted at the following:

- Enabling the Local Authority to meet increasing demand arising from demographic changes with an aging population, and as a result of medical advances as people with complex health and social care needs are supported to live longer
- Helping maintain essential social care services
- Working with health and social care providers to ensure there is a robust and diverse market of care services to meet increasing demand
- Supporting and investing further in preventative services which help people to remain independent
- Helping meet cost pressures arising from the Care Act 2014
- Supporting innovative ways of delivering health and social care services to help realise efficiencies and savings

ii) Please explain how local schemes and spending plans will support the commitment to protect social care.

The BCF allocation to protect adult social care services will focus on the principles of promoting independence and self-care. Many of the services are aimed at helping people to regain and retain their independence, so that they then require reduced levels of support in the longer term following recovery from a period of illness.

However, it is evident that the number of people with complex health and social care needs, including dementia and long term conditions, continues to rise. This places considerable pressure on overstretched health services and on Local Authority care services at a time of severe financial constraints. A number of the services outlined below are therefore aimed at meeting the longer term needs of older people with complex needs, and for younger adults with complex health and social care needs arising from their disabilities. The services that will be funded from the BCF allocation include:

Community-based care services for frail elderly people

These services enable people to live independently in their own homes for as long as possible, through the provision of targeted care and support including home care, high-level dementia care, community equipment, and assistive technology. These services are also focusing on supporting higher numbers of people with dementia to remain living in their own homes. The services are arranged through managed budgets where required, but people are increasingly being supported to arrange and manage their own care services through Direct Payments. Nottinghamshire has one of the highest numbers of people accessing services through Direct Payments, and a high proportion of the BCF allocation for protecting social care services is being used for services purchased through Direct Payments.

Social Work and Occupational Therapy assessment and care management staff

These will be targeted specifically at preventing avoidable hospital admissions, as well as supporting swift and effective hospital discharge, especially in relation to frail elderly people – with the intention of reducing re-admissions following discharge.

Long-term nursing care placements

These support increasing numbers of older people and younger adults who require nursing home placements due to their complex health and social care needs.

Supported living

This is designed to meet increasing demands for supported accommodation for younger adults with complex health and social care needs arising from their disabilities, to enable them to live independently in the community, and to prevent or delay the need for residential or nursing care. Many of the service users also have continuing health care needs.

Community-based care services for younger adults with complex health care needs

These aim to meet increasing demand for large complex packages of care to support people with learning disabilities to remain living at home. The services also enable carers to maintain their employment and to have a break from their caring duties.

Short term and targeted housing-related support services

Such services are for vulnerable people, including people with mental health needs or those who require support to manage alcohol or substance misuse. The services seek to prevent vulnerable people from experiencing crises, which would then require longer term or more costly interventions, such as urgent care and presentation at hospital emergency departments.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties).

As detailed in the list of schemes contained in Part 2 of this plan, each of the three localities has explicitly allocated the mandatory funds for the specific purpose of protecting social care services (summarised in the below table). This commitment is made in addition to other BCF schemes that will also be providing additional support to social care, both directly and indirectly.

Locality	**Protecting Social Care Services**	
	2014/15	**2015/16**
North Nottinghamshire	£2,277,000	£2,277,000
Mid-Nottinghamshire	£6,245,000	£6,245,000
South Nottinghamshire	£7,645,000	£7,645,000
County-wide Total	**£16,167,000**	**£16,167,000**

Supporting the allocation of the funds is a detailed breakdown of the schemes, identification of health gain, and the approximate number of people that each allocation will support.

The local health and social care economy acknowledges and accepts its responsibility to identify funding to support implementation of the new duties that will come into effect from April 2015 as a result of the Care Act (see scheme Z in Annex 1), in line with requirements in the BCF guidance to do so. Based on published national allocations, this amounts to £1,946,000 for Nottinghamshire.

Work is underway to identify the precise methodology for enacting this within the agreed pooled budget, and all parties have committed to identify how this will be achieved. Agreement has been given by all parties to underwrite the appropriate level of funding. Robust arrangements for managing the adverse impacts of any reduction in investment from other BCF schemes are being developed, and are referenced in the risk logs where appropriate.

It is also recognised that an additional £735,000 capital investment funding (including IT systems) is required, but further guidance is awaited as this is not referenced in the published national Care Act allocations.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met.

Nottinghamshire County Council has commenced planning and preparation for implementation of the Care Act requirements. Governance arrangements are in place and progress is being reported, via the Adult Social Care and Health Committee, to the Health and Wellbeing Board.

A small Care Act Implementation Team has been established, led by the Care Act Programme Manager, and ten workstreams plus four enabling workstreams have been set up with identified workstream leads to ensure timely implementation of the new and extended duties and responsibilities. Detailed work has commenced to enable implementation of Part One of the Care Act, the social care reforms, which come into force from April 2015. Some of the work is briefly outlined below:

Assessment, personalisation, and eligibility

- Review of assessment and support planning tools, and development of alternative ways of access and assessment for care and support, including online, telephone, or clinic-based assessments and reviews
- Revision of all guidance, policies, and tools to accommodate the national minimum eligibility threshold

Carers

- Ensuring compliance with new and extended requirements of the Care Act, including the right to assessment, meeting a carer's needs for support, and the duties to assess a young carer or parent carer
- Assessing the impact of the new requirements on cost and demand, and exploring cost effective and efficient approaches to meet new requirements

Prevention and housing

- Reviewing the breadth and coverage of information, advice, and preventative services, and the extent to which integrated services with housing and health partners might deliver better outcomes
- Development of a more integrated solution to accommodation needs

Advice, information, and advocacy

- A review has been undertaken of the 'Choose My Support' online directory, which provides information and signposting. Alternative systems are being looked into and evaluated against the principles laid out in the Act. The aim will be to align this with the information tools used by District and Borough Councils and health colleagues

Strategic market development and quality and risk

- New home-based support and supported living services have been commissioned, jointly with the CCGs, from independent sector providers who embed reablement principles, placing emphasis on promoting independence and self-care
- Reviewing and updating the Market Position Statement to ensure it is fully compliant with Care Act
- Development of a process to undertake to assess and maintain an overview of

provider viability and potential provider failure

Detailed financial modelling and analysis is currently being undertaken to calculate the anticipated additional costs arising from implementation of the Care Act, both in relation to the social care reforms to be implemented from April 2015 and the funding reforms that are due to come into effect in April 2016.

Initial modelling suggests that the funding earmarked in the BCF for implementation of the Care Act may not be sufficient to meet the anticipated full costs of Part One of the Care Act, the social care reforms and the related new and extended duties.

However, the specific funding identified for 2015/16 for implementation of the Care Act will be targeted at the following initiatives and services:

- Targeted services such as reablement, community equipment, and assistive technology, which help prevent avoidable hospital admissions, promote independence, and reduce the need for longer term care and support
- Further development of collaborative and partnership working with the NHS and with local authorities with housing responsibilities (District and Borough Councils) to progress innovative and cost effective ways of commissioning services that focus on short-term support and promote independence and self-care
- Provision of comprehensive information and advice available to the citizens of Nottinghamshire, so that they can plan and make informed choices about their current and/or future care and support needs, and which delay or prevent the need for Local Authority interventions
- Meeting additional demand for carers' breaks and carers' support services, including through use of Direct Payments for carers

v) Please specify the level of resource that will be dedicated to carer-specific support.

Resources are outlined in our Part 2 financial plans. Those schemes specifically dedicated to carers include:

Ref	Scheme	Carer-Specific Support 2014/15 (£000)	Carer-Specific Support 2015/16 (£000)
E	Support for carers	767	666.15
N*	Improved primary care access and support closer to home	0	734
V	Respite Services	325	325
	Total	**1,092**	**1,725.15**

*Note that this is not the entire budget for scheme N, but only the element to support carers.

These schemes will all contribute to our county-wide Carers' Strategy and Action Plan in the attached document 10.

vi) Please explain to what extent has the Local Authority's budget been affected against what was originally forecast with the original BCF plan?

Nottinghamshire County Council's Medium Term Financial Strategy forecasts a £77m budget deficit over the next three years (2015/16-2017/18). This gap takes into account the £16.1m BCF allocation for protecting social care services, and follows total savings already made in previous years and already identified for future years, of almost £200m. The BCF allocation is therefore important in helping the authority to protect social care services, against a backdrop of significant financial challenges.

We will use the momentum, commitment, and relationships gained through developing the BCF plan to continue to explore options for further integration of health and social care that could give rise to further savings (e.g. by reducing duplication of services and supporting a greater emphasis on self-care, to reduce dependence and optimise independence). Work also continues to better understand the implications for the County Council and its partners of these opportunities, and health colleagues are fully engaged in these discussions.

In our April BCF submission, we indicated that we will be allocating appropriate funding for implementation of the Care Act. We have since identified a mechanism for allocating our local proportion of the national £135m contribution to the Care Act implementation within the overall BCF pooled budget, which equates to £1.9m. However, our early modelling suggests that while this will assist with the implementation costs, the ongoing costs arising from the Care Act will add further, significant cost pressures to the Local Authority, which at this time are unfunded.

Our commitment to joint working is exemplified by the financial value of the BCF schemes in 2014/15 and the 2015/16 pooled budget across the county. As part of this submission, the Nottinghamshire BCF plan also sets out further schemes contributing to social care services above and beyond the £16.1m allocation, as we recognise the increasing importance of health and social care integration.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends.

Nottinghamshire is committed to providing 7 day services within the Joint Health and Wellbeing Strategy, and its local planning groups. The principles were consulted on as part of the refresh of the Joint Health and Wellbeing Strategy aligned with all National Conditions.

7 day services to support hospital discharge and avoid admissions to both hospital and care homes are particularly key to supporting the strategic principles. One related initiative to support our vision for 7 day services has been the involvement of primary care in discharge planning following an emergency admission.

Nottinghamshire currently has a number of 7 day services already in place, such as Rapid Response Teams and Intermediate Care Teams, and a number of new services are outlined in the BCF plan, such as a 24/7 acute care liaison service, where gaps in provision have been identified by local planning groups. The continuation and/or expansion of existing services are crucial to delivering the change required. To ensure a consistent approach across Nottinghamshire, a 7 day services working group was established led by a senior Local Authority officer, with CCG and Public Health Consultant input. This working group took a multifaceted approach to:

- Comprehensively baseline the availability of key health and social care services across acute, community, and primary care identified from the Keogh report, the Academy of Medical Royal Colleges 2013 report, Seven Day Consultant Present Care, and expert knowledge of the system
- Follow Cochrane Review processes to systematically search the published literature in order to provide evidence-based advice from published research, locally commissioned research, and evaluations to develop evidence based recommendations on the impact that particular services can have on our BCF goals
- Use these evidence-based statements to develop a county-wide position with timescales for delivery for the duration of the BCF period and beyond
- Work with the three planning groups, which include commissioners and providers, to identify how 7 day services will be implemented in their individual localities

A copy of this delivery plan is included with this plan in the attached document 11.

A process for agreeing Action Plans with providers to deliver the clinical standards for 7 day services is in place. Contract negotiations have already taken place with providers, with final Action Plans to be agreed and varied into contracts. For example in North Nottinghamshire, 7 day services were discussed and agreed at the Integrated Care Board. Following this, Service Development and Improvement Plans for Doncaster and Bassetlaw Hospitals NHS Foundation Trust and Bassetlaw Health Partnerships (Nottinghamshire Healthcare NHS Trust) were varied into provider contracts. Key milestones and delivery timescales will be included within each provider contract as appropriate to that provider.

The desired impact of each service moving to 7 days is indicated in the delivery plan with reference to published literature and local evaluations as applicable, including the impact on admission avoidance and facilitating hospital discharge. These individual schemes will be monitored and evaluated to ensure that the desired impact is being achieved. Evaluation findings of local 7 day initiatives will be shared amongst Nottinghamshire's planning groups. Local planning groups will be responsible for reviewing the findings, and refining plans for their areas as appropriate over the duration of the BCF period.

All local contracts use the nationally prescribed contract framework for 2014/15, and require commissioners and providers to work proactively to develop and improve services for patients. The requirement to deliver service transformation is embodied in local provider contracts, and providers have committed to actively participate in the key planning structures that will deliver 7 day working, particularly around admission avoidance and supported hospital discharge. Progress on delivery through 2014/15 and beyond is monitored through local Transformation Board and BCF structures, but also through the Contract Executive groups of all main provider stakeholders.

The established planning workstreams will deliver the completed Action Plan for the roll-out of 7 day working going forward. During 2015/16 and 2016/17, the full complement of actions described in the BCF will be referenced in all provider contracts. The requirements for the 2015/16 contract round will be fully referenced in the CCGs' commissioning intentions in October 2014 and will form part of the service and quality specifications appearing in draft contract documentation from December 2014. The final specifications will be signed off and agreed in February 2015 as part of the contract sign-off process.

Local planning groups will monitor and manage risks in their own areas. Risks identified by each locality in the risk logs are applicable to the move to 7 day services. For example, each planning unit identified the recruitment and retention of sufficient numbers of suitably qualified and skilled staff, which is a key enabler for delivering 7 day services.

Additional county-wide risks pertaining to 7 day service implementation are highlighted in the main risk logs.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services.

Plans to use the NHS umber as the primary identifier for correspondence across Nottinghamshire providers is progressing well and on track. Formal agreement has been reached across health and social care providers that the NHS Number will be the primary identifier across health and social care records. Good progress has been made during 2014/15 for expansion of the NHS Number use.

The NHS Number is currently in use in all NHS organisations, and used as the primary unique and unambiguous identifier, supporting communication with other providers of healthcare services for the purpose of direct patient care. With modern systems in place, the timeliness of NHS Number matching is primarily at the point of contact via PDS linked PMI trace. Recent research puts tracing/use of NHS number at 98% in the main providers, with the Ambulance Service matching 65% of electronic records within 24 hours.

Matching and recording of NHS Number across social care systems is in place and ongoing via direct entry or batch tracing of NHS number via PDS. Key systems have been modified to support the storage and use of the key identifier. Using the MACS Service, social care system data has been submitted from the local authorities and matched to NHS Numbers, which are then data quality checked and uploaded. This work is progressing, but there is still further work to be done, particularly on matching those records that do not return with a positive identification.

Early identification of the NHS number is important as it forms the underpinning link between records across all systems. For this reason, processes have (and must continue to be) reviewed to ensure this happens at the first point of contact within the care system. The idea of a Nottinghamshire-wide integration system to provide the cross-organisational data required to provide a “whole system” Nottinghamshire Care Record has been signed up to by all members of Connected Nottinghamshire. The Connected Nottinghamshire Programme of work is driving the strategic direction for this integrated record. It is hoped that a recent joint Nottinghamshire health and social care bid for national funding will provide a boost to the speed at which the technology to support this can be delivered. A contractual Commissioning for Quality and Innovation (CQUIN) scheme has also been put in place with all NHS providers locally to drive information sharing and support this development.

Until this new technology is available, cross-organisational access to systems at specific points of care delivery is being put in place to support the immediate operational needs for teams working across health and social care. This “turn chair” type system access, while not ideal due to potential requirement for dual entry, gives the ability for care to be better co-ordinated. It offers visibility of all aspects of the care being delivered – this is one of the capabilities set out as a priority in the early business re-design workshops.

The table below sets out the forthcoming key milestones, along with expected and required dates. The overall plan is reported by the Connected Nottinghamshire Programme Director and monitored by the Connected Nottinghamshire Board. A number of the milestones are inter-organisational, and some require cross-organisational

delivery.

Milestone	Date
Completion of NHS Number tracing in local authorities (MACS)	September 2014
Interim solution – cross-organisational access to key systems (Framework, Carefirst, EMIS, SystmOne, plus localised requirements for teams)	October 2014
Processes in place for resolution of non-matched and ongoing number matching	December 2014
Review of processes to ensure early identification of NHS number	(Continual review process as services come online with NHS number access) Target date April 2015
Integration technology in place to support Nottinghamshire Care Record information sharing	January 2015 (Phase One)
Integration technology in place to support Nottinghamshire Care Record workflow	October 2015

Connected Nottinghamshire also manages the risks and issues associated with this work. The key risks relating to provision and use of the NHS Number are shown in the main risk logs.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK).

The Connected Nottinghamshire Programme has been set up to support integration across health and social care providers in Nottinghamshire. It maintains a strategic oversight of system developments, supporting the move to information that can follow the citizen/patient in a safe, secure, and reliable way. This requires the use of published Open APIs, as well as a number of other functional requirements. As part of any procurement exercise undertaken, the requirement for use and publication of Open APIs is now mandated.

A standards-based approach is the strategic direction across Nottinghamshire, and the Nottinghamshire IT Managers Group and Data Advisory Group, working to support the Connected Nottinghamshire work at an operational level, supports setting the standards to use or working to create them where they do not exist. While it is frustrating that there are not more Interoperability Toolkit (ITK) standards to support enriched integration of information and messaging/workflow exchange, those that are available are used. Where they exist, standards-based protocols, messaging, and data standards are followed. These are either sector-specific or IT best practice standards.

The issue of legacy system publication of APIs remains a challenge in some areas. Older legacy systems are an area where obtaining APIs can be difficult. Some of these systems are based on non-current database and application/programming technologies. Assessment of the systems across Nottinghamshire has been carried out, and although Open APIs might not be available for all systems, it is felt that there are credible, safe, and secure mechanisms through which data can be accessed despite this, when a form of integration platform is used (be that a localised integration engine or system-wide integration tool). Hosted primary care and community care systems have been difficult to integrate in some areas, but it is hoped that with the latest GP System of Choice (GPSoC) specification that this will change to allow easier cross system access.

The Commissioning for Quality and Innovation (CQUIN) scheme across NHS providers for information sharing supports providers developing mechanisms to provide cross organisational data flows. While this work has started with the Comprehensive Geriatric Assessment and End of Life datasets, it is anticipated that the integration technology put in place to support these will provide a platform for further developments.

Currently, approximately 65% of existing systems have defined APIs. It is anticipated that with the organisational migration plans currently in place that this will move to 95% in the next 18 months.

Part of the work to support the Nottinghamshire Care Record is assessment of providers' internal systems to identify APIs. Where these are not available the alternate methods for data exchange are to be identified. It is recognised that some data items may not be available in real time, but rather a batched or cached version of the data would be held. Assessment of the time sensitivity of these data items is part of the work to achieve the Nottinghamshire Care Record.

The table below sets out the forthcoming key milestones, along with expected and required dates.

Milestone	Timescale
Data sharing via APIs or identification of alternate method	January 2015 (Phase One)
Integration technology in place to support Nottinghamshire Care Record information sharing	January 2015 (Phase One)
Assessment of key organisational systems and API statue	(Ongoing due to local organisational procurement/system changes and updates) Target date April 2015
Assessment of key data items to be shared, and mechanisms to support sharing	April 2015
Integration technology in place to support Nottinghamshire Care Record workflow	October 2015

Connected Nottinghamshire manages the risks and issues associated with this work. The key risks relating to provision and use of Open APIs are shown in the main risk logs.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

Nottinghamshire is working together as a health and social care community to develop and implement system-wide best practice information policies and protocols to support the sharing of patient/citizen confidential information.

The Nottinghamshire Record and Information Sharing Group, which is GP and Caldicott Guardian led, is implementing the actions from the Caldicott 2 review and subsequent response by the Department of Health. This group brings together the professional standards and best practice guidance to ensure the appropriate level of information is available to support the delivery of the best possible care. A standardised consent form is being developed (current draft attached in document 12) to be shared across all providers to support the complex requirements of sharing across multiple providers. Accompanying guidance to public and care professionals has been produced and it is hoped that this work will simplify consent capture while supporting sharing for the delivery of joined-up care. A communications campaign to highlight the need to share information is to be delivered alongside the launch of these new tools.

There is heterogeneity in the maturity of the information systems across Nottinghamshire. Some are very advanced and have complex models for IG consent, while other systems have little or no ability to collect information on consent to share. Part of the requirement for delivery of the Nottinghamshire Care Record, and the integration technology that will support it, is that the ability to communicate, record, and revoke consent is possible. This new technology will offer a way to manage consent across care providers.

The interim phase of information sharing is well underway, and in relation to IG is primarily internal system focused. Use of “turn chair” cross-organisational access to systems in key parts of care provision is providing a mechanism to access information where systems aren’t joined up. Supporting this is the use of contractual arrangements for employment and confidentiality, information sharing agreements, and the overarching Information Sharing Protocol for Nottinghamshire (attached in document 13).

All member organisations of the Records and Information Sharing Group complete the required Information Governance Toolkit returns, and are meeting the required minimum standards. Working to implement the aims of the Caldicott 2 review is a core function of the group, and in particular to promote the sharing of information for direct care.

Work on the capture and use of consent against the NICE Clinical Quality Guidance is underway, and forms part of the baseline work. Once this is completed, it will give further intelligence on the future steps needed to support the best practice adoption of the best consent model.

The table below sets out the forthcoming key milestones, along with expected and required dates.

Milestone	Date
Completion of standard consent form and roll out	January 2015
Completion and sign up to updated Information Sharing Protocol	January 2015
Confirm consent model to be implemented as part of Nottinghamshire Care Record integration tool work	April 2015
Baseline of consent	April 2015

The Records and Information Sharing Group reports into the Connected Nottinghamshire Programme Board and manages the risks and issues associated with this work. The key risks relating to the IG plan are shown in the main risk logs.

d) Joint assessment and accountable lead professional for high risk populations

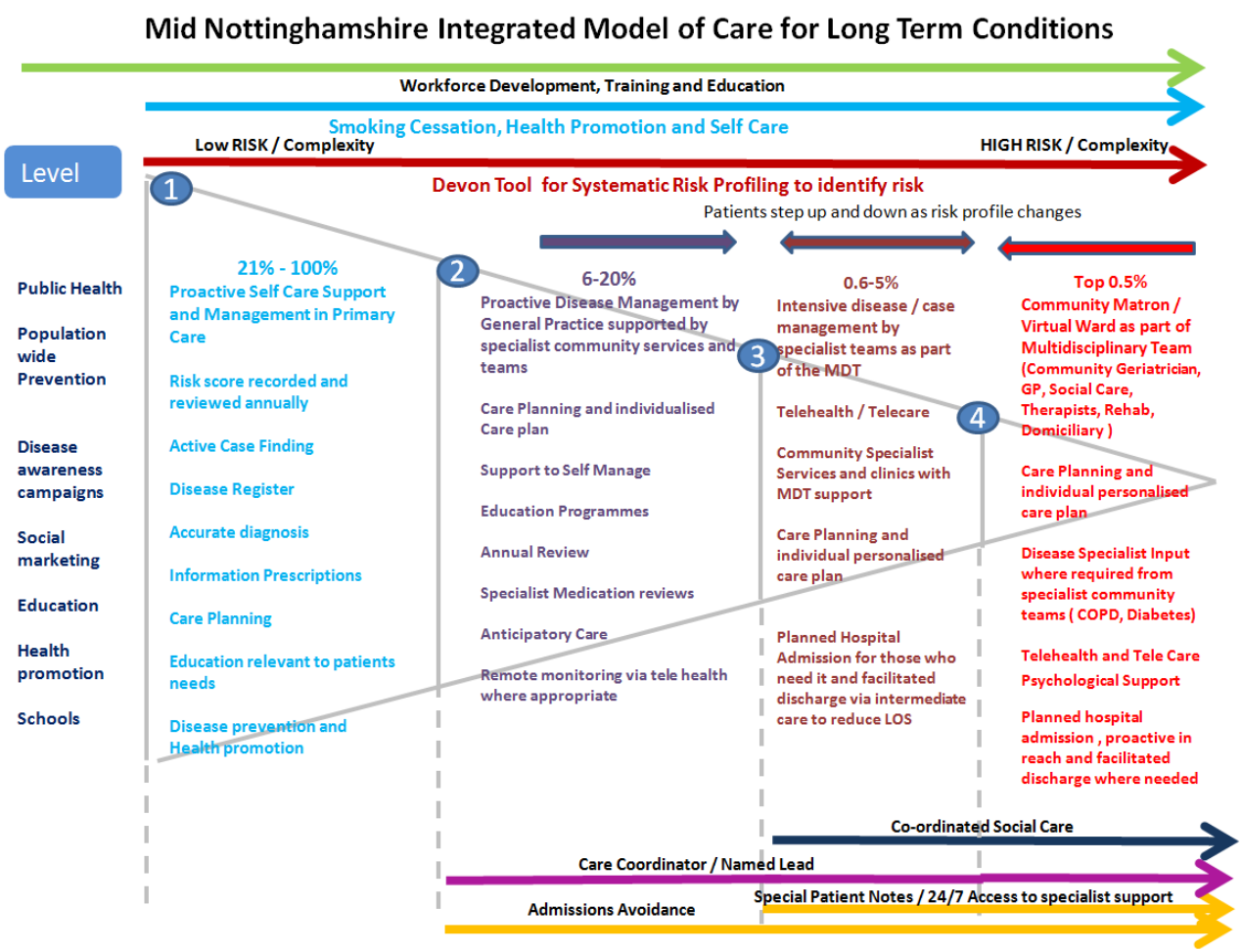
i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them.

A systematic process is employed to risk stratify the whole of any GP practice population by using a Combined Predictive Model tool (Devon tool) or Care Plan Management tool, which give high accuracy levels predicting risk of hospital admission.

South and Mid-Nottinghamshire use the Combined Predictive Model tool, which is web based and accessed via a platform known as e-healthscope. The tool combines risk register data from the practices' clinical management systems, with their hospital activity data within e-healthscope, and applies a risk (of future admission) to the entire registered population of the practice. The information is refreshed and utilised every month in every practice as part of the MDT meetings, which involve the practice GPs and the MDT members.

This process has been developed and embedded across South and Mid-Nottinghamshire since 2009. All GP practices are now using the Devon tool by using the risk score to risk stratify the whole of the practice population by levels 1- 4 risk of hospital admission where level 4 is highest risk (see Long Term Conditions pathway on the next page).

Generally, around the top 0.5% of any practice population is at level 4, or very high risk of admission. The next 4.5%, or level 3 patients, are at high risk of admission. The tool can also demonstrate those patients whose risk score has rapidly increased within a given timeframe, and therefore may soon become level 3 or 4, even though they may currently be below this.



Similar to the Combined Predictive Model tool, North Nottinghamshire use the Care Plan Management tool, which was developed in partnership with the South Yorkshire and Bassetlaw Commissioning Support Unit, and is also being used by Sheffield CCG. The tool ranks patients in order of Care Plan Management (CPM) score – the higher the score, the greater the risk of an admission into hospital.

Both tools generate a list of patients within registered GP practice populations to be discussed at a monthly multi-disciplinary team (MDT) meeting, normally chaired by a GP, so that the necessary support can be offered by integrated teams or virtual ward teams to prevent an avoidable admission. The MDT will also use softer intelligence gathered from the professionals present to identify those who may benefit from interventions from the integrated teams but who have not yet been flagged by the tool (for example when there has not been a recent history of admission or attendance at secondary care, hence SUS data not strongly influencing risk score).

By using both a good IT-based tool that is easy to use together with more local and softer intelligence from the professionals who know their patients and carers well and understand what the normal stable condition is for a patient, it is possible to identify patient numbers and type of support required. We are working towards enhancing the current configuration of data available for the tool to include a comprehensive and wide set of primary, secondary, and community care data.

The integrated care teams across Nottinghamshire include or link with social workers with access to social care data systems at their clinical work base, facilitating retrieval of

centrally-held data sources that help to inform risk identification, plus other social care history of interventions and joint planning of care with wider social care teams. The wider MDT also encompasses clinicians from Mental Health Services for Older People, as well as the third sector to ensure delivery of a holistic service.

Moreover, risk of admission can be raised by any team member on an ad hoc basis and does not need to wait to be discussed at the monthly scheduled MDT meeting.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population.

The MDT meeting provides a forum in which the integrated teams can engage in the joint process to assess risk and plan care but, as with identifying risk, the team members can initiate a discussion at any time.

Patients with a high or escalating risk of admission are reviewed, and an MDT case management plan is developed and mobilised. Patients identified by this process are admitted onto the caseload or virtual ward, with their needs fully assessed and reviewed as part of MDT meetings until they are stepped down to the most appropriate level of care within the wider integrated health and social care team.

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

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

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

It is likely that lead accountability for oversight and ownership of the patient's care plan will nearly always sit with the GP, but could be another care professional according to the patient's particular health and social care needs. Medical accountability will remain with the GP, but care co-ordination and delivery responsibility will be allocated to the individual professional who can most effectively manage the integration of required interventions through the MDT.

The model of the integrated care team includes a voluntary sector worker to both assess needs for support from the third sector, as well as contributing to holistic care planning and provision of low-level support as appropriate. Team members will liaise with wider community teams, for example with mainstream mental health services, so that the most appropriate specialist support and advice can link with the integrated team care co-ordinator. The integrated team would allocate a lead professional to ensure that all care planning is patient-centred and co-ordinated with all professionals involved.

There are occasions when other mainstream services are more appropriate to become the patient's key care co-ordinator in order to support the person well, such as if a person requires specialist learning disability support or has established good relationships for dementia care where changing the main care co-ordinator would compromise outcomes for patients.

Professionals working in the acute sector work closely with the integrated care teams to ensure that risk, and planning of care to address that risk, is shared in a timely manner through care co-ordination and community hubs based in each locality. This is both as

people are assessed on attendance at the front door, or during their stay in hospital, and (wherever possible) for the integrated teams to be involved in joint discharge planning very soon after admission to acute services. In this way, both clinical and social care professionals plan care jointly between hospital-based and community services.

The integrated care teams, and in particular the mental health nurses in the teams, have established links with hospital-based mental health services, such as Rapid Response Liaison Psychiatry (RRLP) and Acute Care Liaison, as well as community based teams like mental health intermediate care teams and community dementia liaison services to facilitate seamless support for people with mental health problems.

Referrals from the integrated care teams (which include integrated mental health workers and volunteers whose role is to enhance access to IAPT, dementia diagnosis and other support mechanisms) to IAPT are increasing, and this is expected to be a continuing trend. In Mid-Nottinghamshire, services specifically target older people and Eastern European communities, since they currently appear to be under-represented in IAPT referrals.

Across Nottinghamshire, GP practices have signed up to deliver the Avoiding Unplanned Admissions Enhanced Service. This enhanced service is designed to help reduce avoidable unplanned admissions by improving services for vulnerable patients and those with complex physical or mental health needs, who are at high risk of hospital admission or re-admission. The aims are to encourage GP practices to:

- Increase practice availability via timely telephone access
- Identify patients who are at high risk of avoidable unplanned admissions, establish a minimum two per cent case management register, and proactively manage these patients
- Review and improve the hospital discharge process for patients on the register, and co-ordinate delivery of care
- Undertake internal practice reviews of emergency admissions and A&E attendances

iii) Please state what proportion of individuals at high risk already have a joint care plan in place.

All individuals identified as high risk of admission by the integrated care teams via the monthly MDT meetings or by ad hoc discussion have a joint care plan shared by all professionals involved across health and social care. This is supported by IM&T developments to provide online access to, and sharing of, clinical records where permission is given by the patient for the professionals, including the trained support workers, to view and make entries.

Further developments are planned in relation to sharing care planning to support comprehensive geriatric assessment building on a pilot within the last twelve months to implement an electronic template with connectivity using SystmOne IT software, enabling secondary care and primary care professionals to jointly work contemporaneously on care planning.

The principle of developing a care plan with the patient as an active partner is fundamental to the approach used by the integrated care teams. Professionals have already been trained as Trainers to roll out the Year of Care approach to care planning, which utilises motivational interviewing techniques and encourages individuals to make choices about how their care needs will be met with the professional, and for these choices to be adopted in their care plan.

8) ENGAGEMENT

a) Patient, service user, and public engagement

Please describe how patients, service users, and the public have been involved in the development of this plan to date, and will be involved in the future.

Our vision of integrated care is important, but it is how outcomes are met and experienced by the citizen that really matters. Nottinghamshire's plan for integrated care has therefore been designed with the needs of the citizen at its core. Accordingly, we have deliberately implemented all engagement activity at locality level, based on prior experiences on how to best achieve deep and impactful engagement. A further county-wide communications and engagement approach will be developed if necessary as the BCF schemes are implemented.

Patient representatives across the county have been engaged in the development of the plan through the HWB Stakeholder Network. Healthwatch are also represented on our Health and Wellbeing Board, as well as the South Nottinghamshire Transformation Board. This Transformation Board is co-chaired by a lay member (who is also a patient), and is supported by a Citizen Panel made up of patient representatives from all twelve organisations involved. In the same vein, a member of the Citizen Board advises the Mid-Nottinghamshire Transformation Board.

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

North Nottinghamshire

As part of the development of its five-year strategy, Bassetlaw CCG has been undertaking a review of all the patient and public feedback it has received during the last year. This includes feedback that has been received through partner organisations such as providers, local authorities, and voluntary organisations. It includes informal feedback and comments, as well as the output of more formal engagement activities and events. The feedback has been mapped against priority areas to establish what is already known about people's views.

This exercise enabled shared learning across the planning area, especially where feedback on one particular service or experience is more widely relevant. The next stage in this process is for commissioning leads to review the existing information and identify key areas where they would like more detailed feedback to develop an engagement framework. This framework will link directly to the plans for the BCF, and will be used to inform proposals throughout the BCF period.

Mid-Nottinghamshire

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

programme of outreach events continues.

South Nottinghamshire

From September 2013 onwards, the three South Nottinghamshire CCGs and Nottingham City CCG have carried out a large-scale Call to Action engagement exercise to involve patients, the public, and partners (including Healthwatch), in how the NHS should respond to meet the challenges of the future. There have been more than 40 events and this significant engagement with a wide range of individuals with different experiences of health and social care has helped inform the debate as to how health and social care services can make bold change. At the end of January 2014, one such exercise engaged over 130 patients.

Future engagement with patients, service users, and the public for the BCF is being carried out at an organisational level, and at a health and social care economy level. User-led representation happens through the engagement itself and, in relation to the decision making boards, forms part of the governance structures. With respect to the governance structures, engagement is assured through the South Nottinghamshire Transformation Board, and involves a co-ordinated approach with the various partners, including health, Healthwatch, and Nottinghamshire County Council. The Transformation Board is informed through the Citizens' Advisory Group, who has responsibility for overall assurance on patient and public involvement, including proportionality, methods used, and intelligence gained.

Operationally, an engagement group has been established with the relevant individuals from each organisation in order to co-ordinate engagement activity and to allow for the sharing of intelligence, which then informs the engagement plan as approved by the Citizens' Advisory Group. The overall approach through the Citizens' Advisory Group is also informed by People's Councils of each CCG, which are Committees of the Governing Bodies and meet regularly. The members of the People's Council are patients and the public, and include user feedback on plans and commissioning documents, outlining patient and public engagement. The Local Authority also includes user-led representation in their governance structure.

Further to the governance structure, due to the breadth of the BCF and the crossover with other initiatives taking place in the health and social care community, a two-pronged approach is being followed whereby individual organisations will be carrying out engagement activities relative to their engagement strategy and information will be fed back to the central group alongside wider engagement activities specifically targeting relevant information for the BCF. There are three stages of engagement, which are:

- General feedback on health and social care services
- Specific workshops on proposed changes and redesigns including user-led events
- Full consultation

All of these are supported by a "you said/we did" framework, which includes:

- Intelligence being presented back to patients and the public with a demonstration of how it has influenced discussions and, if relevant, decisions. This will be done through patient and public events and workshops either at an organisational or South Nottinghamshire level
- The Citizens Advisory Group receiving assurance that the level of engagement

has been appropriate and proportionate, and that intelligence has been applied within discussions and decision making, as well as validation through Healthwatch that the intelligence is representative of feedback they have received

- Promotional material, including a transformation website detailing patient and public activity, intelligence gained, and subsequent impact on the BCF

Engagement with hard to reach groups is incorporated into the overall process through a record of which groups and individuals have provided feedback, and identifying any gaps to actively seek feedback, as well as co-ordinating with partner organisations on intelligence already held and opportunities to engage with relevant individuals. Engagement with hard to reach groups is also co-ordinated through our Equality and Diversity Forum.

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

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans.

i) NHS Foundation Trusts and NHS Trusts.

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

Nottinghamshire has the following main acute provider hospitals:

- Doncaster and Bassetlaw Hospitals NHS Foundation Trust – DBH; operating from two sites within Bassetlaw
- Sherwood Forest Hospitals NHS Foundation Trust – SFH; operating from two sites in Mid-Nottinghamshire
- Nottingham University Hospitals NHS Trust – NUH; operating from two sites in Nottingham

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

An Operational Planning Event for the BCF plan was held in early December 2013, with providers attending, where it was agreed that provider representatives would join the BCF Local Planning Groups as part of our resolute commitment to co-developing our plans for integrated care alongside providers. This event set out the emerging strategic objectives, taking account of local plans and pressures, with a second summit at the end of July that brought commissioners and providers together once again as BCF plans continue at pace.

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

North Nottinghamshire

Bassetlaw CCG has strong relationships with its providers across all sectors. The acute trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT), has worked closely with Bassetlaw CCG, community providers, and Nottinghamshire County Council over the past 3 years through the local strategy group to develop health and social care plans to address avoidable hospital admissions and reduce delayed transfers of care. The strategy group was instrumental in developing plans for the reablement monies in 2010/11, which have formed the starting point for further planning for the BCF and Bassetlaw's five-year integration plans. The Strategy group feeds into the Bassetlaw Integrated Care Board, on which DBHFT has four members: three executive directors,

and a clinical director.

The North Nottinghamshire System Resilience Group and Integrated Care Board have been engaging clinical and non-clinical members at a senior level from local acute, community, and mental health care trusts. The Bassetlaw Integrated Care Board has also been mobilised as part of BCF implementation in North Nottinghamshire.

In North Nottinghamshire, the implications of the BCF and five year plans are reflected in provider operational plans. While these high-level implications are included in plans and the direction of travel is agreed in principle, the detail and impact on Doncaster and Bassetlaw Hospitals NHS Trust is still to be ascertained and reflected in plans (as outlined in Annex 2 for this Trust).

Mid-Nottinghamshire

In 2013, the five organisations involved in the delivery of health and social care in Mid-Nottinghamshire (Newark and Sherwood Commissioning Group, Mansfield and Ashfield Clinical Commissioning Group, Nottinghamshire Healthcare NHS Trust, Sherwood Forest NHS Foundation Trust, and Nottinghamshire County Council) agreed to work together to design a “blueprint” for the future delivery of services that would meet the needs of the population both now and in the future, and do so while operating under the financial constraints that exist.

At the outset, the organisations agreed a series of overarching objectives of the design phase of the programme. These included working with partners to develop a shared vision and case for change, and developing an impact assessment to analyse the impacts of change in acute and out-of-hospital services and the providers of those services.

Organisations across Mid-Nottinghamshire have now developed shared strategic cognition, so Sherwood Forest Hospitals NHS Foundation Trust’s strategic plan is predicated on the commissioners’ planning assumptions, and the Trust is planning to reduce capacity and cost base in line with the BCF targets. All partners acknowledge that there is a significant degree of organisational risk arising from removing capacity and cost at this scale and pace, but having agreed a collective approach to risk identification and mitigation – this is being effectively managed as the implementation work progresses.

South Nottinghamshire

There is recognition and support of the importance of developing integrated service models that better meet community needs, and therefore mitigate demand for acute care. Joint provider/commissioner work is developing a service improvement plan, which will outline actions to implement the clinical standards set out in the NHS Services, Seven Days a Week Forum.

Whole system transformation work to date has seen NUH as a significant contributor to shaping discussions and delivery, for example as a partner in the Greater Nottingham Frail Older People Programme and the Urgent Care Working Group and its sub-groups. This included participation in system-wide analysis of the reasons for delays to transfer of care out of NUH and the approach to assessing the amount and type of alternative community services that are needed to reduce pressure on the acute beds. NUH will be part of ongoing discussions about future capacity needs through the System Resilience

Implementation Group. This service change needs to ensure greater access to alternative services both to prevent admission to, but also support better transfers of care from, acute facilities.

To deliver the BCF plan, the Trust will continue to actively engage with other health and social care providers. NUH is a key member of the South Nottinghamshire Transformation Board, which is an NHS Commissioner, NHS provider, and Local Authority Board established to oversee the development of the five-year strategy and Transformational Plan for South Nottinghamshire, straddling two Health and Wellbeing Board areas. This Board will support the implementation of BCF interventions across the three South CCGs, as well as Nottingham City CCG, which is part of the South Nottinghamshire unit of planning but falls in a separate Health and Wellbeing Board area.

Recognising the need for ambition, service change at real scale, and pace of delivery, senior clinical staff time has been committed to this process as evidenced through their participation in recent local health economy planning events to develop system-wide clinical models for the next five years.

As part of the analysis supporting the development of the South Nottinghamshire Transformation five year strategy, a process is underway to triangulate Commissioner QIPP and NUH CIP plans against BCF schemes so that benefits align. There will be an impact on NUH from both the Nottinghamshire County BCF, Nottingham City BCF, and Derbyshire County BCF plans, so this analysis will apply a consistent approach across all BCF areas. Baseline activity levels have already been agreed between the CCG Consortium and NUH, following a number of planning sessions. Two subsequent Confirm and Challenge sessions were held between NUH Directorates and CCGs to confirm the underlying demand projections and the deliverability of this demand within the available capacity. This collaborative approach is an indicator for future planning.

The current evidence-based QIPP schemes address the need to reduce avoidable hospital emergency admissions, prevent inappropriate attendances to A&E, reduce unnecessary elective referrals, and improve the outcome and experience for patients through the reduction in lengths of stay etc. A number of these QIPP schemes will contribute towards the successful achievement of the BCF ambitions. This process has enabled commissioners and providers to mitigate the risk of any double counting between QIPP and BCF schemes.

Benefits evaluation will be focused around demonstrating the impact and effectiveness of schemes. The analysis will be tailored to each scheme to quantify the impact against agreed milestones. For emergency admissions, the use of forecasting techniques, statistical significance and segmentation by diagnosis will be essential to demonstrate achievement of the metric. Delayed transfers of care analysis will focus on nationally available data, local benchmarking, and trend analysis. Schemes that impact on other activity types will be monitored using a range of nationally and locally available data.

The availability and development of the NUH workforce will be a significant element alongside partners in delivering the required change, building upon the various pathways where they already support the delivery of community based care. Work is already underway with local partners to ensure effective commissioning and development of the wider health and social care workforce, and NUH plays an active and leadership role in the work of the Nottinghamshire LETC. There is recognition that the timely supply of this

workforce is a key risk for all providers.

NUH recognises the scale of the transformational and financial challenge that faces the system in creating sustainable health and social care economies for the future, and in which the BCF presents an important lever. The Trust therefore accepts the part it must play in delivering changes to its own services and ways of working.

Nottinghamshire Healthcare Trust (NHT) has also been engaged in the BCF Working Group and process to develop the BCF plan, and is fully supportive of the service change and levels of transformation required in order to achieve this. At this stage, the Trust have reflected the overall ethos and direction of travel into their business plan, which includes County Health Partnerships as the provider of community services, and then will continue to refine the operational detail included as schemes come online. The full impacts to individual providers are reflected in new contracting models and service agreements. Therefore, in order to deliver the BCF plan, NHT will continue to develop alliances and partnership working with other providers to reduce fragmentation, better manage the interface between providers, and facilitate the provision of shared care that is wrapped around the person.

The BCF plan offers significant opportunities for growth and development in community services to build capacity, capability, and new service offers. This will come with significant challenges requiring a high level of change management, organisational, system, and workforce development as NHT radically change ways of working, redesign and reconfigure existing services, develop new service offers, and create a workforce that looks and behaves very differently in an environment of blurred boundaries. This will require capacity and skill in managing change, project management, and service redesign.

For the Trust's mental health services, the focus will continue to be on ensuring that they meet the needs of people who present in crisis and build capacity and capability to care for people safely in their own homes, as well as reducing the need for people to attend either ED or be admitted to an inpatient facility. The Trust will work with all acute providers in continuing to develop the Rapid Response Liaison Service to ensure that people who do present in ED are appropriately assessed and treated in a timely manner, and also to support and facilitate discharge as appropriate.

Workforce changes probably form the most significant challenge to the successful delivery of this plan. For example:

- Recruitment, i.e. availability of suitably skilled staff
- Building new integrated teams and multi-agency working (primary, community, and mental health teams)
- Changes to terms and conditions of employment to facilitate 7 day services
- Developing new roles, e.g. primary care facing mental health practitioner
- Developing increased clinical skills to practice level
- Changing a task-focused culture to promote choice, personalisation, self-care, recovery, reablement, and wellbeing

ii) Primary care providers.

To deliver the BCF plan, GPs as providers will need to be aware of the change in service provision of all other providers. The BCF plans will depend considerably on GPs' in hours and CCG commissioned Out of Hours providers knowing the changing landscape and making most appropriate use of it.

General practice is reflecting and restructuring as a provider system to a more integrated possibly federated provider model. This will put primary care in a better position to support a 7 day service. Different delivery models will be explored through development of a Primary Care Strategy. The strategy, which encompasses all Nottinghamshire CCGs other than Bassetlaw, was completed in June 2014 and can be found in the attached document 14.

There are serious workforce issues in general practice across the county, with a high percentage of the skilled workforce ready to retire in the next five years. There will need to be a strategic approach both at a local and national level to encourage recruitment. An increasing number of GPs have portfolio careers which can both reduce availability and reduce flexibility, but sometimes provide valuable skills to support the service transitions required.

The value and relevance of 'skill mix' deployment in primary care will assume greater importance. Skilled support from community staff including nursing and therapists, from pharmacy as well as dentists and optometrists will all facilitate delivery of the BCF plan and 7 day services. The Community Services provider is also working collaboratively to address the required transition and transformation required to help facilitate the delivery of 7 day services in primary care.

The possible alteration of 'Acute Demand Management' in general practice will create a workforce change and potentially free GPs to proactively manage vulnerable people and those with long-term conditions to a higher level of specification, and thus hopefully reduce acute care requirements and the hospital footprint. This is essential to the BCF.

Changes to the General Medical Services (GMS) contract from April 2014 also support more proactive integrated and personalised care through:

- Ensuring that all people aged 75 and over have a named, accountable GP who is responsible for overseeing their care
- Introducing more systematic arrangements for risk profiling and proactive care management, under the supervision of a named GP, for patients with the most complex health and care needs
- Giving GP practices more specific responsibilities for helping monitor the quality of out-of-hours services for their patients and supporting more integrated working with out-of-hours services

The Out of Hours providers have a strong history of local service provision and awareness of local systems. This will enable an IT co-ordinated platform to support and facilitate 7 day services, while multi-location access to key patient records will lead to improved care and safety. Innovative new ways of working will also deliver extended primary care access for both booked urgent and planned care – 8am-8pm Monday to Friday, and 8am-6pm Saturday and Sunday. Primary care services will be:

- Designed in sufficient capacity to meet local need
- Delivered by local clinicians – not locums
- Supported by clinical protocols created to define new ways of working and how practices will work together
- Backed by solid joint working and the coming together of a new team to deliver the project against very challenging time frames

The BCF plan aims to ensure systematic implementation of primary and secondary prevention and chronic disease management in primary care through benchmarking and targeted incentive schemes. A key focus will be integrating physical, social, and mental health in a wraparound citizen-oriented model.

iii) Social care and providers from the voluntary and community sector.

Our comprehensive engagement process has so far included District and Borough Councils, acute providers, community services, the independent sector (including care homes), mental health, voluntary organisations, and the East Midlands Ambulance Service (EMAS).

A county-wide consultation between health and social care has also been concluded, including providers and all key stakeholders, regarding budget cuts required by the County Council and the potential impact upon them of any reduction in funding arrangements. The results were presented to elected members, and plans agreed by the Council in late February. The development of our BCF plan has been fully cognisant of these plans.

Adult Social Care (Nottinghamshire County Council)

The County Council commissions a range of community-based care and support services from independent sector providers to support people to live independently in their own homes. The Council has contracts with over 400 care and support providers for a range of services including domiciliary care, supported living for people with learning disabilities, physical disabilities and/or mental health needs, and community equipment services, including minor adaptations. Many of these services are commissioned jointly with the CCGs.

One of the primary objectives is to ensure that people have access to services that prevent avoidable admissions to hospital and divert people away from, or delay the need for, long-term care in residential or nursing homes. There is a strong emphasis on reablement and rehabilitation, so that people are supported to regain and retain their independence and maintain self-care wherever possible.

From a provider perspective, implications of the BCF plan include:

- Ensuring there is sufficient capacity among providers now and in the future to meet increasing demand for community-based services
- Ensuring the social care workforce has access to and is supported to undertake the relevant training and have the right skills to help people to regain and retain their independence and to manage self-care
- Ensuring the workforce has the experience and expertise in caring for people in their own homes when they may have a range of complex health care needs and/or are at end of life
- Ensuring care staff are able to deliver personalised care to meet people's outcomes – this will be a greater challenge with the roll-out of personal health care budgets
- A focus on 'commissioning for outcomes', which will mean cultural changes across providers

Providers will need to be given the opportunity, and the responsibility, to develop and agree the individual support plan together with the patient/service user and their family members so that they can find flexible, innovative, and cost-effective ways of delivering the required care and support services.

Care Homes and Homecare

The intended impact of our plans is that more people are supported to live independently and safely in the community for as long as possible. This may negatively impact on the number and duration of care home beds commissioned for long-term care across the nursing and residential sector. We envisage that there will be an increased demand for care homes that can support service users with higher levels of need, such as nursing and dementia needs, and for short-term services focused on enabling service users to return home. Furthermore, we expect that there will be an increase in demand, and in the complexity of cases, for domiciliary care providers.

As such, we have already been engaging with providers and wider stakeholders to discuss the strategic commissioning intentions through engagement events and contract negotiations. These discussions have also involved their role in avoiding unnecessary admissions to hospital, facilitating timely discharge, and sharing pertinent information with health and social care professionals. The Local Authority is working with providers and colleagues from CCGs and the CQC to drive quality standards in care homes and for homecare providers.

For example, a strategic review was completed for care homes to guide commissioning intentions, and a Dementia Quality Mark has been developed for care homes to provide a high standard of care to people with dementia, which has been awarded to 32 providers across the county. The Local Authority is also sponsoring and financially supporting a number of workforce development initiatives across the independent care home and domiciliary care sectors. This will develop capacity to enable appropriate support for people to remain at home wherever possible.

North Nottinghamshire

In North Nottinghamshire, the community and voluntary sector have been actively involved in supporting consultation for the five-year strategic plan, and we are working closely with them on delivering community facing aspects of the strategic plan (for example, social prescribing). Where appropriate, steering groups for the five strategic priorities have membership from the community and voluntary sector. For instance, the Care Homes steering group has representatives from community and voluntary sector care homes, and from Bassetlaw Action Centre.

Mid-Nottinghamshire

Adult social care delivered by Nottinghamshire County Council is a key partner in our transformation plans, and this partnership is fundamental to the delivery of schemes within the BCF. Adult social care is represented on the Mid-Nottinghamshire Transformation Board, and representatives from the localities have been involved in the design and implementation planning of all of our schemes. They are a fundamental provider in our proactive care model, both within the hospital and community settings and our strategic visions around reducing long term care are well-aligned.

Improved understanding of both health and social care services, and how they support reablement, are allowing us to think innovatively of how resources are used to support upstream or early intervention as prevention rather than reactive support following crisis. Our different approaches on assisted technology have also been shared to maximise the benefits within the development of our schemes.

Our combined knowledge and use of the voluntary and community sector are added to

by the relationships with our Community Voluntary Services (CVS) in Mansfield, Ashfield, Newark, and Sherwood localities. Representatives of the CVS in each locality sit on the CCGs Stakeholder Reference Group in Newark and Sherwood and the Citizens' Reference Panel at Mansfield and Ashfield. They provide a real connection to our communities, and to reaching our citizens to get the patient and carer voice into our strategies and policies, as well as our service design. The CVS act as a conduit for communications and engagement, working closely with CCG officers and supported by formal contracts with the CCGs.

Mid-Nottinghamshire's CCGs recognise the importance of the third sector in current provision that supports the agencies across health and social care, and their potential to enhance future service aspirations and developed schemes. A marketplace event 'All Together Healthier' has been held with around 80 people attending, where four workshops took place on the topics of Commissioning, Communications, NHS/VCS working together, and Integrated and Self-care. The aim of the conference was to:

- Raise the profile of the diverse contributions that voluntary and community groups can make to the health agenda, and to look at ways of clearly capturing the value and impact
- Enable the NHS and VCS bodies to better understand each other, and for VCS organisations to understand the policies, priorities, and direction of travel of the CCG and other health providers
- Build trust between voluntary and community groups to help with joint approaches to tendering
- Improve and clarify lines of communication and engagement between voluntary organisations and different parts of the NHS
- Clarify how VCS might be engaged at all stages of the planning/commissioning cycle
- Work with the CCG to ensure that the commissioning process is accessible to voluntary organisations. This included looking at the process itself and how VCS providers could be more effective by working together and accessing specialised support (there were concerns that VCS providers could develop all the necessary expertise to tender but the process could still exclude them)
- Explore how to sustain and build patient and user engagement

The Self-Care Strategy has also been developed by this sector informed by contributions from a design workshop event. Over 77 people attended, including patient representatives, social care, health, and public health, working together through design principles to identify priorities for the project team. The project team itself is made up of CVS, community pharmacy, District Council, social care, assisted technologies team, and CCG officers. As referenced earlier, the CCGs have Stakeholder or Citizen Reference Panels that, along with CVS colleagues, have representatives from social care, District Councils, and Chairs of patient participation groups (volunteers that work to support GP practices).

The Mid-Nottinghamshire transformation plans and BCF schemes are therefore well informed by this sector, and their contribution continues.

South Nottinghamshire

Nottinghamshire County Council delivers adult social care services, playing a key role in

the delivery of BCF schemes. Adult social care is represented on the South Nottinghamshire Transformation Board, and representatives from the localities have been involved in the design and implementation planning of all of our schemes. They are a fundamental provider in our proactive care model both within the hospital and community settings, and our strategic visions around reducing long term care are well-aligned.

Our improved understanding of how health and social care services support reablement is allowing us to re-think resource usage to support upstream or early intervention as prevention, rather than reactive post-crisis support.

In South Nottinghamshire, CCGs work closely with CVS and Volunteer Bureaux to support patients and carers to achieve and maintain good health and wellbeing. British Red Cross and Crossroads East Midlands work closely with CCGs in providing crisis response services to support both Choose to Admit and Transfer to Assess models of care. Both third sector providers are well-integrated with the core adult community health services and acute Trust. Support to Thrive is also embedded across CCGs to deliver proactive health and wellbeing and promotion of self-care.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

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

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

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

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

Clinicians and care professionals have been fully engaged in the design of the new care system, and are committed to making the changes effective. In the unlikely event that the impact of the change is not as great as anticipated, the community services will be further enhanced to bring about the required shift of care from secondary care. A number of pilot schemes are underway that provide an evidence base for future success, and confidence in delivery is enhanced by these results. Further mitigation, should the positive impacts upon acute activity take longer than envisaged, will include a major focus on organisational development and acceleration of the required workforce change. In recognition of the importance of developing the appropriate workforce in a timely manner to deliver citizen-centred integrated services, a system-wide post has been created (covering the East Midlands region). This is a senior role, within Health Education England, funded by commissioners, and demonstrates a commitment to re-shape the workforce at pace. There are also strong plans within local risk registers to ensure that workforce transformation does not become a material limiting issue to successful

integration.

The Health and Wellbeing Board have also committed to supporting the health and social care system in re-aligning public expectations to support the shift away from the acute system as default, towards home/community-based care wherever feasible, focusing on proactive care and self-management as the preferred option.

We have undertaken differential impact analysis on providers in the acute sector and beyond across Nottinghamshire, a summary of which is below.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust

The Integrated Care Board has focused on working across the health and social care economy on five key strategic priorities detailed elsewhere in our BCF plan. The pathway includes the whole health and social care economy and has been influenced by engagement with providers, patient and service user feedback, and an independent report from the Emergency Care Intensive Support Team. As a key partner, DBHFT are leading on the Post Acute Care strategic priority within the plan.

A number of key principles were agreed with all partners on the behaviours expected when developing the work plans for each element, including:

- Work with partners to develop a shared vision and case for change
- Develop an impact assessment, analysing the impacts of change in acute and out-of-hospital services and the providers of those services
- Shift care into closer-to-home/better value care settings where appropriate
- Optimise the use of fixed costs, such as estates, with locally required activity – including acute, community, private. and non-healthcare
- Provide single points of access for patients, and integrated provision of services (which may require single management control)
- Using all of this to enable the system to cope with growing demand within expected resource constraints
- To design interventions that, once implemented, will make a significant contribution towards the NHS and Adult Social Care Outcomes Frameworks

The ICB members have held a confirm and challenge session on all five work group plans to ensure they are robust, and will meet the challenges presented by the BCF. A joint approach by health providers and the CCG using a range of agreed assumptions is modelling the impact of service change interventions on acute activity using a range of currencies, including length of stay, number of admissions, and bed days/numbers.

Through the joint ICB arrangements, very clear sight will be maintained of actual activity shifts and consequent financial implications to commissioners and providers. This information will be visible to all parties.

The ICB will be overseeing progress of the BCF plan locally, and will continue to monitor performance against key metrics and refresh the system-wide modelling of the impact that the BCF to ensure that we are on target. The priorities within the plan have been used to shape in-year contract discussions and commissioner QIPP/provider CIP plans. QIPP/CIP plans have been through an assurance process through the ICB to ensure that

there is no duplication.

Because of the geographical nature of the Trust, DBHFT works with two CCGs and two local authorities, consequently spanning two Health and Wellbeing Board areas. The process for agreeing plans for the BCF has been mirrored by both CCGs, and the Trust has been an active member of both Boards. The Trust has good integrated models of care currently and has made great advances in working together with local authorities to benefit patients.

The DBHFT annual plan for the next two years has also been shared widely with both CCGs (Doncaster and Bassetlaw) in order to triangulate Trust assumptions on possible reductions in emergency activity with the CCGs. The DBHFT bed plan makes agreed assumptions on potential reductions in length of stay due to 7 day services and improved information sharing and discharge processes, including transfer to assess.

The intended investment schemes are planned, over the next two years, to result in reductions in admissions and A&E attendances to DBHFT. These investment schemes are being discussed with DBHFT at the Integrated Care Board. A number are, however, still in the planning stage and therefore, while in the CCG plans and BCF plan, there will not be a consistent replication in the Trust plans until we have completed the detail behind each of the programmes of work. There is therefore a risk to savings, but as these are phased towards 2015/16 rather than 2014/15, this provides some element of mitigation. The potential savings have not yet been stress tested or quality assured, so the clinical or financial risk to the provider is not yet fully understood. This work will continue into the autumn to ensure our plans are deliverable, and the impact on DBHFT fully understood.

Mental health is identified as a strategic priority within the Bassetlaw five-year plan. The Bassetlaw CCG Governing Body held a development session in July 2014 to discuss parity of esteem and an action plan is being developed based on this session.

Sherwood Forest Hospitals NHS Foundation Trust

The commissioners of services from Sherwood Forest Hospitals NHS Foundation Trust have developed a strategy that places whole system integration of hospital, community, social, and primary care centrally in the vision to address feedback that services are currently too fragmented and difficult to navigate. Their aim is to move from a model of predominantly reactive care to one of proactive care, eliminating hospital admissions as a default for people who are not acutely unwell but need help and support. Delays that do not add value will be reduced significantly by changing the way that people work in partnership on a day-to-day basis, and by removing process barriers to cross-system working. Planned care will be delivered in a more effective and sustainable way, reducing administrative complexity for professionals and patients, while re-invigorating working relationships and dialogue between primary and secondary care clinicians.

<u>The Current Model of Care</u>

Through engagement with key stakeholders, data analysis, and document review, a baseline for the current health and social care economy was established. This highlighted a significant overall financial challenge.

In January 2013, the total cost of the physical health and social care economy was £398m. For 2012/13, it was forecast that the financial deficit of the health and social care

economy would be £19m. If services were to continue as they currently are and taking into account funding levels, population growth, and inflation, this financial gap could increase to at least £70m and possibly be more than £100m by 2018.

Design Principles

The design principles were put together by the system leadership Board (comprised of primary and secondary care clinicians, senior executives, and social care leaders), and then validated by the care design groups (comprising care professionals from all sectors, together with patient representatives). The principles are identified below:

- Prevent illness or crises where possible – and transfer resources (people, physical assets and finance) from reactive services to support this
- Shift care into closer-to-home/better value care settings where appropriate
- Only provide services where there is the critical mass/volumes for the services to be delivering high outcomes and be economical, but also repatriate activity from out of area/private provision where this delivers better outcomes
- Optimise the use of fixed costs such as estates with locally required activity – including acute, community, private, and non-healthcare
- Provide single points of access for patient, and integrated provision of services (which may require single management control)
- Using all of this to enable the system to cope with growing demand within expected resource constraints
- To design interventions that once implemented will make a significant contribution towards the NHS Outcomes Framework

Working in conjunction with the Blueprint workstream, a significant data analytics workstream was tasked with the gathering and modelling of quantitative data to produce analytics on current services in Mid-Nottinghamshire. This workstream also took responsibility for modelling the impact of the proposed design options coming out of the care design groups.

The approach taken was to provide an indication of the expected impact of our interventions on the financial challenges facing the health and social care economy by constructing a series of tactical models and calculations based on the best available data from a range of publicly available sources and information provided to us by the participating parties.

While findings will need to be revisited and tested in detail throughout implementation, the results provide a clear and robust indication of the benefits and costs associated with the blueprint proposals.

Using a range of agreed assumptions, the impacts of service change interventions on acute activity have been modelled using a range of currencies, including length of stay, numbers of admissions, and bed days/numbers. The detail arising from this modelling has been fed in to the CCGs' five-year strategy, but also used to shape in-year contract discussions and commissioner QIPP/provider CIP plans.

As the programme now moves from design to implementation, local governance arrangements have been reconstituted to ensure absolute triangulation of BCF investment proposals, local commissioning QIPP schemes, and joint transformational

initiatives. Local providers and commissioners have developed a “dashboard” of common information and analytical models to create a single evidence base to monitor the impact of changes.

As the Blueprint design outcomes and supporting analytics form the CCGs’ two- to five-year strategy, they also shape BCF schemes and QIPP/CIP plans, meaning that there is no scope for duplication or double counting.

The overall programme has been predicated upon a “total activity and cost of provision model”, and an analysis of impact on each provider produced based on current PbR arrangements and income and expenditure plans. Through the joint PMO arrangements planned, very clear sight will be maintained of actual activity shifts and consequent financial implications to commissioners and providers. This information will be visible to all parties.

It is, however, acknowledged by all parties in the Transformation Partnership that to be effective in the context of a “shift left” model, with activity and consequent funding moving from the acute sector to more appropriate home and community settings, successful interventions in primary care, community care, and self-care will be paramount to manage demand and improve the management of patients with complex and multiple long-term conditions. The way in which the analytical models underpinning plans have been designed means that there is a visible causal link between investment in services and improved outcomes. It will be critical to ensure that these are continuously reviewed and plans iterated accordingly should the anticipated beneficial impacts not materialise.

It is also worth noting that a particular factor exists in Mid-Nottinghamshire that requires more sophisticated approaches to be considered in separating the burden of fixed overheads from service provision, as a result of the acute PFI hospital incurring a significant fixed charge for a further 30 years, which will not diminish if demand for traditional acute care patterns is reduced. Sherwood Forest Hospitals NHS FT and the commissioners recognise that this will need very careful management and impact assessment as estates cannot be decommissioned in a way that directly correlates with reduction in acute activity, and to do so may well penalise provider financial viability and dis-incentivise providers to exhibit system behaviours.

Commissioners and providers will therefore continue to work together to best match the more integrated models of care essential to ensure system sustainability and meet population health need, but also best deploy fixed assets. The commissioners are now sponsoring a major piece of work to create a whole health and social care economy estates strategy to ensure that estate is provided according to need, not ownership, and that the burden of excess estate cost that cannot be removed for commercial reasons is not borne by individual providers, as population requirements drive new ways of cross-organisational working.

In its Strategic Plan (2014/15-2018/19), Sherwood Forest Hospitals NHS FT recognises that in order to offer really effective urgent and emergency care in its hospitals, the system needs primary, secondary, community, and social care services to be more proactive in the way they support frail older people, and those with single or multiple long-term conditions, and that currently too many people come to hospital acutely ill because the resources to support them in the community are inadequate. The Trust acknowledges that the Commissioners’ five-year strategy aims to reduce these demands on hospital services by providing better, more seamless packages of support in the

community for those who might be at risk of an emergency hospital admission. The FT supports these aims, and is playing a major part in ensuring the success of the integration strategy. This will enable the Trust to manage the acute pathways for those people who really need to come to hospital more effectively, and reduce their reliance on community hospital beds.

By being part of the implementation of the integration strategy, the FT forecasts that it will be able to reduce its underlying deficit. The FT remains committed to working with commissioners to address those factors that generate its operating deficit that can be influenced locally, while still working closely with commissioners and regulators to address the wider issues associated with the cost of the estate.

The FT's strategy makes the following statements in terms of the impact on its current operations and future capacity:

"*The Trust is a full partner in the Commissioners Transformation (Better Together) programme and is committed to its objectives and outcomes. We are represented at all levels in the operational delivery and governance arrangements for the programme. Our financial assumptions are fully aligned with our commissioners and fellow providers, and we have begun to enact this alignment through the 2014/15 contract and the QIPP schemes that are positioned within it.*

We will seize the opportunities presented by the combination of reducing demand upon hospital services and increasing efficiencies in the work that we will continue to do in our hospitals. This will enable us to reduce our overall footprint and cost base as a major step towards achieving clinical and financial sustainability.

Improved provision of services out of hospital to support earlier discharge, combined with our internal pathway improvements are planned to reduce length of stay for emergency patients by around 20%. Together with reduced admissions, this is projected to reduce demand for beds for patients admitted as an emergency by 30% in line with Better Together assumptions. Based on the activity and case mix assumptions, planned reductions in average length of stay and occupancy, future demand for beds is projected to reduce by 27% (or around 140 beds) between the 2013-14 average requirement and 2018/19.

Whilst fully supporting this direction of travel and overall objective, it is important to acknowledge the high degree of stretch that this objective represents. Demographic changes provide a countervailing driver due to the growth in population aged 75 and over, and the historic relationship between length of stay and age at admission."

Both the commissioners and the Trust recognise the imperative to create the capacity in primary and secondary care services, to give the acute hospital the headroom to manage its secondary emergency and elective care effectively. The commissioners are therefore investing transformation funding directly in the Trust, and in community services to enable this, and will continue to link the transformational investment with that aimed at ensuring that key targets for emergency admissions and elective treatments are met.

Nottingham University Hospitals NHS Trust

The identification of schemes has been based on the use of benchmarking information, evidence from other health communities, and an inherent knowledge of existing pathways, as well as an understanding of the health needs of the local population.

External consultants, McKinsey, have been commissioned to review alignment between current CCG QIPP plans and NUH finance and activity modelling. Emerging findings suggest that the plans appropriately target areas where the impact will be greatest.

The current QIPP schemes address the need to reduce avoidable hospital emergency admissions, prevent inappropriate attendances to A&E, reduce unnecessary elective referrals and improve the outcome and experience for patients through the reduction in lengths of stay etc. A number of these QIPP schemes will contribute towards the successful achievement of the BCF ambitions. This process has enabled commissioners to mitigate the risk of any double counting between QIPP and BCF schemes.

As part of the analysis supporting the development of the South Nottinghamshire Transformation five-year strategy, the process continues to triangulate Commissioner QIPP and NUH CIP plans against BCF schemes so that benefits align. There will be an impact on NUH from the Nottinghamshire County BCF, Nottingham City BCF, and Derbyshire County BCF plans, and this analysis will apply a consistent approach across BCF areas.

BCF plan considerations have been fully incorporated into the production of annual planning trajectories submitted to NHS England, which can be seen in Annex 2. A range of factors have been considered that impact on demand such as demographical growth, historical activity trends, and service change. Each factor has been modelled independently to provide a transparent process and enable disaggregation of impacts. This approach has facilitated scenario analysis around partial achievement of BCF from an activity and financial perspective.

Further work across South Nottinghamshire is taking place to understand the capacity and capability requirements for future provision. This work indicates that there will be a reduction on occupied bed days, number of acute level beds, and an increase in community-based services closer to or at home.

The scale of the transformational and financial challenge that the BCF process presents to the Trust is accepted along with the part it must play in delivering changes to its own services and ways of working, including reducing the size of the acute footprint.

Our local providers are fully engaged in the development of the BCF plan and South Nottinghamshire Transformation Strategy, and are fully aware of the requirement placed on all providers to deliver against the metrics contained within the plan.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
A
Scheme name
7 day working
What is the strategic objective of this scheme?
In keeping with modern services the NHS needs to move toward providing a fully integrated 7-day health and social care service. This service should be responsive to citizens' clinical needs, and respond when required, rather than at a particular time of day, or on a particular day of the week. This is in line with the Dec 2013 report NHS Services, Seven Days a Week review, by Professor Sir Bruce Keogh. This will reduce admissions to acute service provision, reduce admissions to long term care, and enhance quality of life, delivering the local concepts of Choose to Admit (CTA) and Transfer to Assess (TTA). The scheme outline has been defined in line with the South Nottinghamshire Transformation Plan which is based on a baseline analysis of current performance, then benchmarked against comparators to identify potential scope for improvement on quality and cost effectiveness. To date, CCG informatics teams have also benchmarked their outcome and ambition data with a range of other sources, including: - Joint Strategic Needs Assessments for Nottinghamshire County Council and Nottingham City Council - Right Care (including Commissioning for Value Packs and the NHS Atlas of Variation in Healthcare) - Public Health England data and toolkits - Office for National Statistics data (on demography and population growth) - Dr Foster benchmarking data (such as that on emergency admissions) - Data from the NHS England Derbyshire and Nottinghamshire Area Team (on population growth) - Local data showing variation between practices and across the four CCGs - National data showing variation between practices - Other tools, such as those to examine statistical significance of variations in data The JSNAs have been used to frame CCGs' strategic commissioning intentions. Our plans are based on JSNA findings and are aligned to the Health and Wellbeing Strategy for the county. Ongoing plans to improve outcomes align to existing JSNAs, and discussions have also been undertaken with public health colleagues to support this.

As a health and social care community it is acknowledged that there are significant financial challenges over the next five years. The CCGs are working closely with Nottinghamshire County Council colleagues in understanding the changes required as a result of the cost reviews and the potential impact on the schemes included in the Better Care Plan. This scheme has been developed to meet best practice and optimum use of resources to ensure high quality and cost efficiencies, to best meet the needs of patient care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A review of the evidence to support 7 day working has been undertaken and mapped against the current provision of acute and community health and social care services.

Following this review local planning will include:

- Evaluation of how local services compare to national / local evidence
- Consideration of the fit with planned services and the financial implications
- Consideration of how existing stakeholder and public feedback can inform the plans for 7 day services and whether additional engagement activity is necessary
- Ascertaining the key information about the existing workforce
    - workforce planning
    - training needs
    - culture change
- Ascertain current activity levels for the key services identified below and determine whether there is sufficient capacity within the system

Alongside this, South Nottinghamshire has been successful in securing funding to support 7 day services in primary care as part of the Prime Minister's Challenge Fund.

The plan is to align our approach to 7 day working across acute, community, social, and primary care, and the voluntary sector. The plan requires:

- A review of the NHS IQ 7 day services toolkit to ascertain if / what further work needs to be done
- A review of the NHS IQ commissioned evaluation of the 13 early adopters who are testing new models of 7 day services and care
- A review of the Academy of Medical Royal Colleges / University of Birmingham (Professor Julian Bion) evaluation of the impact of high intensity specialist-led acute care (HiSLAC)
- Understanding of the relationship with planned services and the financial implications
- Understanding and review of the utilisation of social care functions and services
- Stakeholder and public feedback to inform the plans for 7 day services
- Ascertainment of key information about the existing workforce

- workforce planning
- training needs
- culture change

The acute trusts have come together across the East Midlands, to look at current practice and identify how they need to change the way they work in order to deliver the 10 key principles that have been nationally set out for 7 day working.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The Shared Commissioning Group across health and social care, City and County, is co-ordinating initial commissioner discussions on the implementation of 7 day services.

To ensure alignment of provider actions, progress towards 7 day working across providers is part of the remit of Workstream 2 of the Urgent Care Working Group.

Workstream 2 consists of acute and community providers (Nottingham University Hospitals, County Health Partnerships, CityCare) working together with social care (Nottinghamshire County Council and Nottingham City Council) and NHS England as a commissioner of general practice services.

This sub-group reports back into the System Resilience Implementation Group (SRIG). This is the forum where all the partners across the health and social care system in Greater Nottinghamshire come together on a weekly basis to review current performance of the non-elective pathway and monitor the delivery of the Operational Resilience and Capacity plan. It has representatives from all local CCG Commissioners – Nottingham West, Rushcliffe, Nottingham North and East and Nottingham City, as well as acute and community providers listed above and local authorities as listed above.

All the CCGs listed above are also all signatories to the contracts with Nottingham University Hospitals, County Health Partnerships and CityCare, as well as 3rd sector providers of 7 day services such as Crossroads.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

NHS Services, Seven Days a Week Forum Summary of Initial Findings (December 2013) - to align with the Urgent and Emergency Care Review.

Centre for Workforce Intelligence (2013) Workforce Briefing. What does 24/7 working mean for the health and social care workforce?

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Improved clinical pathways with better outcomes for patients

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

7 Day working is on the work plan for both acute and community providers as part of the Service Development and Improvement Plan in the 14/15 Contracts. As part of this there will be agreed methodologies for measuring individual elements of the schemes. These will then form part of the formal information requirements in the Information Schedule in the contracts to ensure robust reporting. This will allow a comparison across contracts to understand the overall impact across the health community. Alongside this it enables a comparison of activity levels across different parts of the health and social care system to ensure corresponding reductions and increases in activity where anticipated.

Some of the data required is already routinely collected with other elements requiring new or revised data collection approaches. Reporting mechanisms will be defined and implemented alongside development of the scheme's required standards and outcome measures.

What are the key success factors for implementation of this scheme?

Timescale

2016: An understanding of the level of 7 day working, which will have the biggest impact on reducing unplanned admissions, and an understanding of the financial implications.

2017: 7 day working will be in place across relevant services and patients will see improved access to timely and responsive services.

2019: 7 day working will be fully embedded across the health and social care system in South Nottinghamshire.

2021: Patients and service users across South Nottinghamshire will have access to the right services, at the right time and in the right place.

Key success factors for implementation across all providers	Timescales
Identification of the key actions within each service which made the difference to weekend performance and delivery against the KPIs Establishment of immediate plans/actions to sustain improved provision & outcomes – balanced against affordability and provision across a 7 day working period Identification of the resources required to achieve 7 day working on a sustainable basis to feed into strategic direction in the medium to longer term Review of the 7 day provision across wider services to include: primary care, mental health & community services Agreement of actions for each service to comply with the 10 identified standards and establish a matrix to support delivery Review of service models with social care partners to support 7 day working within health Work and engagement with wider independent sector partners, to provide services and support for service provision over weekends, to facilitate timely discharge over 7 days, or in the shorter term to optimise discharge Monday to Friday Continued work with health and social care partners to plan and model future provision over a 7 day week and explore appropriate service models	Ongoing during 2014/15. Preparedness in 14/15 for Implementation in 15/16.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
B
Scheme name
GP access
What is the strategic objective of this scheme?
Our strategic objective is that general practice across the South Nottinghamshire area will deliver equitable, high quality, efficient and accessible primary care services that are clinically effective and have the patient at the centre of care. One of the key elements of this will be to improve quality in primary care, where quality is expressed in terms of three core areas: patient safety, patient experience, and effectiveness of care. General practices within the CCGs have worked with their CCG and the NHS England Derbyshire and Nottinghamshire Area Team to produce a bold and ambitious response to the Prime Minister's Challenge Fund. This provides NHS England with the opportunity to showcase how radical transformation of primary care can take place across a large population, with scale and pace, and which can rapidly be extended to other parts of England. A range of innovative approaches of service offers will be developed and tested during 2014/15 and, following evaluation, will be extended as part of the Better Care Fund (BCF) plans in 2015/16. The scheme outline has been defined in line with the South Nottinghamshire Transformation Plan which is based on a baseline analysis of current performance, then benchmarked against comparators to identify potential scope for improvement on quality and cost effectiveness. To date, CCG informatics teams have also benchmarked their outcome and ambition data with a range of other sources, including: - Joint Strategic Needs Assessments for Nottinghamshire County Council and Nottingham City Council - Right Care (including Commissioning for Value packs and the NHS Atlas of Variation in Healthcare) - Public Health England data and toolkits - Office for National Statistics data (on demography and population growth) - Dr Foster benchmarking data (such as that on emergency admissions) - Data from the NHS England Derbyshire and Nottinghamshire Area Team (on population growth) - Local data showing variation between practices and across the four CCGs - National data showing variation between practices

- Other tools, such as those to examine statistical significance of variations in data

The JSNAs have been used to frame CCGs' strategic commissioning intentions. Our plans are based on JSNA findings and are aligned to the Health and Wellbeing Strategy for the county. Ongoing plans to improve outcomes align to existing JSNAs, and discussions have also been undertaken with public health colleagues to support this.

As a health and social care community it is acknowledged that there are significant financial challenges over the next five years. The CCGs are working closely with Nottinghamshire County Council colleagues in understanding the changes required as a result of the cost reviews and the potential impact on the schemes included in the Better Care Plan. This scheme has been developed to meet best practice and optimum use of resources to ensure high quality and cost efficiencies, to best meet the needs of patient care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The overall aim of the scheme is to enable general practice to play an even stronger role at the heart of more integrated out-of-hospital services that deliver better health outcomes, more personalised care, excellent patient experience and the most efficient possible use of NHS resources. The scheme is aimed at the general population who access GP services.

The proposed scheme will:

- Ensure GP practice provision and access across the CCGs matches the needs of the population and is available for everyone
- Encourage innovative ways of working and sharing of examples of good practice
- Assess and improve overall quality in primary care
- Support the development of services that enable care to be provided closer to home where appropriate
- Reduce the number of unnecessary attendances at Accident and Emergency (A&E), and the number of emergency admissions
- Reduce the number of unnecessary outpatient referrals
- Integrate general practice and improve collaborative working across the whole health care system (including other primary care providers, secondary care, community care, social care, third sector, out of hours medical services, ambulance, and 111 services) in order to ensure patient care is delivered in a 'joined up' manner
- Maximise productivity and ensure the sustainability of general practice so that it can continue to support patients in the context of increasing demand and limited resources
- Enhance the patient experience in terms of responsiveness and improved access, and improve satisfaction by supporting customer care training

The work will include changes in primary care delivery and access such that there will be:

- Access 8am-8pm, and on Saturday and Sunday
- Flexible access, including access to email, Skype and phone consultations
- Electronic prescriptions and online booking of appointments
- Easier, on-line registration and choice of practice
- Joining-up of urgent care and out-of-hours care
- Greater flexibility in how people access general practice, for instance providing options to visit a number of GP surgery sites in their area
- Better access to tele-care to help manage patients in their own homes, as well as increasing access to healthy living apps
- A more integrated approach to providing general practice and wider out-of-hospital services, including “wraparound” community services such as community nursing, community pharmacy, diagnostic services and voluntary sector provision
- A more integrated approach to providing urgent care services across a local health economy
- Extending choice by enabling practices to grow their lists and take on patients from outside traditional practice boundary areas, when the new GP contract arrangements are introduced from October 2014
- More innovative ways for people to access and relate to general practice, building on feedback from the local population, including children and young people
- Testing new ways of commissioning and contracting for primary care services

Implementation timescale

The work represents significant transformational change which will take place over a two year period. Implementation has commenced in 2014/2015, and will be fully rolled out to embrace all facets of the scheme and include all relevant practices starting in 2015.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The local CCGs (including Nottingham North and East CCG Rushcliffe CCG and Nottingham West CCG) are working collaboratively to develop and commission improved GP Access to Primary Care services. GP practices have been integrally involved in the design of service improvements.

Wider stakeholders have been involved with the work to ensure support of the whole health community to the improved access to Primary Care and these include:

- County Health Partnerships
- Nottingham University Hospitals NHS Trust
- East Midlands Ambulance Service
- Community Pharmacy
- NEMS Community Benefit Services Limited

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is significant evidence for the requirement to improve access to Primary Care to ensure optimal care for patients and improve patient outcomes:

http://www.england.nhs.uk/ourwork/com-dev/igp-cta/

2012/3 GP Survey Results (http://www.gp-patient.co.uk/results)

ONS mid-year population estimates NHAIS 2012

Expected Prevalence from APHO model Dec 2011

Expected prevalence models 2011/2 QOF practice populations

Q Research published by HSCIC 1995-2008

The Nuffield Trust, 2013, Securing the Future of General Practice http://www.nuffieldtrust.org.uk/publications/securing-future-general-practice

Kings Fund, 2013, Clinical commissioning groups: Supporting improvement in general practice? http://www.kingsfund.org.uk/publications/clinical-commissioning-groups

NHS England, 2013, Improving General Practice – a call to action Evidence pack http://www.england.nhs.uk/wp-content/uploads/2013/08/igp-cta-evid.pdf

Kings Fund, 2013, Transforming our health care system: Ten priorities for commissioners http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

Health Select Committee, 2013, Report on urgent and emergency services http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/13-07-23-urgemrepcs/

NHS England, 2013, The Keogh Report - High quality care for all, now and for future generations: Transforming urgent and emergency care services in England. The Evidence Base from the Urgent and Emergency Care Review http://www.england.nhs.uk/wp-content/uplo ads/2013/06/urg-emerg-care-ev-bse.pdf

RGCP, 2011, Guidance for commissioning integrated urgent and emergency care: A 'whole system' approach http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Urgent-emergency-care-whole-system-approach.ashx

Price Waterhouse Cooper, 2013, The NHS@75, http://www.pwc.co.uk/government-public-sector/healthcare/nhs75/nhs75-towards-a-healthy-state.jhtml

Royal College of General Practitioners, 2012, Patients, doctors and the NHS in 2022: Compendium of evidence. http://www.rcgp.org.uk/policy/rcgp-policy-

areas/~/media/Files/Policy/A-Z-policy/The-2022-GP-A-Vision-for-General-Practice-in-the-Future-NHS.ashx

Carson D, Clay H, Stern R, 2009. A practical guide to transforming same-day care in general practice: Primary Care Foundation. http://www.health.org.uk/about-us/

Nottinghamshire Emergency Care Whole System Review recommendations (ECIST 2013)

CCG, GP and patient discussions/meetings, workshops across CCGs

National and international evidence

Emergency Dept. admission analysis (Dr IM), Chesterfield A & E study (March 2013)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Outcomes will be measured through:

- Numbers of GP appointments
- Numbers of nurse appointments
- Numbers of minutes of appointments
- Numbers of extended appointments available for patients with long term conditions
- Days / hours of opening
- Numbers of patients reporting positive feedback / experience (family/friends)

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

As part of the Prime Minister's Challenge Fund process an organisation has been commissioned locally to understand and comprehensively evaluate the impact of this scheme. This includes patient and carer experience and feedback.

A quarterly monitoring process is in place to monitor the impact of the scheme against its KPIs. This is submitted to NHS England.

The established Prime Ministered Challenge Fund Delivery Group for Nottinghamshire and Derbyshire has been established to share practice and learning across the area. This will maximise opportunities for shared risk e.g. workforce implications. Additionally

the Delivery Group has been established to manage the governance process at a local level and has a central role in the implementation, oversight and assurance of the allocation.

Locally, the CCGs monitor this scheme through governance processes including regular performance reports to the Clinical Cabinet or equivalent.

What are the key success factors for implementation of this scheme?

The key success factors for this scheme include:

The skills and expertise and availability of the staff required to work in the schemes. Without suitably skilled staff the schemes will not deliver the required outcomes and to this end much work is being undertaken to ensure that the workforce is available and trained. This includes:

- Working with other providers to source and share staff
- Development of the specification of core competencies
- Development of training packages to ensure that staff can achieve the core competencies
- Consideration of different professionals (e.g. prescribing pharmacists) to fulfil the roles
- Integration of staff from different providers.

Without effective integration the schemes will not be effective and efficient and as such the outcomes and KPIs will not be achieved to the anticipated levels. Work is therefore being undertaken with the providers to facilitate integration at both a strategic and operational level to include:

- Contractual arrangements
- Resolution of IT and information sharing issues
- Team development, staff communication and involvement
- Facilitation of the resolution of communication issues between providers

Patient understanding and acceptance of service is vital to ensure that they not only use the services appropriately but also feel confident that the service they have received has met their needs. If this is not the case not only will the anticipated outcomes not be achieved but the patient experience will not be satisfactory and demand for services may increase if the patient requires affirmation from the GP for the treatment provided via other means. To mitigate this, work with the patient includes:

- Regular patient feedback about the service taking action as necessary
- Involvement of the patient in the design of the schemes
- Development of patient information

Without the availability of suitable premises to deliver services the schemes would not be able to operate effectively which again would impact negatively on the anticipated outcomes. Therefore focus has been placed on developing or sourcing suitable premises from which to deliver the services. This includes looking at alternative solutions should the primary choices not be available or are delayed in being available.

A significant aspect to the schemes is to release clinical time to enable primary health care to be delivered differently and more effectively. This in turn will ensure sustainability of Primary Care and reduce the need for secondary care interventions. It is therefore key that any released time is used effectively by the clinicians in order to achieve the projected outcomes. To that end work is ongoing with the clinicians to develop new ways of working, e.g. offering longer appointment times for the more complex patients, and to ensure good practice is shared across the area.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
C
Scheme name
Proactive and personalised care
What is the strategic objective of this scheme?
Care and support in the community will comprise a comprehensive menu of responses which are co-ordinated and organised to wrap around individuals, their carers, and family, putting them at the heart of the decision-making process. Services will support them to thrive and live as independently as possible through a focus on prevention, early identification of need, timely, appropriate co-ordinated and planned delivery of advice, information, support and care, via a fully integrated local community care team with general practice and primary care as the driving force. This scheme comprises a planned and co-ordinated approach to early identification of risk of deterioration, intervention and care delivery and support to thrive as independently as possible and to maximise recovery following illness or injury. Their care will be provided close to home, and a proactive health and social care approach will be implemented across all sectors. Specifically, this will include: - A local approach to delivery of personalised care - The implementation of tele-health approaches across health and social care - The provision of adaptations and equipment to support health and wellbeing - Enhanced support and care to residents in care homes - Multi-disciplinary care supported by specialised medical input from a community geriatrician model. Ready access to proactive and integrated care will deliver a step change in the management of the health and social care needs of the frail elderly and those with multiple long term conditions and complex needs, from early identification through to treatment and supported self-management, assisted by regular case review. This scheme will support the implementation of the new General Medical Services contract which requires a named, accountable GP to be responsible for overseeing the care of all people aged 75 or over, GPs to supervise risk profiling and proactive care management for patients with complex health and care needs and GP practices to support more integrated working with out-of-hours services. The scheme outline has been defined in line with the South Nottinghamshire Transformation Plan which is based on a baseline analysis of current performance, then benchmarked against comparators to identify potential scope for improvement on quality and cost effectiveness.

To date, CCG informatics teams have also benchmarked their outcome and ambition data with a range of other sources, including:

- Joint Strategic Needs Assessments for Nottinghamshire County Council and Nottingham City Council
- Right Care (including Commissioning for Value Packs and the NHS Atlas of Variation in Healthcare)
- Public Health England data and toolkits
- Office for National Statistics data (on demography and population growth)
- Dr Foster benchmarking data (such as that on emergency admissions)
- Data from the NHS England Derbyshire and Nottinghamshire Area Team (on population growth)
- Local data showing variation between practices and across the four CCGs
- National data showing variation between practices
- Other tools, such as those to examine statistical significance of variations in data

The JSNAs have been used to frame CCGs' strategic commissioning intentions. Our plans are based on JSNA findings and are aligned to the Health and Wellbeing Strategy for the county. Ongoing plans to improve outcomes align to existing JSNAs, and discussions have also been undertaken with public health colleagues to support this.

As a health and social care community it is acknowledged that there are significant financial challenges over the next five years. The CCGs are working closely with Nottinghamshire County Council colleagues in understanding the changes required as a result of the cost reviews and the potential impact on the schemes included in the Better Care Plan. This scheme has been developed to meet best practice and optimum use of resources to ensure high quality and cost efficiencies, to best meet the needs of patient care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

In line with the South Nottinghamshire 5 year plan this scheme supports the implementation of the local programmes known as Support to Thrive, Choose to Admit, and Transfer to Assess. The primary patient cohort being targeted in this scheme are the over 75s and those with long term conditions at risk to admission.

Personalised care

Personalised care will be delivered through personalised care plans, goal setting, promoting independence through reablement goal setting and shared decision making wherever possible in the person's own home, for all patients with long term conditions and frail older people.

Anticipatory care plans, including anticipatory medication, will also be in place for all patients on end of life registers. There will also be improved access to support for

personal lifestyle advice and behaviour modification to reduce risk factors through a menu of self-care resources.

- Establish multi-disciplinary and multi-agency integrated care teams to improve access to local services through an integrated multi-agency community hub, using predictive risk modelling and case management.
- Establish comprehensive range of rehab and reablement services.

Telehealth

Patients will be supported to manage their own care through the implementation of tele-health models of care. This will be targeted towards patients with long term conditions.

Equipment services

Adaptive equipment will be provided in a timely manner, to ensure that patients can maintain their independence and safety within their home environment.

Enhanced support and care to residents in care homes

Case management of care home residents will be improved, to shift the focus away from reactive care (responding to call outs and crisis management) towards a holistic, proactive approach. Each care home resident will have person-centred health and social care and support plans, including advanced care planning. This is a multi-professional response across general practice, community services and ambulance services. This will lead to an increase in the confidence and ability of care home staff to deliver high-quality co-ordinated care.

Community geriatrician

This approach complements the delivery of proactive care through the provision of comprehensive geriatric assessment in community settings, linking with primary care and community services in a planned approach. Consultant geriatricians will provide expertise to multi-professional teams working with complex patients and provide case review and direct patient care with smooth access to secondary care as appropriate.

Implementation timescale

2014/15: Primary care, community services and third sector are implementing enhanced support for patients identified as at risk, and who will benefit from enhanced proactive care.

This represents significant transformational change and forms a substantial element of the South Nottinghamshire Transformational Strategy, and will continue into year 2.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

Commissioners:

Nottingham North and East CCG, Nottingham West CCG, Rushcliffe CCG lead the commissioning of proactive care primary and community services.

Nottinghamshire County Council leads the commissioning of equipment services in

collaboration with CCGs.

Providers involved in this work:

- GP Practices – personalise care and enhanced support to care homes
- County Health Partnerships – enhanced support to care homes
- Nottingham University Hospitals NHS Trust – Community Geriatrician
- British Red Cross – Equipment services

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcome

CCG Primary Care Strategies 2014-2019

Avoiding Hospital Admissions, December 2010, The King's Fund

Care Planning: improving the lives of people with long term conditions. RCGP 2011.

Nottinghamshire Emergency Care Whole System Review recommendations (ECIST 2013)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

It is expected that outcomes will be measured through:

- Delivery of whole system vision
- Improved patient outcomes
- Better patient and carer experience
- Sustainability of health and social care economy
- A reduction in length of stay, especially for ambulatory sensitive conditions
- Decreased inappropriate use of Accident and Emergency/999
- Increase in the number of patients dying in their place of choice
- Benchmarking, including peer review on quality metrics, reducing unwarranted variation
- Reduction in numbers of conversions from residential to nursing home care

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monitoring of the outcomes through exiting data analysis mechanisms for hospital activity. Patient feedback via local mechanisms and PALS/Complaints services. Existing monitoring information at a County level for care home admissions. Contracts in places with GP Providers, Community Services Providers, Acute sector provider and voluntary sector, monitored through contract monitoring schedules/meetings Reporting to CCG Clinical Cabinet or equivalent and/or Health and Wellbeing Board Reporting to patient engagement groups e.g. CCG People's Councils or equivalent
What are the key success factors for implementation of this scheme?
Provision of IT information accessible across providers – supported locally by Connected Nottinghamshire Workforce including training and education – early planning in place as part of the South Nottinghamshire transformation work. Contracting mechanisms – early work is taking place to look at different ways of contracting for services such as accountable care organisations Working collaboratively across providers – a series of steering groups and workstream meetings enable this to happen. The outcomes will be more difficult but not impossible to achieve and local sharing of good practice and learning will enable the scheme to implement at pace. All partners are fully engaged with the proposals and are working alongside commissioners to move at scale towards implementation. Regular reporting of outcomes and achievements is shared with key stakeholders.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
D
Scheme name
Community care co-ordination
What is the strategic objective of this scheme?
The purpose of this scheme is to provide a more responsive range of community health and social care services which deliver care closer to home, through more flexible co-ordination and delivery of integrated health and social care provision. This will support the local programmes known as Choose to Admit and Transfer to Assess, through the enhancement of community co-ordination systems, e.g. community care co-ordination team, community hubs, and integrated reablement teams. This in turn will enhance the community ward approach. The scheme outline has been defined in line with the South Nottinghamshire Transformation Plan which is based on a baseline analysis of current performance, then benchmarked against comparators to identify potential scope for improvement on quality and cost effectiveness. To date, CCG informatics teams have also benchmarked their outcome and ambition data with a range of other sources, including: - Joint Strategic Needs Assessments for Nottinghamshire County Council and Nottingham City Council - Right Care (including Commissioning for Value Packs and the NHS Atlas of Variation in Healthcare) - Public Health England data and toolkits - Office for National Statistics data (on demography and population growth) - Dr Foster benchmarking data (such as that on emergency admissions) - Data from the NHS England Derbyshire and Nottinghamshire Area Team (on population growth) - Local data showing variation between practices and across the four CCGs - National data showing variation between practices - Other tools, such as those to examine statistical significance of variations in data The JSNAs have been used to frame CCGs' strategic commissioning intentions. Our plans are based on JSNA findings and are aligned to the Health and Wellbeing Strategy for the county. Ongoing plans to improve outcomes align to existing JSNAs, and discussions have also been undertaken with public health colleagues to support this. As a health and social care community it is acknowledged that there are significant financial challenges over the next five years. The CCGs are working closely with

Nottinghamshire County Council colleagues in understanding the changes required as a result of the cost reviews and the potential impact on the schemes included in the Better Care Plan. This scheme has been developed to meet best practice and optimum use of resources to ensure high quality and cost efficiencies, to best meet the needs of patient care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The key to effective co-ordination is the assessment process – the right assessment, at the right time, in the right place, by the right team. The community needs to take responsibility for the discharge of patients from secondary care. This will include planning the discharge from the time of admission into secondary care, and ensuring the development and provision of responsive community services to facilitate timely discharge.

Community services will be co-ordinated and responsive to actively support citizens to remain at home and avoid unnecessary admissions through choose to admit approaches.

The proposal is to:

- Develop a health and social care assessment service that is community based, supports patients seamlessly from hospital to home, and is jointly developed and delivered across health and social care
- Provide in-reach into the hospital and follow the patient into their own home
- Redesign and align the acute social care, reablement and community hospital/ intermediate care resources to support this approach
- Understand the impact upon social care resources across the acute and community settings, to ensure that these are planned and reviewed accordingly in order to utilise resources effectively
- Undertake testing of this approach, specifically in health care of the elderly
- Ensure that monitoring systems are in place to actively track the patient during an acute hospital stay to enable repatriation home once medically stable
- Enable an understanding of available local community capacity to ensure rapid transfer of care to the appropriate community setting
- Ensure continuity of care across the whole health and social care system from step up services through to step down, following or avoiding an acute hospital episode

Delivery of reablement services for patients with low-level needs to support both admission avoidance and transfer to assess approaches. This resource will form part of the multidisciplinary team designed as a community ward model.

In line with the South Nottinghamshire 5 year plan this scheme supports the implementation of the local programmes known as Support to Thrive, Choose to Admit, and Transfer to Assess. The primary patient cohort being targeted in this scheme are the

over 75s and those with long term conditions at risk to admission.

Implementation timescale

Work is under way to redesign the social care resources and align these within the acute setting to the city social care resources, to standardise and improve efficiency options. This enables the remaining resources to be redeployed to community services, and align these with primary care, and acute services. Delivery and impact will be realised during 14/15 and will continue to be refined in 15/16.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

A collaborative partnership is being developed between health and social care commissioners to design and implement this revised approach. This is being undertaken in consultation with the main stakeholder provider groups to ensure that the reconfigured services are maximising the provider skills and experience of developing new and innovative, flexible approaches to whole system process changes. These are therefore more likely to enhance the ownership and utilisation of efficient and robust cohesion along the delivery chain.

Health and Social care commissioners

- Nottingham North and East CCG
- Nottingham West CCG
- Rushcliffe CCG
- Nottinghamshire County Council

Providers

- County Health Partnerships
- NCC START reablement services
- 3rd sector providers
- GP practices

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is significant evidence of the effectiveness of early supported discharge for stroke patients. This learning and good practice is being used to inform local approaches for frail older people.

The Nottinghamshire Community Programme service evaluations, proof of concept testing and audit (2012-2014)

Care Coordination through integrated health and social care teams. Kings Fund 2011

Transforming our healthcare system: 10 priorities for commissioners. Kings Fund 2013

Nottinghamshire Emergency Care Whole System Review recommendations (ECIST 2013)

Utilisation reviews (NUH/SFHT 2010, Community Hospitals 2011, Intermediate Care 2011)

Integration of primary and secondary care - Kings Fund (Dec 2010)

Emergency department Front door (further evidence needed) Kings Fund (Dec 10)

DH (2002) Avoiding and diverting admissions to hospital - a good practice guide

Audit Commission (2002) Integrated services for older people The Stationery Office

Curry N, Ham C (2010). Clinical and Service Integration. The route to improved integration. London: The King's Fund

DH (2006) Our health, our care, our say: a new direction for community services

Thome B, Dykes A K, Hallberg I R. Home care with regard to definition, care recipients, content and outcome: systematic literature review. Journal of Clinical Nursing 2003; 12(6): 860-872

Early Supported Discharge SIGN guidance (2002)

Early senior review in A/E Kings Fund (Dec 10)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The outcomes for people will improve as we are able to understand the ways our providers deliver care, agreeing standardised workforce competencies, tools and systems which mean that we can focus commissioning efficiently and effectively focusing on the services people need. We will measure achievement of outcomes through robust jointly-agreed KPIs, which reflect the needs, aspirations, and values of those for whom

the services are designed. Our measures of health gain will be devised through a process of integrated partnership to engage with the desired outcome measures of stakeholders.

Satisfied Patients

- Qualitative and quantitative analysis of patient experience

Motivated and positive staff

- Staff questionnaires, training, and development
- Proportion of WTE working in services

Outcomes

- Mortality and morbidity rates
- Case management of long-term conditions
- Proportion of people entering long-term care
- Patients managed in community bed services
- EOL plans in place/Preferred place of death
- Suitable housing options

Financial Management

- A reduction in acute bed capacity through the increase in community bed/at home places
- Information and advice to self-funders
- Unplanned admissions
- Delayed transfers of care
- Re-admission rates

The joint commissioning group across City and County will be responsible for developing the approach, sharing good practices and disseminating the learning from practice. Relevant CCG/LA groups will receive reporting on the progress of the scheme.

What are the key success factors for implementation of this scheme?

Key success factors are:

- Aligned and shared processes and assessment tools
- Improved and efficient use of resources
- Cultural shift from acute to community to manage and respond to health and care needs
- One social care pathway between City/County social care
- Aligned working practices which deliver key objectives. To facilitate this, we are utilising:
    - Experienced senior staff from NCC leading on aligning integration models
    - Partnership commissioners have previously successfully delivered on service remodelling integrated services
    - Citizen, provider, clinical, staff and 3rd sector engagement

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
E
Scheme name
Support for carers – including short breaks and respite care
What is the strategic objective of this scheme?
Nottinghamshire's Integrated Commissioning Carers' Strategy is overseen, developed and updated by the Nottinghamshire Carers' Implementation Group, comprising representatives from all Clinical Commissioning Groups, Nottinghamshire County Council, carers from all localities and key stakeholders. The current year's plan is jointly funded and contains a number of initiatives to be implemented in 14/15 with a view to evaluating these and from 2015/16 onwards, continuing those that can demonstrate improved outcomes for carers and value for money. The JSNA has been used to develop and inform the Integrated Commissioning Carers' Strategy. The joint Carers' Implementation Group reports into the Older People's Integrated Commissioning Group and ultimately to the Health and Wellbeing Board.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Rationale: The Carers' Strategy was developed in response to local need and national drivers, and reflects the plans developed by the clinical commissioning groups. In addition, the strategy addresses the Carers' Survey 2012. The 2011 Census report identified that there has been an increase in the number of carers in the last decade by 7,517 across Nottinghamshire (excluding Nottingham City). There are now 90,698 carers in the county; 57,426 carers are providing between 1-19 hours of care per week, and the number of carers now providing over 50 hours of care per week has reached 21,680. From April 2013 to March 2014, the council assessed and reviewed 4,719 carers, of whom 3,470 received a service. Based on population data, the value of the support provided by informal carers in Nottinghamshire would be around £1,656 million. It is therefore both ethically and economically sound to support carers to continue in their

caring role.

The Care Act 2014 emphasises the importance of supporting carers, parity of esteem for carers and the cared-for person, principles of wellbeing and personalisation, universal rights to information and advice and carers' rights to an assessment and services. The expectation is that the Act will increase demand for both provision of carers' assessments and also services.

Brief descriptions of schemes:

Dementia 'Compass' support workers

To commission and evaluate 'Compass' workers who will provide practical and emotional support to carers of people experiencing dementia.

End of Life Carers Service

To commission and evaluate an 'End of Life Carers Support Service' providing practical and emotional support for 'end of life' carers

NHS Carers' Breaks (DPs)

To improve access to NHS Carers' Breaks and enable a greater choice of alternatives for the 'cared for' person to choose from, through the use of Personal Health Budgets as Direct Payments for carers.

GP practices / NCC interface

Implement the role of carers' champions within general practice in order to identify more carers and target support to those that need it.

Carers' universal services & engagement

Jointly re-commission Information and Advice service for carers, to develop an Information Hub.

BME & seldom heard carers service

To develop a support service designed to meet the specific needs of BME Carers.

Carers training incl. 'moving and handling'

a) To run training courses ('Caring with Confidence') across the county
b) To increase awareness of and recruitment to 'Looking After Me' course
c) To provide input into Carer Information Support Programme (CrISP) for carers of people with dementia, run by the Alzheimer's Society on a rolling programme

Communications and engagement

A range of initiatives that improve the use, content and range of existing information supported by approaches to pro-actively target and engage carers who may benefit. This includes work with community pharmacists, development of a specifically designed carers' point of information display for GP practice waiting rooms & clinics and information packs tailored to meet the needs of carers of people with dementia.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on the Carers' Implementation Group and the Carers' Commissioning Forum (key commissioners from health and social care). The joint Carers' Implementation Group reports into the Older People's Integrated Commissioning Group and ultimately to the Health and Wellbeing Board.

Commissioners: all CCGs and Nottinghamshire County Council

Provider – various including:

- Nottinghamshire Healthcare NHS Trust
- Central Nottinghamshire Clinical Services (CNCS)
- Alzheimer's Society
- Carers Federation
- GP surgeries.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence base:

Evidence shows that supporting carers has been demonstrated to be cost effective. The Department of Health "Impact Assessment" includes a number of aspects, such as improved support for carers and carers' assessments. It details the figures for funding for carers' assessments and provision of support, and also the savings that the Department of Health believe will arise from improved support for carers, which is recognised in the Care Act 2014.

A 2013 review of the evidence base for funding carers was commissioned from the Institute of Public Care for Nottinghamshire in order to inform the carers' strategy and review of existing services. This identified a number of critical factors of successful carers' support services:

- Early identification
- A focus on outcomes
- A focus on improving and measuring quality of life

Referenced documents:

Nottinghamshire Joint Strategic Needs Assessment

Carers at the heart of 21st Century Families and Communities; (Department of Health, 2008)

Care and Support Legal Reform (Part 1 of the Care Bill) Impact Assessment (8 May

2013), Department of Health.

Institute of Public Care, Oxford Brookes University: Evidence Base for Carer Support 2013

Adult Social Care and Health Carers' Survey 2012

Improving How Direct Payments work for People with Dementia – Final Project Report 2014

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

All initiatives aim to deliver the following outcomes:

- Carers can balance their caring roles and maintain their desired quality of life
- People know what choices are available to them locally, what they are entitled to, and who to contact when they need help
- Carers can access support in their local area
- Earlier diagnosis, intervention and reablement mean that people and their carers are less dependent on intensive services
- Carers have choice and control over how they receive support
- Carers feel that they are respected as equal partners throughout the care process
- People who use social care and health services, and their carers, are satisfied with their experience of care and support

In addition:

Dementia 'Compass' support workers

- People with dementia and their carers are less dependent on intensive services, through earlier diagnosis, intervention and reablement

NHS Carers' Breaks Direct Payments

- Carers have greater choice of alternatives
- Increased numbers of carers report that they spend as much time as they want on what they enjoy (Social Care Survey)

GP practices and Local Authority interface

- Increased numbers of carers report that:
- Information and advice were easy to find (Social Care Survey)
- That they get enough encouragement and support in their role

Carers' universal services - engagement and communications

- Increased numbers of carers report that information and advice were easy to find (Social Care Survey)

BME & seldom heard carers service

- Increased numbers of carers from BME communities state that they get enough encouragement and support in their role (Social Care Survey)

Carers training including 'moving and handling'

- Carers can balance their caring roles and maintain their desired quality of life
- Carers are confident and have the skills they need

Each service specification is outcome focussed with relevant performance metrics and milestones included.

Timescale

This will be defined by the evaluation of the success and outcomes of the schemes during 2014/15 which will inform the commissioning strategy from 2015/16.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

All local CCGs work in partnership with Nottinghamshire County Council and have developed an Integrated Carers Commissioning Strategy, which aligns with wider commissioning plans across health and social care.

The Strategy is overseen by the Carers' Implementation Group, (see above).

In addition, a regular Carers Commissioning Forum brings together key commissioners from health and social care across the county to discuss the strategy and joint working.

The voice of the carer is essential to this work and is incorporated wherever possible: e.g.

- carer representatives are integral to the Carers' Implementation Group
- carers will be involved in the tendering of the Carers' Universal Services
- consulting with carers' groups
- a county-wide Carers' Conference was held in May 2014 where carers were asked for their views on the Strategy, etc

Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies and the use of specialist analytical software where appropriate. This will involve a comprehensive evaluation of Carers' Services, planned for Autumn 2014.

What are the key success factors for implementation of this scheme?

Key success factors for the scheme include:

- Partnership working – our local health and social care community working together, with carers integrated into wider projects; e.g. self-care and primary care
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes.

Delivery timelines for schemes are shown below:

1. Dementia Compass Workers: evaluate the delivery of this service by March 2015.

2. End of Life Carers Support Service: evaluate the delivery of this service by March 2015.

3. Development of a new Carers Information Pack by October 2014.

4. Carers Roadshows across the county by December 2014.

5. Carers Support service: to recruit a Community Care Officer to liaise with Primary Care Teams to promote Carers Registers within General Practice by March 2015.

6. Carers' Personal Budgets: to offer 150 carers a Personal Health Budget for respite breaks, by March 2015.

7. Training for carers: to deliver 6 Caring with Confidence courses / Looking after Me courses by March 2015.

8. New, jointly commissioned Universal Services for Carers (including advice, information, training and engagement) will be tendered, awarded and services due to start in April 2015.

9. Evaluation work: to complete an evaluation report by November 2014 to inform carers tendering process for the county.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
F
Scheme name
Protecting Social Care Services
What is the strategic objective of this scheme?
The emphasis for social care support for adults aged over 18 years will be on developing individual and community resources. These will be designed to meet the strategic objective of preventing, delaying or reducing the need for health and social care and support. This is in line with the new Care Act which puts new duties and responsibilities on the Council. This includes the need to: - Focus care and support on promoting wellbeing and preventing or delaying the need for social care support - Ensure that people are given advice and information to help them to plan for the future and to ensure they know where to go for help when they need it As part of this the Council will always consider the most cost effective way of offering social care support to a person. The objective will be to reduce the number of people that need long term social care support and to maximise the choice and control for those people who are eligible. This is in the context of increasing demand and numbers of frail and vulnerable older people and younger adults with complex health and social care needs. In addition the Local Authority continues to face significant financial constraints This scheme is one of the national conditions of the Better Care Fund. The strategic objective of this scheme is to meet the needs of increasing numbers of frail and vulnerable elderly people and younger adults with complex health and social care needs, at a time when the Local Authority continues to face significant financial constraints, and also has to meet new and extended duties and responsibilities arising from the Care Act 2014.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Context Over the last few years, the Local Authority has been adapting to a period of rapid change in terms of:

- implementation of personalisation, enabling service users and carers to have choice and control over the services they receive and the ways in which the services are delivered
- significant reductions in funding for social care services over a protracted period
- increasing demand as a result of demographic changes with an aging population, and as a result of medical advances as people with complex health and social care needs are supported to live longer

In addition, the Care Act 2014 represents the biggest change in how social care is delivered for over 70 years, and will lead to significant changes for the Council, partner organisations and providers, service users and carers. Most of the changes will need to be ready for April 2015.

The Act places new and extended duties and responsibilities and the Council will need to use the BCF to:

- Implement the new national eligibility criteria
- Have the capacity to undertake more carer assessments and provide services and support to meet these needs
- Create additional resources to provide more information and advice to enable people to self-care and reduce the numbers of people needing long term health and social care
- To invest in preventative and reablement services that increase people's independence and reduce the investment demands on local CCGs
- Increased capacity to undertake financial and assessment support to people who fund their own care

The implementation of the Care Act is being undertaken in partnership and is being overseen by a dedicated Care Act Team (see Annex 1 for Scheme Z for further details). As part of this the following work streams have been established:

- Assessment and Care Management
- Advice, Information and Advocacy
- Front-end
- Paying and Charging For Support
- Carers
- Strategic market development
- Prevention and Housing
- Quality and risk
- Safeguarding
- Workforce
- ICT
- Communication and engagement

Schemes

This scheme meets the requirements arising from the JSNA and has been developed in accordance with the JHWS.

This Scheme is being targeted to services and support which meet the objectives of the Care Act, to meet increased demand for support, and to prevent people needing long term health and social care to alleviate pressures on health services. This includes:

- Services which enable people to live independently in their own homes for as long as possible through the provision of targeted care and support including home care and community equipment. The services will be arranged through personal budgets to provide better outcomes. Increasingly people are being encouraged and supported to commission the services themselves through Direct Payments in order that they have more choice and control
- Services targeted specifically at preventing avoidable hospital admissions and on supporting swift and effective hospital discharge especially in relation to frail elderly people and with the intention of reducing re-admissions following discharge. This includes increasing the number of people that have an agreed discharge plan for planned admissions
- Supporting increasing numbers of older people who require nursing home placements due to their complex health and social care needs including challenging behaviour due to dementia
- Supporting health colleagues in reducing unnecessary admission to hospital from Care Homes
- Meeting increasing demands for supported accommodation for younger adults with complex health care needs arising from their disabilities, to enable them to live independently in the community and to prevent or delay the need for residential or nursing care. Many of the service users also have continuing health care needs
- Meeting increasing demand for large complex packages of care to support people with learning disabilities to remain living at home. The services also enable carers to maintain their employment and to have a break from their caring duties
- Maintaining housing-related support services for vulnerable people including people with mental health needs, or those who require support to manage substance misuse, in many cases preventing people requiring urgent care and presenting at hospital emergency departments
- Supporting carers to enable carers to continue to caring (see Annex 1 for Schemes E, N and V for details on our joint approach with Nottinghamshire's CCGs)
- Reducing the numbers of people that have a delayed discharge from hospital attributable to social care, with an overall objective to have zero delays

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This scheme is led by Nottinghamshire County Council and is being developed in partnership with the three Nottinghamshire Transformation Boards:

Commissioners: Nottingham City CCG (as members of the South Nottinghamshire Transformation Board), Rushcliffe CCG, Nottingham North & East CCG, Nottingham West CCG, Bassetlaw CCG, Mansfield and Ashfield CCG, and Newark and Sherwood

CCG

Providers: Nottingham University Hospitals, Nottinghamshire Healthcare, Nottingham CityCare Partnership, County Health Partnerships, Bassetlaw Health Partnerships, Doncaster and Bassetlaw Hospitals, Sherwood Forest Hospitals, Central Nottinghamshire Clinical Services (CNCS)

Councils/Third Sector: Nottinghamshire County Council, Nottingham City Council (as members of the South Nottinghamshire Transformation Board), Carers Federation, Nottinghamshire's District and Borough Councils

The JSNA is used to inform the strategic commissioning plans of the CCGs and the Local Authority in relation to frail older people and younger adults with complex health and social care needs. Progress in relation to the services outlined above is reported to the Health and Wellbeing Board on a regular basis

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Assumptions

Nottinghamshire's Joint Strategic Needs Assessment (JSNA) estimates that by 2025 there will be 196,600 people aged 65+ living in the county – 23% of the total population. The largest increase is expected for people aged 75-79 increasing by approximately 16,000.

The numbers of people aged 85 and over with a limiting long-term illness are expected to double by 2030. The prevalence of dementia is expected to rise across Nottinghamshire by 88% between 2010 and 2030 from 9,800 to 18,400 because of the ageing population. It can therefore be assumed that the demand for health and social care services for people with multiple and often complex health care needs will continue to rise.

Evidence base

Evidence shows that the right level of support provided to patients and their carers, at the point of crisis, will help prevent the need for long term interventions. In response, the CCGs and the Local Authority are seeking cost-effective ways of delivering services with a clear focus on promoting independence and on self-care. Many of the services outlined above seek to help people to regain and retain their independence so that they require reduced levels of support following the period of crisis.

It is, however, evident that the numbers of people with complex health and social care needs, including dementia and long term conditions, continues to rise. This places considerable pressure on overstretched health services and on the Local Authority care services at a time of severe financial constraints. A number of the services outlined above are therefore aimed at meeting the longer term needs of older people with complex needs and younger adults with complex health and social care needs arising from their disabilities.

In the development of each service, we are working closely with the Nottinghamshire

Public Health department to implement evidence based practice. This scheme has been developed with reference to the following:

- Nottinghamshire Joint Health and Wellbeing Strategy
- Nottinghamshire Joint Strategic Needs Assessment
- Adult Social Care and Health Carers' Survey 2012
- Care Act 2014
- Published evidence and local evaluation of direct payment trailblazer (e.g. TLAP, Improving How Direct Payments work for People with Dementia – Final Project Report 2014)
- Published evidence base and local evaluations of intermediate care, reablement and out-of-hospital services (e.g. findings from the National Audit of Intermediate Care)
- Published evidence and local evaluation of early intervention and prevention services (e.g. locally commissioned report from the Institute of Public Care)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Outcomes

Outcomes will be measured through:

- numbers of people with long term conditions and complex disabilities supported to live independently in their own homes
- reductions in the numbers of care home placements, particularly in residential care
- increase in the number of people who are able to regain and retain their independence so they require less support over time
- reductions in length of stay in acute and community services
- reductions in emergency admissions and re-admissions
- improvement in patient experience
- improvement in quality of life for carers

Specific data on performance, efficiency and quality outcomes are currently being worked up as part of the programme and are not yet available.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Nottinghamshire County Council is ultimately responsible for delivery of outcomes. This scheme will be monitored by the Health and Wellbeing Board, the Adult Social Care and Health Committee, and the three Nottinghamshire Transformation Boards for each unit of planning.

Review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies, and the use of specialist analytical software where appropriate.

What are the key success factors for implementation of this scheme?

Key success factors for the scheme include:

- Ensuring efficient use of resources – working closely with our health and social care community commissioners and providers to deliver integrated care and support for our citizens within limited resources is essential to delivering outcomes
- Partnership working – our local health and social care community are working together through the Health and Wellbeing Board and BCF Working Group
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes
- Training - frontline staff need to have the skills and expertise to deliver services that reable citizens. This has been factored in to delivery plans
- Market management – as a health and social care community we are working with local providers to ensure that the future needs of our population can be met

Timescale

The services are in place and are being delivered to meet needs. Nottinghamshire County Council continues to monitor the impact of the services in relation to the outcomes identified above.

- 2016: Financial challenges will be met across health and social care through increased joined up work and efficiencies made through improving community services across health and social care
- 2017 – 2019: more people will be supported to live independently
- 2019 – 2021: Patients and service users across Nottinghamshire will have access

to the right services, at the right time and in the right place

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
G
Scheme name
Rehabilitation/reablement services – at home and community bed based
What is the strategic objective of this scheme?
The purpose of this scheme is to ensure timely and responsive services closer to home to meet the needs of patients with a range of health and social care needs. The scheme delivers a range of services which promote increased independence through targeted reablement plans, thereby reducing people's reliance upon long term services and admissions to residential services. This scheme delivers the local approaches of Choose to Admit and Transfer to Assess through the enhancement of community services as an alternative to admission to acute services and to facilitate discharges. The scheme outline has been defined in line with the South Nottinghamshire Transformation Plan which is based on a baseline analysis of current performance, then benchmarked against comparators to identify potential scope for improvement on quality and cost effectiveness. To date, CCG informatics teams have also benchmarked their outcome and ambition data with a range of other sources, including: - Joint Strategic Needs Assessments for Nottinghamshire County Council and Nottingham City Council - Right Care (including Commissioning for Value Packs and the NHS Atlas of Variation in Healthcare) - Public Health England data and toolkits - Office for National Statistics data (on demography and population growth) - Dr Foster benchmarking data (such as that on emergency admissions) - Data from the NHS England Derbyshire and Nottinghamshire Area Team (on population growth) - Local data showing variation between practices and across the four CCGs - National data showing variation between practices - Other tools, such as those to examine statistical significance of variations in data The JSNAs have been used to frame CCGs' strategic commissioning intentions. Our plans are based on JSNA findings and are aligned to the Health and Wellbeing Strategy for the county. Ongoing plans to improve outcomes align to existing JSNAs, and discussions have also been undertaken with public health colleagues to support this.

As a health and social care community it is acknowledged that there are significant financial challenges over the next five years. The CCGs are working closely with Nottinghamshire County Council colleagues in understanding the changes required as a result of the county council efficiency requirements and the potential impact on the schemes included in the Better Care Plan. This scheme has been developed to meet best practice and optimum use of resources to ensure high quality and cost efficiencies, to best meet the needs of patient care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This scheme will develop an extensive range of community capacity which will reduce reliance on acute hospital care and provide care closer to home. The assumption is that this type of out-of-hospital care will improve patient outcomes and quality of life and avoid unnecessary hospital admission. Specifically, services will be enhanced through:

- Community health and social care alternatives to hospital based care (Choose to Admit)
- Services at home following repatriation from hospital to home-based or community bed-based health and social care services (Transfer to Assess)
- The proposal is to build on the 2 elements of the current service reablement/rehabilitation provision:
- Clinical rehabilitation
- Complex rehabilitation

The proposal is to develop integrated community reablement/rehabilitation services which respond to the right care in the right place at the right time. This will be designed to meet medium and high levels of health and social care needs for patients in their own home or in a bed based service provided in a local nursing care facility. This will manage increased patient complexity in the community. The scheme will offer step up and down responses, to prevent hospital admissions and to facilitate timely discharge. This will decrease levels of ongoing reliance upon services, through promoting independence and improving patient choice and control of what and how services are delivered to meet their outcomes.

A reconfiguration of service provision towards an increased flexibility and capacity of provision, will ensure that the community bed capacity will have the ability to manage more complex nursing needs, delivering transfer to assess as close as practicable to a citizens own home. This will facilitate an increased patient flow and improved pathways within the system to provide better outcomes for people. A new homecare contract will be negotiated with the council to enable the timely provision of an integrated night sitter service, to support patients to remain in their own home during a period of rehabilitation and assessment. This will particularly benefit citizens with dementia and increase the opportunity to maximise independence and reduce the numbers of long term care admissions as a result of prolonged periods in the acute and /or residential and nursing facilities.

A reconfiguration of the existing end to end process is underway with regards to the social care and health interventions, with the aim of improving the integration of teams and maximising resources while decreasing the numbers of duplicated processes and assessments within the existing patient pathways.

In line with the South Nottinghamshire 5 year plan this scheme supports the implementation of the local programmes known as Support to Thrive, Choose to Admit, and Transfer to Assess. The primary patient cohort being targeted in this scheme are the over 75s and those with long term conditions at risk to admission.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

A collaborative partnership is being developed between health and social care commissioners to design and implement this revised approach, this is being undertaken in consultation with the main stakeholder provider groups to ensure that the reconfigured services are maximising the provider skills and experience of developing new and innovative, flexible approaches to whole system process changes. These are therefore more likely to enhance the ownership and utilisation of efficient and robust cohesion along the delivery chain.

Health and social care commissioners

- Nottingham North and East CCG
- Nottingham West CCG
- Rushcliffe CCG

Providers

- County Health Partnerships
- NCC START reablement services
- 3rd sector providers
- GP practices

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is significant evidence of the effectiveness of intermediate care services and hospital at home services in improving patient outcomes and reducing the impact on long term care placements.

Utilisation reviews (NUH/SFHT 2010, Community Hospitals 2011, Intermediate Care 2011)

Integration of primary and secondary care **–** Kings Fund (Dec 2010)

Emergency department front door (further evidence needed) Kings Fund (Dec 10)

DH (2002) Avoiding and diverting admissions to hospital – a good practice guide

Audit Commission (2002) Integrated services for older people The Stationery Office

Curry N, Ham C (2010). Clinical and Service Integration. The route to improved integration. London: The King's Fund

DH (2006) Our health, our care, our say: a new direction for community services

Thome B, Dykes A K, Hallberg I R. Home care with regard to definition, care recipients, content and outcome: systematic literature review. Journal of Clinical Nursing 2003; 12(6): 860-872

Early Supported Discharge SIGN guidance (2002)

Nottinghamshire Emergency Care Whole System Review recommendations (ECIST 2013)

Early senior review in A/E Kings Fund (Dec 10)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Outcomes will be measured through:

- Improved access to the right service at the right time
- Improved patient outcomes
- Improved patient and carer experience
- Reduction in length of stay in acute and community services
- Reduction in emergency admissions and re-admissions
- Reduction in inappropriate use of Accident and Emergency/999
- Reduction the number of long term care placements made
- Reduction in reliance upon / levels of social care packages

The joint commissioning group across City and County will be responsible for developing the approach, sharing good practices and disseminating the learning from practice. Relevant CCG/LA groups will receive reporting on the progress of the scheme.

What are the key success factors for implementation of this scheme?

Key success factors are:

- Improved and efficient use of resources
- Cultural shift from acute to community to manage and respond to health and care needs
- Aligned working practices which deliver key objectives. To facilitate this, we are utilising:
    - A best in class NCC reablement service, with robust measurement of outcomes and deliverables to facilitate the knowledge base and learning
    - Experienced senior staff from NCC leading on aligning integration models
    - Partnership commissioners have previously successfully delivered on service remodelling of integrated services
    - Citizen, provider, clinical, staff and 3rd sector engagement

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
H
Scheme name
Home care and occupational therapy services & Additional Support to Social Care
What is the strategic objective of this scheme?
The purpose of this scheme is to provide interim home care services and timely assessments to help facilitate prompt hospital discharge of frail elderly people, to prevent delays in hospital discharges, to reduce re-admissions, and to avoid premature or unnecessary admissions into long term residential or nursing care. The scheme outline has been defined in line with the South Nottinghamshire Transformation Plan which is based on a baseline analysis of current performance, then benchmarked against comparators to identify potential scope for improvement on quality and cost effectiveness. To date, CCG informatics teams have also benchmarked their outcome and ambition data with a range of other sources, including: - Joint Strategic Needs Assessments for Nottinghamshire County Council and Nottingham City Council - Right Care (including Commissioning for Value Packs and the NHS Atlas of Variation in Healthcare) - Public Health England data and toolkits - Office for National Statistics data (on demography and population growth) - Dr Foster benchmarking data (such as that on emergency admissions) - Data from the NHS England Derbyshire and Nottinghamshire Area Team (on population growth) - Local data showing variation between practices and across the four CCGs - National data showing variation between GP practices - Other tools, such as those to examine statistical significance of variations in data The JSNAs have been used to frame CCGs' strategic commissioning intentions. Our plans are based on JSNA findings and are aligned to Nottinghamshire's Health and Wellbeing Strategy. Ongoing plans to improve outcomes align to existing JSNAs, and discussions have also been undertaken with public health colleagues to support this. As a health and social care community it is acknowledged that there are significant financial challenges over the next five years. The CCGs are working closely with Nottinghamshire County Council colleagues in understanding the changes required as a result of the cost reviews and the potential impact on the schemes included in the Better Care Plan. This scheme has been developed to meet best practice and optimum use of

resources to ensure high quality and cost efficiencies, to best meet the needs of patient care.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The scheme provides capacity for interim home care services to enable prompt and effective discharge from hospital. At times, patients experience delays in discharge from hospital because of limited home care capacity within the community, and because of the time it takes for longer-term care packages to be set up. This is especially the case for people with complex health and social care needs, who require two or more care workers and up to four home care visits per day.

This scheme seeks to provide a quick response for patients who are ready for discharge through the delivery of short term and often intensive care and support within the patient's home. The scheme ensures that a care and support package is put in place with little notice and within 24 hours from the point a patient is deemed medically fit and safe for discharge. The scheme has the added benefit of avoiding the need to use interim residential or nursing home placements, which in themselves can result in premature admissions in to long-term institutional care.

The scheme also funds some additional social work and occupational therapy capacity within the acute and community hospital settings to ensure timely completion of assessments of need so that the most appropriate services can be put in place to enable prompt and safe hospital discharge.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This scheme is being led and developed through the South Nottinghamshire Transformation Board with partner organisations.

Nottinghamshire County Council, Rushcliffe CCG, Nottingham North East CCG and Nottingham West CCG are the commissioners for the service.

Social work and occupational therapy are provided by Nottinghamshire County Council.

Crisis homecare services are provided through a contract with Crossroads Care East Midlands.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There is significant evidence that the right level of timely, and at times intensive, care and support provided to some patients upon discharge from hospital, together with appropriate support to their carers, can help them to regain their confidence and can support them in promoting their independence in the longer term. The absence of these services often results in premature and unnecessary admissions in to residential or nursing care.

This service model has been tested and comprehensively evaluated. An evaluation plan has been agreed with the commissioners to capture activity since service inception and changes to service delivery over time.

Reference documents

- 'Outcomes Matter; effective commissioning in domiciliary care' – LGiU Oct. 2012
- 'Close to home – An inquiry into older people and human rights in home care' – Equality and Human Rights Commission, November 2011
- 'Integrated services for older people' - Audit Commission, 2002
- 'Avoiding and diverting admissions to hospital - a good practice guide' – Department of Health 2002
- 'Our health, our care, our say: a new direction for community services' – Department of Health, 2006
- Wiltshire Council; Help to live at home service – 'An outcome-based approach to social care' Institute of Public Care, Oxford Brookes University, April 2012

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Outcomes will be measured through:

- Improved access to care and support services at home at the point of hospital discharge
- Improved outcomes for patients and their carers
- Reductions in length of stay in hospital
- Reductions in hospital re-admissions
- Reductions in the number of short term and long term residential and nursing

home placements

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The service is monitored by the South Nottinghamshire Transformation Board, the Older People's Integrated Commissioning Group and the Health and Wellbeing Board.

Review processes are in place to inform commissioning decisions accordingly, and evaluation of specific services is presented to the South Nottinghamshire Transformation Board for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies, and the use of specialist analytical software where appropriate.

What are the key success factors for implementation of this scheme?

Key success factors for the scheme include:

- Partnership working – our local health and social care community are working together through the Transformation Board.
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes. Where there are multi-disciplinary cross agency teams, a partnership approach has been taken.
- Management of the contract to ensure that appropriate support is put in place in a timely manner – timelines for timeliness of the intervention are specified in the contract with Crossroads Care East Midlands (1-2 hours depending on the type of support). The contract for this service is monitored by commissioners on a monthly basis, including how swiftly support is put in place. Poor performance will be managed and escalated as appropriate.

Timescale

The scheme has commenced and evaluation is being undertaken to determine the impact in terms of reduced length of stay in hospital. Work is under way to assess the amount of interim home care capacity required to ensure that no patients have to wait in hospital while longer term packages of care and support are being arranged.

Delivery and impact are being realised during 2014/15 and will continue to be monitored and evaluated during 2015/16.

2016 – 2019: there will be no one waiting for discharge from hospital once they are medically safe to be discharged.

2019 – 2021: Patients and service users across South Nottinghamshire will have access

to the right services, at the right time and in the right place.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
I
Scheme name
Transformation programme management
What is the strategic objective of this scheme?
To provide executive leadership, co-ordination/programme management and project management/change management capability and capacity to support the implementation of joint integration and transformation projects across health and social care. The Transformation Programme team will interface closely with staff leading integration projects within individual organisations in order to align activity and maximise the impact of the project resource across the system.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A Transformation Programme director will lead a small dedicated team who will work across health and social care, to provide expertise, capacity and co-ordination, and ensure the delivery of schemes through a programme management office function. This team will interface closely with staff leading integration projects within individual organisations, in order to maximise the impact of the project resource across the system. The Transformation Programme director will also ensure the delivery of a cross system organisational development (OD) programme to support successful collaborative working and culture change. This will include staff at all levels and in all care settings. At an executive level this will include establishing a core shared purpose, sharing mechanisms for managing financial risk and benefit, sharing agreement of ultimate arbitration when there are unresolved disagreements, sharing the agreement of the clinical basis for change, and building strong interpersonal relationships. The Transformation Programme will adopt a two-pronged approach: a. Optimising the current system including implementing transformational initiatives that are local to organisations (e.g. in primary care) as well as system wide (e.g. clinical navigation) b. Delivering a programme of large scale, strategic, whole system transformational change (accountable care systems – initial plans are currently being developed)

Current transformational initiatives include:

1. Clinical Navigation

The Navigation work stream aims to ensure that patients are navigated through the system appropriately and where possible reduce avoidable admissions.

Specifically the work will:

- Reduce avoidable admissions to Nottingham University Hospitals (NUH)
- Ensure patients receive timely and appropriate care, relevant to need, in the appropriate setting
- Ensure provision of appropriate, high quality clinical care for (more) patients
- Simplify current navigation processes, addressing issues concerning location of service, clinical triaging and co-ordination with NUH capacity

This will be provided through:

- Urgent access for GPs to senior clinical advice in hospital
- Developing systems for urgent out-patient review – provided by specialties and accessible to GPs
- Enhanced Clinical Navigation process
- Implementation of urgent GP review in order to facilitate discharge from Acute Medicine Receiving Unit (AMRU)
- Implement existing but inactive/stalled initiatives, e.g. ophthalmology triage
- Improve information collection and sharing, e.g. developing transfer of care package

2. Re-admissions

The re-admission reduction work stream will drive and enable improvement work across NUH and the wider health and social care system, to:

- Continue to reduce differences in how re-admissions are defined and measured by different stakeholders through the adoption of a service improvement approach and the shared use of new datasets.
- Continue to help understand why re-admissions occur (clinical and non-clinical reasons) through person-centred reviews during the re-admitted hospital stay.
- Use the outputs of the reviews to enhance our understanding and further describe and deliver the changes needed to improve patient care and reduce re-admissions.
- Provide best practice in the monitoring and reporting of re-admissions. This includes the development of dashboards using the new NUH datasets and external peer data to measure re-admissions and implement the plans for reduction.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The Transformational Team has been deliberately placed outside the organisational structures of the health and social care system so that it can promote and support an organisationally 'agnostic' approach which is focussed on how the whole system can support the needs of the local population. This approach has the support of three CCGs in South Nottinghamshire and Nottinghamshire County Council which will shortly be formalised in a Partner Compact. An Assurance and Governance structure is currently being finalised which will outline how collective decisions will be made and the arrangements for mediation and arbitration where agreement cannot be reached. This involves CCGs, Nottinghamshire County Council, NUH, and Nottinghamshire Healthcare NHS Trust.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The successful implementation of complex change requires senior executive support, high-level co-ordination and oversight, project management resource, and investment in change management activities/staff engagement.

References:

John P. Kotter: Accelerate: How the most innovative companies capitalise on today's rapid-fire strategic challenges – and still make their numbers: (Harvard Business Review Nov 2012)

NHS England: Planning and delivering service changes for patients (Dec 2013)

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

This is an enabler to the delivery of other Better Care Fund (BCF) schemes.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
A strategic dashboard is being created to measure the health and performance of the system as a whole. This will include indicators on system-wide structure, process and outcome and is currently being developed for agreement in October 2014.
What are the key success factors for implementation of this scheme?
- Transformation Director in post – June 2014 - Programme management office function in place - November 2014 - Organisational development programme developed - November 2014 - Clear governance processes including decision making, accountability and escalation that are aligned to the Health and Wellbeing Board - November 2014 - Clinical Navigation System launched – October 2014 - Access to 'urgent' clinic slots – September 2014 - Routine delivery of readmission reviews in assessment wards – October 2014 - Pathway improvements scoped and changes implemented for readmitted patients – various - some changes in place by November 2014 - Discharge information reviewed and recommendations enacted – January 2015

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
J
Scheme name
Disabled facilities grants
What is the strategic objective of this scheme?
Providing funding and facilitating adaptations to homes of disabled people. The grants are administered by each of the district councils in Nottinghamshire. The grants are given as a result of a statutory duty imposed by legislation. Disabled Facilities Grants (DFGs) have a substantial impact on reducing falls which is a major theme within the JSNA. A key message in the update of the JSNA (2014) indicates high and increasing levels of disability in Nottinghamshire. The provision of DFGs also aligns with the Nottinghamshire Adult Social Care Strategy, and Priority 4 of the Nottinghamshire County Council Strategic Plan.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The scheme is ongoing and the way it is delivered is very prescriptive due to the legislative basis. The potential for change therefore is limited. Disabled Facilities Grants provide for adaptations to enable a disabled occupant access to the dwelling and use of all facilities in it. Outcomes therefore include allowing a disabled person to live in their own home and maintain their independence, as well as providing them with a much better quality of life. Adaptations also reduce the need for care, either residential or provided in the home, and reduce the risk of falls which can result in prolonged hospitalisation and ongoing health issues. Projected volume of adaptations, given consistent future funding, is as follows: From April 2014 to: - April 2016 – 949 dwellings adapted - April 2017 – 1371 dwellings adapted - April 2019 - 2215 dwellings adapted - April 2021 – 3059 dwellings adapted

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The delivery chain for DFGs is well established. The service is quite unusual in that the district councils are both commissioners and providers of the service. This cannot be changed due to the statutory nature of the service. Similarly, the involvement of the Occupational Therapists from the County Council is a statutory requirement.

Each Local Authority provides the service in its area. Work is underway to provide a uniform procedural approach throughout the county. This is because despite the statutory nature of the service, there are some variations in service delivery throughout the county.

Budget spend will be reported monthly to the BCF Monitoring Group and results for the performance indicator of "Customer Satisfaction" will be reported quarterly to that group. Quarterly updates on both metrics will be reported to the County Chief Executives Group. Quarterly meetings of operational officers from each district council will be held to monitor each of the above plus the other performance indicators, as well as monitoring working practices to ensure consistency.

All performance and other monitoring data will be collected and co-ordinated by one named officer.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A number of research reports highlight the effectiveness of DFGs. These include:

- "Disabled Facilities Grants in England: a Research Report", Astral Advisory for the District Councils Network and the Society of District Council Treasurers. April 2013
- "Money Well Spent: the Effectiveness of Housing Adaptations". Frances Heywood. Joseph Rowntree Foundation. July 2001
- "Better Outcomes, Lower Costs: Implications for Health and Social Care Budgets of Investment in Housing Adaptations, Improvements and Equipment: a Review of the Evidence". Heywood F. & Turner L. School for Policy Studies, University of Bristol on behalf of the Office for Disability Issues, Department for Work and Pensions 2007
- Care and Repair Cymru, Press release: 'Programme for Older People in Wales, saves over £100 million', 17 October 2012

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Impact

The key success factor will be the service user being satisfied that the adaptation meets their identified need. Adaptations clearly reduce the need for care provision, both residential and services provided at home. Published research has shown this to be the case and also highlights the positive effect DFGs have on other factors such as quality of life and dignity.

Timescale

Ongoing

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Work is underway to ensure procedures adopted by all the districts are standardised. Performance information is now being recorded for a number of stages of the process. This will provide valuable data to allow benchmarking to be undertaken.

Performance will be reported on, along with number of completed cases, spend against budget, and user satisfaction.

Performance at the following stages of the process is now being recorded:

- Average time from referral to approval
- Time from first visit to approval
- Time from receipt of full application to approval

What are the key success factors for implementation of this scheme?

- Adequate staffing resources within district councils
- Adequate staffing resources within Occupational Therapy at County Council
- Operating systems in place which ensure effective and efficient processing of grant enquiries.
- Projected numbers of Disabled Facilities Grants completed:
- From April 2014 to:
    - April 2016 – 949 dwellings adapted
    - April 2017 – 1371 dwellings adapted

- April 2019 - 2215 dwellings adapted
- April 2021 – 3059 dwellings adapted

The above factors are currently in place. Staffing resources are of course liable to change at any time.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
K
Scheme name
Locality Integrated Care Teams (LICTs)
What is the strategic objective of this scheme?
Reduce the time spent avoidably in hospital through integrated care and better community services (development of an integrated proactive and urgent care system): This scheme is one of a number of schemes that need to be developed conterminously in order to have their full impact so links to the development of improved primary care and specialist Intermediate care. The impact of these interventions is expected to reduce non-elective admissions and deliver savings associated with A&E conveyances, A&E attendances and prescribing.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The locality integrated care teams (LICTs) will provide enhanced community services which will work proactively to identify and prevent crisis occurring and providing appropriate support, should crisis occur, to quickly and safely enable the patient to return to their place of residence and wellbeing with the support they need. To support the LICTs we will develop a care navigator system to provide a single point of access for health professionals. This will enable easy identification of services to help maintain people at home. The focus of this scheme is predominantly but not exclusively on the frail elderly with co-morbidities, which include dementia. As the integrated teams become established and mature in their operation and other developments within the system are implemented the teams will be able to move further down the risk profile and will target patients at a lower risk of admission thus offering preventative care to a wider range of patients. **Local Integrated Care Teams (LICTs)** Eight locality based multi-disciplinary teams have been established encompassing health, mental health, social care and rehabilitation professionals. The multi-disciplinary team (MDT) have incorporated Nursing and Social Care professionals, including Community Matrons, District Nurses, and a dedicated specialist Mental Health nurse, physiotherapist and occupational therapist. Also included in each team will be dedicated specialist nurses for COPD, Diabetes and Heart Failure, still to be recruited.

The teams will focus on providing holistic and co-ordinated care for those patients with the most complex needs and work in what is known as a virtual ward model. Each ward is permanently attached to a defined group of GP practices. Patients admitted to the ward will be chosen primarily from the lists of patients identified by the risk profiling within each of those practices, as well as patients who become known to the team through local intelligence or referral from other services. The GPs within the practices will work as part of the ward MDT when their patients are admitted.

These multi-disciplinary iIntegrated care teams will conduct monthly MDT meetings to undertake risk stratification, identification and review of patients at high risk of future admission as well as case review of patients on the current case load. Although this proactive measure serves to identify patients at most risk the team will also support those patients identified by GPs going about usual business and who are presented with patients whose condition/circumstances have changed. Equally the team supports discharged patients and ensures they are supported in their home to regain independence and avoid re-admissions. These activities will be routed through the team on a daily basis.

The inclusionof a dedicated social worker ensures that there is a responsive service in place for professionals to engage and plan care packages, with the social worker pivotal to operationalising those plans.

The intention is to move the team to 7 day working once established. Consideration will be given to how this is introduced as it is dependent upon other services being in place within the system and also operating on a 7 day basis.

They will then use multi-disciplinary case management to deliver co-ordinated care in the patients' homes using the staffing, systems and daily routines of a hospital ward, but without the infrastructure and overhead costs of a hospital building, delivering care in the patient's own home, or usual place of residence.

The teams will work specifically to:

1. Predict and avert crisis and hospital admission

2. Support recovery and return to independence following a crisis or acute admission

The teams will work closely with the Mid Notts Specialist Intermediate Care team (intervention M) to ensure that handover of patients between the two teams is seamless, co-ordinated with care plans that are jointly developed, with input from the patient and carer / family.

A key principle of this approach is that care will be provided to all patients regardless of where they are domiciled. Therefore if a patient is in a care home but via the risk stratification process is identified as having a high risk of admission, or is being discharged following an acute admission, the teams will deliver the appropriate support to that patient within the care home as part of this service.

They will work closely with the care homes linked to the GP practices within their localities to build relationships and cultivate a partnership appoach to caring for the patients resident within each home. Already engagement events have been run to get an understanding of how care homes operate and what the common issues are around care

planning and managing crisis. Further events around care planning are to be scheduled with care planning training delivered across the sector from September 2014 with an evaluation at 6 months planned.

The MDT will share a common set of electronic notes and charts, conduct daily virtual "ward rounds" and hold monthly face to face MDT meetings in each GP practice. Each ward will have a dedicated ward co-ordinator or ward Clerk, who will provide administrative support and act as a point of contact for patient's carers and members of the team. This role will be pivotal in supporting and co-ordinating members of the MDT, arranging, co-ordinating and providing logistical support for monthly MDT meetings and co-ordinating patient activity.

Care navigator

The Care Navigator will be a 7-day service for health and social care professionals. The service will operate from 8am – 10pm each day as it is unlikely that effective navigation would be possible in the overnight period. When called out of hours the Care Navigator will give the caller the option to leave a message or to be put through to the crisis team. This will help to minimize unnecessary admissions to hospital overnight.

Professional staff will phone when they have a patient with an urgent care need and they are looking for community alternatives to admission or to support a discharge from hospital or care home. GPs will be encouraged to use the service for all unplanned hospital admissions with the exception of patients with clear life threatening conditions, and children. Contact with the service should be made as soon as it is suspected that a person's needs are deteriorating rather than waiting for crisis point when admission may not be avoidable.

The directory of services is currently in development.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The commissioners involved in this are Mansfield & Ashfield CCG, Newark & Sherwood CCG, along with the Local Area Team from NHS England in terms of primary care. The provider organisations include community, social care services, mental health, voluntary sector, primary and secondary care. The integrated team membership includes specialist services for LTC which will be supported by specialist consultant support and leadership. Key relationships with care home providers and support services are essential to ensuring confident and co-ordinated care is delivered.

The scheme has clincial leadership from commissioner and provider organisations that will drive implementation supported by a service development team. The lead provides regular updates against milestones to the Transformation Board. The lead providers will also be supported in the development of a joint organisational development plan.

Both the LICTs and the Care Navigation hub will form part of an overall system that will be commissioned for from 2016. Implementation of the LICTs is being delivered through existing contract arrangements with individual organisations responding to a service specification to ensure clarity on service model and expected outcome. Procurement of the Care Navigation Hub will be informed by a service specification. Reporting and

monitoring arrangements are in place for the LICTs. As stated earlier, the Transformation Board oversees the delivery of the milestones and is made up of all the stakeholders involved and so holds all the organisations to account.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence base for integrated care is still relatively small as there have been few large scale trials and there is no national evidence base to demonstrate the effectiveness of a care navigator service.

For LICTs:

- The most well-known and successful example of integrated care is that of Kaiser Permanente in the U.S. which focuses on integrating services and removing distinctions between primary and secondary care for people at all stages of the risk pyramid. Multi-disciplinary teams operate out of specialist centres and people with Long Term Conditions are stratified and appropriate interventions delivered dependent on their risk levels.
- The DH funded a programme of integrated care pilots involving 16 areas in England all trialling various degrees of integration from disease specific integrated care pathways to organisational integration across health and social care services. The Torbay ICP which focused on delivering a locality based service, aligned with general practices and comprising integrated health and social care teams, for the care of older people, has demonstrated measurable progress in reducing reliance on acute hospital services and a reduction in emergency bed days used**.**

Locally, the PRISM programme in Newark and Sherwood which has been underway for 1 year has shown demonstrable reductions in emergency admissions for patients with Long Term Conditions and the model is predicated on the three drivers identified above.

For the care navigator, local opinion is that that the system is key for the transformation of the system. Analysis of the current system for those people who present to A&E with social problems (as reported by the A&E data set) shows 45% are admitted - with a care navigator service many of these could be directed to services better able to meet their needs.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Overall, the full impact of the five-year Better Together programme is expected to deliver the following reductions:

- A&E attendances -15%
- Non-elective admissions -19.5%
- Bed days -30%

Part 2 sets out the forecast reduction in non-elective admissions and reduced pharmacy costs associated specifically with this intervention. The LICTs are in place and we expect benefits from 2014/15.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators have been developed to monitor the impact of this specific scheme on avoided admissions and its consequential impact on reduced non-elective admissions. The transformation team reviews the data; the data is validated and then used to report to the commissioners and the BCF Steering Group

The KPIs will be refined and developed based upon the experience of delivery particularly on areas of new measurements. Benchmarking with other developments nationally will also be conducted to ensure the scheme benefits from learning of similar programmes. King's Fund analysis via PIRU has provided a synthesis of the metrics being used and acknowledgement needs to be given to the balance between the number of indicators against implementation practicalities.

As part of the primary care strategy a quality dashboard has been developed that also evidences individual practices' impact upon non-elective admissions which, along with other indicators, will evidence the impact of changed practice and behaviours as a consequence of enhanced community support.

A Quality Impact Assessment has also been completed for the scheme specifically, while the scheme as part of the overall integration programme has also been subject to Equality & Diversity and Health Impact Assessments.

What are the key success factors for implementation of this scheme?

- Workforce: Recruitment and changed patterns of working to deliver 7/7.
- IM&T: Access to information and consent to information sharing.
- Primary care engagement: co-ordinator of care planning.

Delivery will be supported by the Better Together Programme which has cross-cutting workstreams of both workforce and IM&T.

A project plan and milestones have been developed with a PMO in place to monitor progress. Establishing the LICTs commenced in 2013/14 and teams are expected to be fully mobilised by 1 April 2015.

Once teams are in place the development of standard operating procedures to support effective working in addition to any learning will mean that the model will be refined through a continuous improvement process.

2016 – The locality Integrated teams will have increased the scale of connectivity between primary care and services with the patient at the centre of care planning.

2017 – The teams will have impacted upon the highest risk patients and will be able to increase the potential of working with more patients at a lower level of risk and with more proactive management.

2019 – The skill mix of the team will have been enhanced to adapt to more preventative strategies taking into account the different needs of the population and as a consequence of the wider the system changes in primary, community and intermediate care.

2021 – The team will have supported the improved management of the frail elderly and those with long term conditions achieving a significant reduction in the need for emergency care, fulfilling the Better Together blueprint ambitions.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
L
Scheme name
Self-Care Management
What is the strategic objective of this scheme?
Reduce the time spent avoidably in hospital through integrated care and better community services (development of an integrated proactive and urgent care system). Empowerment of people through better understanding of the health and social aspects and their ability to act and be supported. Co-creation of wider support services by the third sector in supporting carers, increased volunteering and training of professionals.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Systematisation of self-care and care planning: dedicated and targeted support for patients to self-care and to identify the information and access to the support services that they need to enable them to become more involved in their own care and maintain their wellbeing. This scheme covers the whole population with an element of service provision in operation already but which is not part of a co-ordinated system approach. The development of a Self-care strategy and implementation plan is near completion. It has a strong connection with the LICTs (Scheme k) who have a voluntary worker as part of their core team who will make links and support triage of need and development of care plans. The Mid-Nottinghamshire self-care pathway will provide a person-centred, integrated and co-ordinated approach to the provision of self-care support and services for patients with long-term conditions and their carers. The approach will provide access to and support for self-care and care planning to patients at all levels of risk and disease progression and to healthcare professionals requiring information about the support services that are available. It will be underpinned by education and training for healthcare professionals to provide them with the skills they need to work in partnership with patients using a collaborative process of shared decision making to agree goals, identify support needs and develop and implement action plans. The Year of Care training programme, currently underway

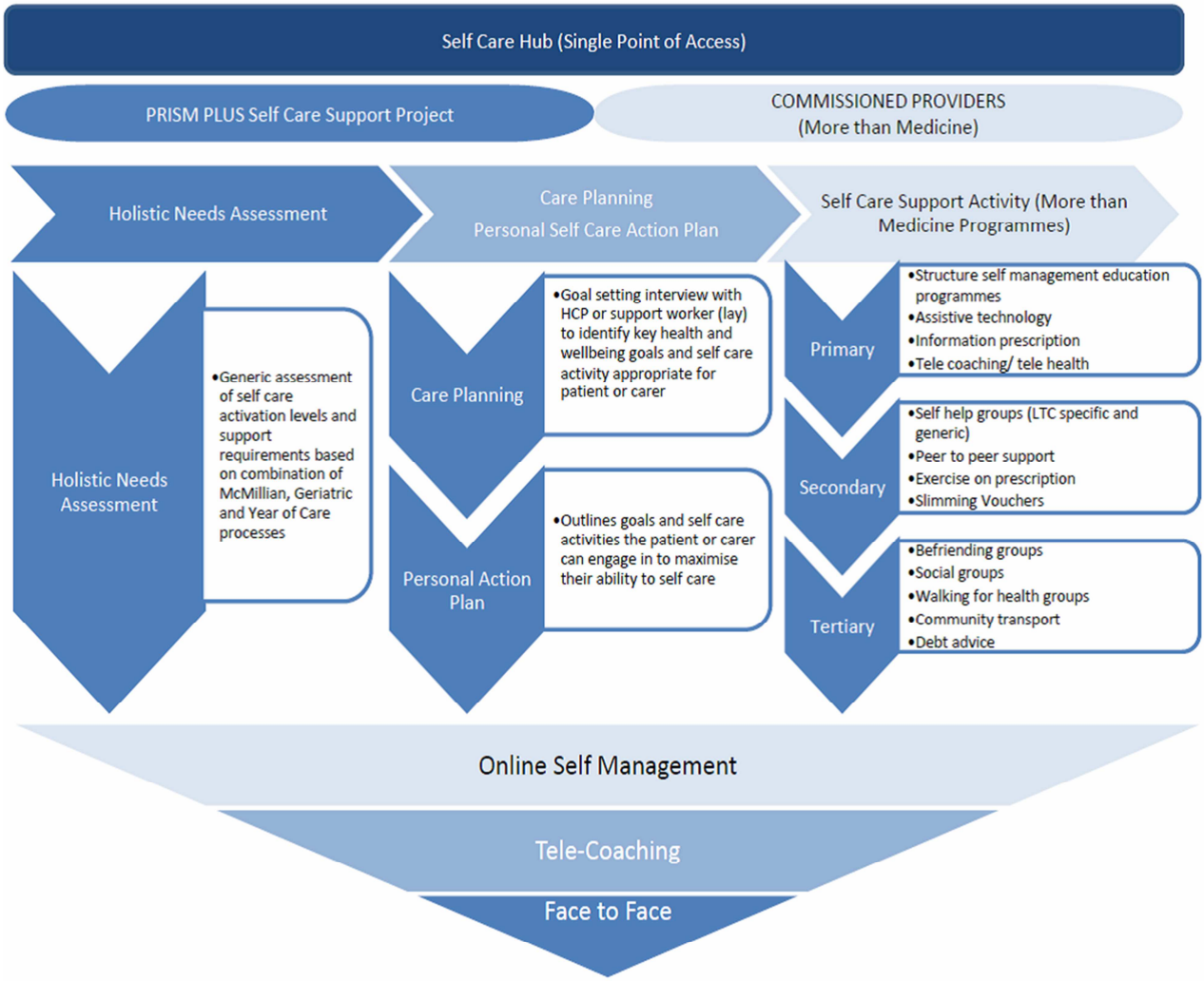
within Newark and Sherwood CCG, will be extended to include GPs and members of the MDTs across Mansfield and Ashfield.

The utilisation of assistive technology such as FLO will be considered during all care planning discussions and patients supported to utilise on line support where appropriate. FLO, named after Florence Nightingale – is currently helping around a thousand patients across Nottinghamshire to help them remember to take medication, give up smoking, lose weight and for people with high blood pressure. It also works with landlines by making automated calls. It is being used across the county in community care, mental health services, acute hospitals including Nottingham University Hospitals and Sherwood Forest Hospitals NHS Trusts, and social care.

The Integrated Care proposal proposes to further continue this roll out and from 2014 increase the numbers of patients utilising FLO technology by 20% per year.

Partnership with and services from the third sector will be developed wherever possible. The two key enablers for this new approach will be the development of a new Self-Care Hub and Scale up of the PRISM Plus volunteer programme. This can be summarised by the diagram on the next page.

Figure: Mid-Nottinghamshire Enhanced Patient Management Model - Overview



Self-Care Hub and PRISM PLUS

This service will bring together all self-care activity and support across Mid-Nottinghamshire and act as a single point of access to relevant support for both healthcare professionals and patients.

The hub will take on responsibility for the co-ordination and delivery of both existing and new structured education programmes for Long Term conditions. The hub will work closely with commissioners to identify what type of programmes are required, and develop a rolling programme, which may be delivered by third parties of education. It is recognised that many of the elements of structured education for specific LTC's are common across all LTCs, allowing some economies of scale to be achieved via delivery of generic modules within specialist programmes.

It will enable patients to access information and support to better manage their long term condition, to be signposted to self-care options, which can help them to make positive life style changes and learn essential skills.

- The hub will be based in the Ashfield Health Village and third / voluntary sector providers of self-care and support will be encouraged to co-locate to create a one stop shop for patients.

- A satellite hub will be located in Newark to facilitate access for Newark residents and reduce travelling requirements for the Newark staff.
- A Directory of Services (DOS) will be developed which will detail all self-care support and services available. This will be incorporated into the DOS of services that is being developed for the Care Navigator service.
- A virtual platform will also be created to allow for remote/online access

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The commissioners involved in this are Mansfield & Ashfield CCG and Newark & Sherwood CCG. The provider organisations are already in place with regard to service provision and are made up of the local third sector providers. Local CVS organisation across the localities of the mid-notts footprint are also currently commissioned to deliver sign posting. The co-ordination of the Self-Care Hub and delivery of care plans needs to be commissioned following agreement of the strategy and implemenation plan.

Engagement events on Self-Care and marketting events with the Third sector have been conducted to ensure that there is a clear understanding of the provision required and the options for providers to collaborate in advance of the commissioning process.

The scheme will form part of an overall system that will be commissioned for from 2016.

As stated earlier, the Transformation Board oversees the delivery of the milestones and is ensuring that the Third Sector are a key stakeholder in our commissioned solutions.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence is clear that patients who are empowered, knowledgeable and supported, utilise services less and have better health outcomes.

We used two key publications:

1. "The Proposal for People Powered Health" Nesta and the UK Innovation unit - estimate that the NHS in England could realise savings of at least £4.4 billion a year if it adopted systematic application of strategies which involve patients, their families and communities more directly in the management of long term health conditions. These savings represent a 7% reduction in spending in terms of reduced A&E attendances, planned and unplanned admissions, and outpatient admissions.

2. Expert Patent Programme, 2010 showed that patients who took part in effective self- care / self-management programmes went on to use fewer NHS frontline services, amounting to an average cost saving per patient of around £1500 per year, every year.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

No specific benefits are set out in Part 2 associated with this. The service is an enabler and will facilitate the effectiveness of the other interventions.

As this is a cultural change for both professionals and patients to embrace and practice, the impact will be some time in becoming evident and will vary at locality levels but the intended impact is to release capacity in the system and promote alternative support to achieve the required outcomes.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This scheme is dependent upon an agreed strategy that ensures all have the same understanding of self-care and self-management with an implementation plan. Recent engagement events are informing this strategy and the considerations needed around implementation. A service specification will be developed to ensure the service meets agreed requirements.

Key performance indicators will be developed to monitor the impact of this specific scheme on use of the hub, access to the virtual hub as two examples. Survey questionnaires to monitor the use by professional teams and the make-up of services within the Directory of Services will also be completed.

- Number of patients with a clinical management plan with Self-Care
- Number of patients with a personalised care plan and who have been involved in creating the content.
- Number of patients on the PRISM PLUS case load
- Utilisation of the Self-Care hub
- Utilisation of patient and carer satisfaction questionnaires – LTC6 (six item pt questionnaire)
- Uptake of personal health budgets
- Uptake of support services and Education programmes

The transformation team will review the data; the data is validated and then used to report to the commissioners and the BCF Steering Group

A Quality Impact Assessment will also been completed for the scheme specifically, while the scheme as part of the overall integration programme has also been subject to

Equality & Diversity and Health Impact Assessments.
What are the key success factors for implementation of this scheme?
- A self-care strategy and implementation plan are to be agreed by October 2014 - A Self-Care Strategy that is owned and endorsed by all stakeholders and creation of a facility central to the population to support and empower patients. - Development of the Third Sector in understanding the population needs and adapting to the system changes through increased collaborative working. An engagement event has already taken place with a further market management event planned in November 2014. - Communications and Engagement with the population to ensure they understand the ability and accessibility of services. This will be an ongoing approach informed as developments progress and better connections are made. A project plan and milestones have been developed with a PMO in place to monitor progress. Key milestones are: - Finalise spec – August 2014 - Procure – November 2014 - Mobilise – January 2015 Project management is being managed through the Better Together implementation support (intervention O).

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
M
Scheme name
Specialist Intermediate Care Team
What is the strategic objective of this scheme?
Reduce the time spent avoidably in hospital through integrated care and better community services (development of an integrated proactive and urgent care system): - Increasing the number of patients treated at home rather than in bedded facilities supporting avoided admissions - Reducing delays in discharge and enable more effective patient flow in the system - Increasing the proportion of older people living independently at home following discharge from hospital
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Specialist Intermediate Care Service (SICT) will be a new multi-disciplinary health and social care service, whose aim is to bridge the current gap between the acute and community services and act as the link between services to facilitate effective admissions avoidance, reduce delays in discharge and enable more effective patient flows through the system. The SICT will meet high-level health care needs as part of the virtual ward MDT - whether to prevent the need for hospital admission or to support discharge from hospital following an acute admission / crisis. However, for some patients in crisis, there will be a need for a more immediate response (within 2 hours) than can often be met by the wider MDT, or Intermediate care team, if a hospital admission is to be prevented. This is particularly so outside of normal working hours where Virtual ward cover may be reduced, such as overnight. The team will be a joint Heath and Social care team, which aims to make best use of existing staff resource in both hospital and community settings by joining up many of the functions currently conducted separately by health and social care teams. They will work closely with the Virtual ward MDTs under a single management structure. They will work with hospital teams at the front door and on the wards to deliver services with the aim of both preventing unnecessary hospital admissions AND facilitating and

supporting effective discharge from acute services.

The service will interface with and provide support across three specific parts of the integrated model and team members will rotate on a 6 monthly basis between the three functions to reduce risk of deskilling and enable team members to build effective knowledge of and relations with services in the community.

1. Support to the Single Front Door at A&E to support the *"discharge to assess"* processes

2. Co-ordinating and supporting timely discharge from hospital following an acute admission or for patients requiring end of life care.

3. Delivery of time limited (up to 14 days) of intensive Intermediate Care and Rehabilitation in the community following either a community based crisis (step up care) or following an acute hospital admission (step down care) including end of life care

A workshop event has already taken place to understand better the current service provision and processes to inform the change process. The key issue is identifying the demand to then determine the capacity.

The Integrated Care teams will be supported by a new crisis response team to support patients at home until other services can be activated. The crisis team will be part of the specialist intermediate care team, and this crisis function described below will be available 24 hours a day 7 days a week.

This model ensures that the service is responsive to the need for immediate support to prevent an unnecessary admission, but also allows access to and back up from the clinical expertise within the SICT for situations where a patient's condition begins to deteriorate or additional input is required - for example review by a consultant, or admission to an intermediate care bed.

The crisis response service will provide intense and focused health and social care (including personal care) to assist people through a worsening crisis to continue living in their own home and maintain independent living skills reducing the admissions to permanent residential care. The key elements are a rapid response in the individual's home, a thorough assessment and an integrated care package allowing for short term results and a long term solution.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The commissioners involved in this are Mansfield & Ashfield CCG and Newark & Sherwood CCG. The provider organisations include community and secondary care with a strong relationship around workforce transfer as a consequence of shifts in activity and service provision.

The model will be supported by a service specification which identifies the outcomes required.

The lead providers will also be supported in the development of a joint organisational

development plan.

The scheme has clincial leadership from commissioner and provider organisations that will drive implementation supported by a transformational team. The lead provides regular updates against milestones to the Transformation Board.

The scheme will form part of an overall system that will be commissioned in 2016. Implementation will be delivered through existing contract arrangements with individual organisations but with clear expectation, reporting and monitoring arrangements in place, as drescribed in a service specification. As stated earlier, the Transformation Board oversees the delivery of the milestones and is made up of all the stakeholders involved and so holds all the organisations to account.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

As early as 2002 the Kings Fund in a publication on intermediate care (Developing Intermediate Care: A guide for health and social services: Jan Stevenson and Linda Spencer, Kings Fund, 2002) summarised the evidence base:

- 'There is a large and growing body of research evidence to support proposals to introduce intermediate care.

- This evidence has its limitations: partly because it does not always compare like with like, and partly because there are still large gaps in our understanding of the subject.

- Evidence on the shortcomings of current rehabilitation services shows the main problems to be early discharge, lack of co-ordination between services and the persistence of the practice of ‘minding’ older people.

- Research has demonstrated that intermediate care has much to offer to people in acute hospital beds, long-term residential care and the community.

- A wide range of current services – in health, social care and housing – has been shown to have the potential to contribute to the delivery of intermediate care – some more so than others.

- There has also been research into how intermediate care can help people with specific conditions into related services (including equipment services and voluntary sector services) and into operational aspects (including assessment and team working).'

The local utilisation reviews demonstrate clearly that patients are often in care settings when their care needs could be met in other settings, often at home or in home care settings.

Local rapid response services have been effective in reducing hospital admissions:

- The SFHFT MaDSS service supported by EDASS has demonstrated the value of

this type of rapid deployment resource but is not available to people outside of hospital.

- The Urgent Care Support Service that operates in Rushcliffe CCG is considered to have saved 323 admissions into hospital or residential care between March 2011 and July 2013 giving a saving of £785,000.00.

While the King's Fund report on avoiding hospital admissions reported there was no evidence identified in relation to rapid response teams and their effectiveness in preventing admissions it went on to comment:

*'In order to put the findings of this review into context, it may be useful to reflect on the views of those in the front line of health care delivery. A Delphi study to elicit the views of an expert panel of health professionals on the interventions that were most helpful in reducing unplanned admissions found that the highest-rated interventions involve the direct delivery of rapid access care in the community. Access to rapid response nursing and social care at home intermediate care and acute nursing home beds, mental health crisis teams, rapid access specialist clinics, and increased nursing home capacity for acute illness were identified as key interventions to reduce admissions' ("*Avoiding Hospital Admissions: What does the Research Evidence Say?"; King's Fund, Sarah Purdy, December 2010*).*

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

This scheme is one of a number of schemes that need to be developed conterminously in order to have their full impact; hence it links to the development of improved primary care and Locality Integrated Care Teams. The impact of these interventions is expected to reduce non-elective admissions and deliver savings associated with reduced length of stay (bed days), A&E conveyances, A&E attendances, reduction in permanent residential admissions and prescribing. We may also see a reduction in delayed transfers of care (associated with the reduced length of stay) but it is not possible to clearly link the two. Overall, the full impact of the five-year Better Together programme is expected to deliver the following reductions:

- A&E attendances -15%
- Non-elective admissions -19.5%
- Bed days -30%

Part 2 sets out the forecast reduction in non-elective admissions A&E conveyances, A&E attendances, and reduction in permanent residential admissions.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Key performance indicators will be developed to monitor the impact of this specific scheme on avoided admissions and its consequential impact on reduced non-elective admissions. Where a hospital episode has been necessary, the reduction on the length of stay and avoidance of transfer to long term care will also be monitored. The transformation team reviews the data; the data is validated and then used to report to the commissioners and the BCF Steering Group

The KPIs will be refined and developed based upon the experience of delivery particularly on areas of new measurements. Benchmarking with other developments nationally will also be conducted to ensure the scheme benefits from learning of similar programmes. King's Fund analysis via PIRU has provided a synthesis of the metrics being used and acknowledgement needs to be given to the balance between a number of indicators against implementation practicalities.

A Quality Impact Assessment has also been completed for the scheme specifically, while the scheme as part of the overall integration programme has also been subject to Equality & Diversity and Health Impact Assessments.

What are the key success factors for implementation of this scheme?

The cross cutting theme for Workforce will be instrumental in supporting the skills and knowledge of the changing workforce in ensuring they can deliver dual elements of provision of both health and social care.

- Dynamic workforce development: a positive change to traditional operational ways of working
- IM&T: Information access and information sharing
- Increased connectivity of the system and responsive services that avoid crisis and admissions plus support early discharge and earlier return to independence of patients and in their own homes. Transfer to Assess in place.
- Increased confidence of the population and in health and social care professionals as patients, carers and families receive the right level of support that impacts on behaviours around accessing emergency services
- A real shift of care from emergency and acute needs plus long term care beds.

Delivery will be supported by the Better Together Programme which has cross-cutting workstreams of both workforce and IM&T.

A project plan and milestones have been developed with a PMO in place to monitor progress. Key milestones are:

- Develop specification – October 2014
- Commence recruitment – December 2014
- Phased introduction of teams – April 2015
- Full mobilisation of teams – April 2016

Once teams are in place the development of standard operating procedures to support effective working in addition to any learning will mean that the model will be refined through a continuous improvement process, created through the rotation of staff.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
N
Scheme name
Improved primary care access and support closer to home
What is the strategic objective of this scheme?
Reduce the time spent avoidably in hospital through integrated care and better community services (development of an integrated proactive and urgent care system).
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
During the recent engagement activities, the need for improved access to Primary Care has been a constant theme. The annual GP survey indicates that satisfaction with General Practice is below the national average. The vision in Mid-Nottinghamshire is to ensure that a consistently high quality of care is provided by all practices, with patients being seen in a timely manner. The population served is c 350,000. It is clear that one size does not fit all when working with General Practices. Within Mid-Nottinghamshire, GP Practices range from single-handed practitioners, to large multi partner practices. Some work, in largely rural areas, whereas others serve the towns in the area. There are some Practices that provide very good access and that have adopted new ways of working such as telephonic triage. However, in other practices patients perceive that there are difficulties in getting access to the service. Practices across Mid-Nottinghamshire will want to address these challenges in ways that fit their circumstances and ethos. There is early interest among some local practices to work collaboratively to develop many of these ideas, whereas other practices will look to change their own internal working practices. Mid-Nottinghamshire is also developing schemes to supplement GP provision including urgent primary care and a care homes nurse practitioner Many of the interventions that we know make up a high quality service for patients with urgent needs are within the scope of everyday practice - access to timely appointments, matching capacity to demand, continuity of care. There are several practical guides available nationally that provide a framework for Practices to deliver significant change in working practices (e.g. Primary Care Foundation, Dr First, etc.). Our proposals have tried to be cognisant of both the evidence relating to improved

access to Practices and the emergent national policy in relation to primary care.

The intention is to develop a framework for improving access to primary care with a scheme to support practices with 3 main sections:

- Review of existing access – to identify current capacity and demand levels, and identify any anomalies through engagement with the practice population (e.g. linking to the Practice Participation Groups)
- Development of plans to respond to any gaps identified in the Access Review, and to identify steps to improve access. This may include revision of Access Policies, providing prompt response for those patients who perceive they have urgent needs (e.g. by ensuring that where a home visit is required, this can occur in a timely manner with a GP who can spend time with the patient and defining a plan for marketing services for specific patient groups).
- Implementation of plans identified through the review, including any centrally identified changes (e.g. digital access, response to urgent care calls from other providers e.g. EMAS, A&E, and NHS 111).

This work will provide a firm basis for all practices moving forward to deliver 7-day working in the future. The workload within some practices is such that some struggle to release time to consider alternative ways of working. Therefore it is proposed that there will be dedicated expert resource, provided by the CCG, to work with practices to review how they manage their resources to best effect. This is supported by local improvement schemes for practices, agreed with the Area Team to drive improvements.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The Local Area Team, NHS Derbyshire & Nottinghamshire are currently commissioners of primary care, with CCGs commissioning enhanced services. A move toward co-commissioning has been expressed by both Mansfield and Ashfield and Newark & Sherwood CCGs and we are hopeful for a positive response on this initiative in October 2014.

Across the footprint there are 44 practices providing primary care services.

The scheme has clincial leadership and commissioners are working through the LMC in informing the sector on the system developments and how this sector can respond to the changing service needs with modern and innovative service delivery options.

The CCG and LAT will ensure the following:

- CCG dedicated resource to work with practices to implement the nationally available tools to improve access.
- A local improvement scheme for practices to put in place new ways of working that will improve access as well ensuring that Special Patient Notes are created and updated for all appropriate patients. In addition, changes will be made so that where an urgent home visit is requested, there will be a rapid assessment (within 30 minutes) by a clinician - normally this will be by phone, but in some cases the

clinician, knowing the patient's condition, may choose to plan an early visit.

- Use of the Primary Care dashboard to reduce variability of practice across practices

The scheme will form part of an overall system that will be commissioned in 2016. Implementation is being delivered through existing contract arrangements with individual organisations but with clear expectation, reporting and monitoring arrangements in place.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There have been a number of national documents that highlight how access can be increased within existing resources and the role that primary care can play in the urgent care system, whatever their characteristics - in particular how Practices can support the reduction of avoidable emergency admissions to hospital. These documents have the support of the Royal College of General Practitioners; with some have been written by the College.

The Primary Care Foundation in 2009 undertook some detailed research supported by the Department of Health resulting in the publication of a practical guide for Practices outlining key lessons for improving urgent care. This work suggested that high quality urgent care depended on four factors:

- Access
- Speed of initial response
- Capacity
- Assessment

Recent research by Imperial College found that General Practices providing more timely access to primary care had fewer self-referred discharged A&E visits per registered patient (for the most accessible quintile of practices, RR = 0.898; P<0.001). The research concluded that policy makers should consider improving timely access to primary care when developing plans to reduce A&E utilisation.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

We expect this improved access to primary care and additional proactive teams to have an impact across a wide range of measures including non-elective admissions, A&E conveyances, and A&E attendances. This is reflected in Part B.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

A Primary Care dashboard is being developed to reflect the challenges and performance at each Practice. This will be a valuable source of information about standards of care - the CCG will work with Practices to reduce variability across Practices and ensure that consistently high standards of care are delivered. This will be achieved by working jointly with the Local Area Team: NHS Derbyshire & Nottinghamshire.

Innovations supported via the Challenge Fund will offer us tested service options that can be rolled out across the planning footprint, not a one size fits all but relevant to the practice make-up. These innovations will come from across the wider footprint of the Local Area Team NHS Derbyshire & Nottinghamshire.

What are the key success factors for implementation of this scheme?

- Delivery of Primary Care Strategy: Operational plan to be developed by October 2014
- Workforce development: Resources to support the up-skilling of primary care to deliver wider range of services across the medical, nursing and Allied Health Professional contingents of primary care
- Workforce: Recruitment of GPs
- IM&T: Access to information and information sharing
- Improved relationship with care home providers and an alignment of the service provision to the standards and quality of care delivered in Care Homes

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
O
Scheme name
Better Together Implementation Support
What is the strategic objective of this scheme?
To provide the expertise and capacity to work alongside the CCG capacity in achieving sustainable and high quality commissioned services for the population of Mid-Nottinghamshire.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There are three key areas to this scheme: The first is the external expertise to provide project management support to drive and co-ordinate the delivery of each scheme and manage the interdependencies that exist around the milestones. The second is to bring in external expertise to deliver the cross-cutting Workstream objectives for information management and technology (IM&T).The vision of an integrated urgent care system within Mid-Nottinghamshire requires a step change in the use of IM&T; in particular information sharing and electronic workflow/e-referral will be essential. For example the care navigator service and crisis team are to enable the fast and efficient provision of community-based services to be provided so that patients receive the right care in the right place at the right time. This requires effective technological links to be in place so that data can be shared between professionals to support for decision making, and for services to receive referrals and mobilise within very short timescales. Therefore IM&T is a key enabler in the redesign of the urgent care system. Existing IM&T provision in the Mid-Nottinghamshire region is at differing levels of maturity in different sectors: - Primary Care is well developed technically and from a data quality perspective; it consists of a duopoly of systems (TPP SystmOne and EMIS Web). - Community Care is well developed and uses a single system (TPP SystmOne; although data quality isn't as mature as Primary Care, it is still of a good quality. - Secondary care is more complicated with a plethora of systems. It is not as mature. Although some secondary care services are already well integrated with

Primary and Community Care (e.g. A&E uses TPP SystmOne), others are standalone with little or no integration with the wider care record.

- Social care records are not integrated at all.

To enable the new model of urgent care delivery there are three overarching functional requirements:

1. Risk Stratification: in order to identify patients for appropriate intervention and support in self–care, analysis of health (and potentially social care) data is required. Using the Devon Risk Stratification tool allows categorisation of patients to support this requirement. Currently this tool is hosted in eHealthscope, a locally developed data integration and processing tool.

2. Information Sharing: supporting the patient at any point along the spectrum of their care requires quality information to be available in a timely manner. For most care scenarios this will require real time access to information. While proprietary systems provide approximately 80% of this requirement, integration with other systems is essential.

3. Electronic workflow: the ability to plan the patient's care is underpinned by the need to refer them to the most appropriate service to receive this care. This may be a health, social or 3rd sector service provision. Electronic workflows, such as Choose and Book, electronic tasks or, at a basic level, secure email are ways in which this can be achieved.

The use of TPP SystmOne in so many different areas across the system offers a sound base on which to build the requirements for the new model. It is estimated that this alone offers 75% of the functional requirements identified in those areas that have this system. In order to deliver the remaining functionality in existing services and to provide the new services with appropriate systems there are a number of requirements.

The third element of this scheme is the provision of workforce leadership working with Health Education East Midlands and offering back fills to support the release of a project manager role.

The Nottinghamshire Local Education and Training (LETC) Workforce Council has worked with providers and commissioners across Nottinghamshire to develop a Nottinghamshire Workforce Development Plan for 2013 - 2016. The workforce priorities identified across Nottinghamshire are shown on the following page.

Table summarising the workforce priorities identified by the LETC, and the associated actions

Workforce priorities	Actions
A Workforce fit for the future	Maintaining and expanding services, exploring flexible opportunities to meet service demands with challenges of providing 7-day working and 24/7 services Continue to develop pathways that allow more patients to be followed up at home and receive treatment closer to home Ensure Nursing establishment on all wards is appropriate for current levels of patient acuity and fully established to deliver optimum patient care, clinical outcomes and service delivery
Development of a skilled workforce through education and training	Establish speciality qualification for the majority of clinical staff Develop leadership throughout the clinical nursing bands A skilled workforce, through ongoing development of the current workforce within the service, including skill-sharing and acquisition, through in-service training and joint working between Health and Social Care colleagues. Ensure that all community teams receive training in mental health and dementia
New Ways of Working	To support Clinicians through the planned Health and Social Care Service and workforce integration to develop new ways of working which deliver a more comprehensive service for patients
Medical recruitment	Enhance Junior Doctor recruitment Recruit to vacant positions on the consultant rota and look at increasing weekend commitment of all consultants across specialties
Specialist Roles	Development and audit Specialist Nurse services Increase the numbers of Advanced Nurse Practitioners – Geriatric Medicine, Dementia / Mental Health Allied Health Professional Advanced Specialist roles

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The Better Together governance structure and project support is in place to ensure the schemes can be delivered. With the additional cross-cutting support of IM&T and workforce sustainability of the schemes will be achieved.

Implementation support

The significant change will require dedicated project management support including:

- Programme manager
- 2 x project managers (split between urgent and proactive care)
- IMT project manager
- General project support

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The House of Commons Health Committee Report on Workforce Planning (2007) suggests that 70% of NHS funding is spent on staffing costs and so effectiveness of its workforce determines the effectiveness of the service provided.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

No specific benefits are set out in Part 2 associated with this. The service is an enabler and will facilitate the effectiveness of the other interventions.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Project teams will be held to account against milestones and project deliverables through the Transformation Programme, reporting to the Programme Board with all stakeholders represented and holding the work streams to account.

What are the key success factors for implementation of this scheme?
The scheme is a key part of delivering the Mid-Nottinghamshire CCGs' Better Together programme. Programme delivery will be in line with project plan and in line with budget. Skilled workforce with aligned training opportunities to deliver the interventions described in projects G to P. IM&T solutions for information sharing, risk stratification and electronic workflow to support the interventions described. Better Together is five year programme, of which parts of the project have started but full implementation and full realisation of the benefits is not expected until 2018/19.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
P
Scheme name
Communications and Social Marketing
What is the strategic objective of this scheme?
To ensure the population of Mid Nottinghamshire are involved and informed in the design and delivery of high quality commissioned services in order that they choose the most appropriate health service for their need and deliver a sustainable behavioural change.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Communicating effectively with the public so patients know which service to access and how. The communications activities in relation to key health messages, including Self-Care and signposting to appropriate services, will be significantly enhanced. There will be greater use of social media, as well as the traditional press and other media, as vehicles for key messages. However this alone may not have the impact that is required as despite the use of the 'Choose Well' campaign for some time the public remain uncertain as to which service to access when they have an urgent care need. A different approach is needed if real change is to be achieved in the way people use urgent care services. It is proposed that a social marketing approach is used as an ongoing approach to move beyond merely informing people of alternatives to A&E. There will be focused work with discreet segments of the population in order to understand their reasons for their current use of urgent care services. Seek to achieve a shift in behaviour so that they take more responsibility for managing their health and when they have an urgent healthcare need, they are confident to put their trust in and attend the most appropriate urgent care service. This work will require a dialogue to be developed with willingness for changes to be made to the integrated care system to remove barriers to access where necessary. This combined approach of enhanced general communication and media coverage of health messages supported by the targeted approach described above needs to be sustained with appropriate resourcing to deliver the benefits demonstrated in Merseyside.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The commissioners involved in this are Mansfield & Ashfield CCG and Newark & Sherwood CCG. This cross-cutting workstream will de deliverd through internal engagement teams supported by a communication and media team from GEM the local CSU

As part of the engagement activities within this programme, a cohort of patient leaders has been recruited. The aim is to recruit 300 members of the public and patients (0.1% of the population) to become active participants in the programme. Some will be invited to collaborate in detail with the programme to 'co-create' solutions, and act as 'champions' for the case for change amongst their peer group. This group of actively engaged citizens will also be able to convey key health messages within their own communities.

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A recent publication by the NHS Alliance and Primary Care Foundation states:

'There is no evidence that general education about how to use a system has any impact.

For most people, using the urgent care system is a rare occurrence: once every six years for out-of-hours, on average every three years for A&E'.

In recent years there has been a growing use of social marketing by the NHS. Social marketing borrows tools and techniques, such as insight generation and customer segmentation, from commercial sector marketing and applies them to problems facing our society. Within health, it is most often used to help citizens change their lifestyles (for example by making improvements to the diets, starting a programme of physical activity, giving up smoking or reducing alcohol consumption). It can also be used in other ways, such as changing the way citizens engage with services.

An activity is classed as social marketing when it:

- Is based on real understanding of the target audience: who they are, what they think and believe and what they need.
- Uses insight to develop propositions that offer a real benefit for the audience, not just for the Government.
- Aims to achieve changes to resistant or persistent behaviours, not just to provide information.
- Applies vertically through the process: from understanding the problem and designing the solutions, to delivering and communicating products and concepts.
- Applies horizontally across types of intervention, and is not limited to narrow definitions of communications or marketing.

- Is embraced by all functions, roles and departments, focused on the behavioural goals of the target audience, not the internal structure or divisions of the providers.

The Liverpool Public Health Observatory in 2007 noted:

- Public information campaigns for instance, using social marketing such as "Choose Well" on Merseyside have been shown to facilitate the reduction by 6.4% in A&E attendances during one year. The report included as one of the recommendations from published evidence:
- Public information campaigns using social marketing may be effective in reducing A&E attendance by advertising alternative action

The Greater Midlands Commissioning Support Unit undertook a social marketing project in Milton Keynes where a 6% decrease in A&E attendances was also seen in the target groups for the campaign.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

We expect this increase in communications to reduce A&E conveyances and A&E attendances. This is reflected in Part 2. However, this is also an enabler for other aspects of the programme.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The communication and engagement approach will be held to account against milestones and project deliverables through the Transformation Programme, reporting to the Programme Board with all stakeholders represented and holding the work stream to account.

What are the key success factors for implementation of this scheme?

IM&T – Access to information and information sharing, with the issues of patient consent to sharing being a key determinant for schemes to fully operate.

Interdependency with other schemes; Self-Care Strategy implementation plus hub in place (see Scheme L).

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Q
Scheme name
7 Day access to services – care of the elderly support and integrated primary care
What is the strategic objective of this scheme?
The vision for North Nottinghamshire (NHS Bassetlaw CCG - "A Community of Care and Support") was co-created by local clinical leaders and local managers from both health and social care. It was based around delivering improved outcomes for patients and identifying what improvements local people can expect to see over the next few years. These were identified as being: Better care for our frail and the elderly population; more and better care provided locally; a high quality local Hospital with 7 day working, easy access, and essential services, such as 24 hour Emergency Department, and consultant-led maternity unit; same day GP led care, with access to the right health care professional; more support for independent living with enhanced sheltered housing choices; patients with a mental health condition to receive improved care through teams, professionals and services working more closely together; care homes to be an integral part of our local community; our local organisation to take joint responsibility for improving care and support; integrated delivery of care and support through team working; organisations to work across boundaries; professions to work together in teams with our patients at the centre of their care, and; organisations to openly share and pool resources where it will benefit the patient. To deliver on our vision we believe we need to focus on five specific areas of health and social care in Bassetlaw. They have been classified as our strategic programmes into which all our Better care Fund Schemes fit, and are as follows: - **Supporting People after Acute Illness** – Helping people to become independent after leaving hospital, providing more reablement and rehabilitation support at home and in the community. - **Care for the elderly -** Improving the pathway of care and integrating local services for people aged over 65. - **Care Homes** – Health and social care working together to improve the quality of care and standards and in care homes across Bassetlaw. - **Mental Health** – Improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on hospital / acute based mental healthcare. - **Urgent Same Day Care** - Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including the GP out of hours service. This BCF scheme is overarching and supports all five strategic priorities and is one of the

BCF national conditions.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support? - Integrated care
- Which patient cohorts are being targeted? - People with LTC, the frail and elderly

Bassetlaw CCG is committed to integrating health services where it will improve patient outcomes to do so. National evidence around this integrated model of care shows that integration of care and services can improve the early identification and management of long term conditions, support self-care and facilitate proactive identification of patients at risk of becoming ill and at risk of admission to hospital. Community health care services in Bassetlaw are currently not fully integrated with primary care or social care which results in patients experiencing hand offs throughout their pathway from one professional to another causing unnecessary delay in accessing the right professional at the right time.

As part of the Care of the elderly strategic priority we are working with our community services provider Bassetlaw Health Partnership to develop a community integrated care model that works seven days a week to effectively manage the health and social care needs of frail elderly people in Bassetlaw. This will see the introduction of primary care neighbourhood teams where community services (community matrons, district nurses and therapists) mental health professionals, palliative care specialists, voluntary sector and social workers will work closely with GPs as a multi-disciplinary team providing co-ordinated care for patients. In addition we are also developing a 7 day virtual ward model of community care for patients with more complex needs. This proactive co-ordinated way of working linked in with the personalised care over 75s and risk stratification programme will put the patient and their family at the centre of their care, promoting self-care and improving patient outcomes. It will also facilitate quicker discharge from hospital and because patients will be proactively case managed will avoid unnecessary hospital re-admissions.

A Bassetlaw community geriatrician model of care is also being developed with Doncaster and Bassetlaw Hospitals NHS Foundation Trust which will provide consultant led geriatric care in the community in addition to acute geriatric care in Bassetlaw Hospital. This service which will be part of the virtual ward model will undertake comprehensive geriatric assessments in the community and will provide advice and support to GPs and community services managing the care for older people.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on the Integrated Care Board who are listed below:

- Commissioner – Bassetlaw CCG
- Providers – Doncaster and Bassetlaw Hospitals NHS Foundation Trust; Bassetlaw Health Partnerships; East Midlands Ambulance Service; Nottinghamshire

Healthcare Trust; Nottinghamshire County Council; Bassetlaw District Council

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Summary of the key priorities for this strategic programme:

- Develop a community 'virtual ward' model establishing the benefit to patients in terms of improved outcomes and experience –virtual ward approach based on productive ward and other national / local good practice on integrated care.
- Reconfiguration of Bassetlaw community services into integrated primary care teams with virtual wards aligned to primary care providers, incorporating social care and mental health, and the voluntary sector through a proactive case finding approach.
- Review and redesign of intermediate care provision, reablement and rapid response services to improve access and outcomes, and maximise efficiency – (this will also be a key part of the supporting people after acute illness strategic programme)
- Case management and co-ordinated care utilising the expertise of hospital outreach such as a Community Consultant Geriatrician, Consultant in Palliative Care and Mental Health Teams
- Timely supported transfer from hospital and post hospital transfer of care follow-up
- Enhance the 'Recovery Model' to all patients with Long Term Conditions so that they may improve/maintain their quality of life
- Improved access to palliative and end of life care
- Increased use of tele-health to support self-care and recovery
- Increased use of and improved co-ordination and access to support from voluntary sector services

In the development of each scheme, we are working closely with the Nottinghamshire Public Health department to implement evidence based practice.

Interdependencies

This work stream will work closely with the Bassetlaw urgent care strategic programme and the out-of-hospital strategic programme - supporting people post-acute illness.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Reduced unplanned admissions and attendances to A&E and reduced GP visits. Improved quality of care and patient experience. Reduced length of stay in intermediate care and social care transfer to assess facility with more reablement and support provided in peoples own homes.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This is a joint priority with our partners on the Bassetlaw Integrated Care Board

In North Nottinghamshire, review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group (e.g. Integrated Care Board / System Resilience Group) for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies, and the use of specialist analytical software where appropriate.

What are the key success factors for implementation of this scheme?

The key success factors are:

- Partnership working – our local health and social care community are working together through the Bassetlaw Integrated Care Board.
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes. Where there are multi-disciplinary cross agency teams, a partnership approach has been taken.

It is expected that work on this scheme will start in October 2014. Discussions exploring the model are already underway with the community services provider Bassetlaw Health Partnerships and Nottinghamshire County Council Adult Social Care, Health and Public Protection.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
R
Scheme name
24 hour Mental Health Liaison – adults
What is the strategic objective of this scheme?
The vision for North Nottinghamshire (NHS Bassetlaw CCG - "A Community of Care and Support") was co-created by local clinical leaders and local managers from both health and social care. It was based around delivering improved outcomes for patients and identifying what improvements local people can expect to see over the next few years. These were identified as being: Better care for our frail and the elderly population; more and better care provided locally; a high quality local Hospital with 7 day working, easy access, and essential services, such as 24 hour Emergency Department, and consultant-led maternity unit; same day GP led care, with access to the right health care professional; more support for independent living with enhanced sheltered housing choices; patients with a mental health condition to receive improved care through teams, professionals and services working more closely together; care homes to be an integral part of our local community; our local organisation to take joint responsibility for improving care and support; integrated delivery of care and support through team working; organisations to work across boundaries; professions to work together in teams with our patients at the centre of their care, and; organisations to openly share and pool resources where it will benefit the patient. To deliver on our vision we believe we need to focus on five specific areas of health and social care in Bassetlaw. They have been classified as our strategic programmes into which all our Better care Fund Schemes fit, and are as follows: - **Supporting People after Acute Illness** – Helping people to become independent after leaving hospital, providing more reablement and rehabilitation support at home and in the community. - **Care for the elderly -** Improving the pathway of care and integrating local services for people aged over 65. - **Care Homes** – Health and social care working together to improve the quality of care and standards and in care homes across Bassetlaw. - **Mental Health** – Improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on hospital / acute based mental healthcare. - **Urgent Same Day Care** - Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including the GP out of

hours service.

This scheme is aligned to the Mental Health strategic priority to work very closely with the community crisis intervention team to better support people in crisis over the age of 16 in the community and in A&E.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A 24 hour mental health liaison team based within Doncaster and Bassetlaw Hospitals NHS Foundation Trust covering the emergency department and acute inpatient wards. The MH liaison team will work closely with the crisis team that work in the community. This service will support people presenting in A&E with a mental health condition and/ or are in crisis, the team will work closely with clinicians in A&E and the Assessment and Treatment Centre (ATC) in Bassetlaw Hospital, the GP out of hours service (co-located with A&E) and will liaise the crisis intervention team based in the community.

The service provides liaison support to acute staff in the care and management of patients aged 16 and over that have a mental illness, support will be offered in the form of direct patient assessments and care plans as well as providing training and support to the acute workforce.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on the Integrated Care Board who are listed below:

- Commissioner – Bassetlaw CCG
- Providers – Doncaster and Bassetlaw hospitals FT; Bassetlaw Health Partnerships; EMAS; Nottinghamshire Healthcare Trust; Nottinghamshire County Council; Bassetlaw District Council

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Nationally it is reported that at least 25 per cent of patients with a physical illness admitted to hospital also have a diagnosable mental health condition; a further 41 per cent have sub-clinical symptoms of anxiety or depression. Patients with a physical illness are three to four times more likely to develop a mental illness than the rest of the population: poor concordance with care associated with mental health issues is common and poorly recognised despite being associated with increased morbidity in a range of

Long-Term Conditions. The benefits of Liaison Psychiatry have been recognised in the Mental Health Crisis Care Concordat (DoH 2014). The evidence shows that 74% of people that commit suicide are not known to mental health services- in fact most of the people that commit suicide will have been discharged from Acute care rather than a psychiatric unit.

According to Mental Health partnerships:

- The NHS spent £14 billion on mental ill health in 2010-11.
- Mental illness raised the costs of physical healthcare by an estimated £10 billion in 2010-11.
- It is estimated that 5% of all Emergency Department (ED) attendances are due to mental disorders.
- Self-harm is predominant within this group, accounting for 150,000 – 170,000 ED attendances per year in England. These presentations are often resource heavy and labour intensive.
- Chronic repeat attendees to ED are also an issue in terms of resource cost, and these account for 8% of all ED attendances. The most common reason for frequent attendance is an untreated mental health problem.
- The use of acute hospital services by people with dementia is a rising problem. Emergency admissions for people with dementia account for nearly 10% of all hospital admissions. 95% of acute hospital admissions for people with dementia occur in an emergency, with over 60% of these coming through ED, even though 25% of all emergency presentations in people with dementia are preventable.
- 25 – 33% of patients with a long-term physical health problem also have a concurrent mental illness, which increases the risk of physical health complications and increases the costs of treating the physical illness.
- There is a clear evidence base demonstrating the costs of mental health problems generally, and in relation to the impact on physical health conditions.
- There is policy support to mental and physical health becoming more equal in value.

Local information

Patients that experience a mental health crisis presenting into A&E after 5 pm have a higher chance of being admitted onto a mental health inpatient ward. Over a 6 month period between November 2012 and March 2013 78% of all admissions to the ward happened after 5pm or at a weekend. The acute liaison service has been developed as part of the local MH crisis care concordat requirements. Emergency re-admissions into inpatient wards are also more likely to happen out of hours.

In the development of each scheme, we are working closely with the Nottinghamshire Public Health department to implement evidence based practice.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

The expected outcomes of the service will be to:

- Proactively support patients that present at ED with low/medium level need to reduce the number of crisis admissions.
- Reduce the number of MH inpatient admissions. In particular admissions made out of hours
- To increase to identification of Mental illness attributed to long term conditions and physical illness.
- Reduce the number of frequent ED attendances for mental health conditions by working closely with community teams, third sector and GPs to offer alternative support.
- Reduced LoS in the acute wards particularly for older people and people with dementia – close working arrangements with MH intermediate care teams to support timely discharge.
- Raise the profile of Mental Health and wellbeing

Over the next 5 years we expect to see more patients being cared for in the community using the least restrictive intervention possible for their needs. The services will be recovery-focused and acute liaison will support patients along the recovery pathway by working with agencies to offer alternatives to presenting in ED and crisis teams. The number of inpatient beds will reduce and the access to lower level therapies will increase e.g. IAPT as part of better identification of patient needs and a proactive approach.

Patients with dementia requiring fewer admissions, offering support in ED to prevent admission and offer advice about care needs in the community. Assessing patients at the point of admission to develop discharge plans quickly to reduce LoS.

More people that self harm receiving appropriate early interventions to prevent escalation where possible. Bench mark in current self harm presentations to ED

Financial savings expected from the reduction in IP activity, however the service will be quality focused and assist in ensuring that patients receive the appropriate level care in the most suitable environment.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This is a joint priority with our partners on the Bassetlaw Integrated Care Board.

The plans for the service will be included in the overall strategic plan for mental health and will be part of the crisis concordat declaration that will be a multiagency agreement.

In North Nottinghamshire, review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group (e.g. Integrated Care Board / System Resilience Group) for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies, and the use of specialist analytical software where appropriate.

What are the key success factors for implementation of this scheme?

Key success factors for the scheme include:

- Partnership working – our local health and social care community are working together through the Bassetlaw Integrated Care Board.
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes. Where there are multi-disciplinary cross agency teams, a partnership approach has been taken.

Delivery of service to begin August 2014, team are currently undergoing induction process.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
S
Scheme name
Personalised Care - GP led co-ordinated care for over 75s
What is the strategic objective of this scheme?
The vision for North Nottinghamshire (NHS Bassetlaw CCG - "A Community of Care and Support") was co-created by local clinical leaders and local managers from both health and social care. It was based around delivering improved outcomes for patients and identifying what improvements local people can expect to see over the next few years. These were identified as being: Better care for our frail and the elderly population; more and better care provided locally; a high quality local hospital with 7 day working, easy access, and essential services, such as 24 hour Emergency Department, and consultant-led maternity unit; same day GP led care, with access to the right health care professional; more support for independent living with enhanced sheltered housing choices; patients with a mental health condition to receive improved care through teams, professionals and services working more closely together; care homes to be an integral part of our local community; our local organisation to take joint responsibility for improving care and support; integrated delivery of care and support through team working; organisations to work across boundaries; professions to work together in teams with our patients at the centre of their care, and; organisations to openly share and pool resources where it will benefit the patient. To deliver on our vision we believe we need to focus on five specific areas of health and social care in Bassetlaw. They have been classified as our strategic programmes into which all our Better care Fund Schemes fit, and are as follows: - **Supporting People after Acute Illness** – Helping people to become independent after leaving hospital, providing more reablement and rehabilitation support at home and in the community. - **Care for the elderly -** Improving the pathway of care and integrating local services for people aged over 65. - **Care Homes** – Health and social care working together to improve the quality of care and standards and in care homes across Bassetlaw. - **Mental Health** – Improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on hospital / acute based mental healthcare. - **Urgent Same Day Care** - Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including the GP out of

hours service.

These programmes are supplemented by three key cross-programme requirements, namely the need to:

Increase our 7 day services in hospital, the community and Primary Care and in Hospital; continue with our clinically-led philosophy, and; retain our relentless focus on quality, safety and patient experience.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The *2014/15-2018/19 Everyone Counts Planning for Patients* specifies a national focus on frail elderly patients aged 75 and over and those with complex needs. The 2014/15 GP contract sets out specific requirements for all patients over 75 to have an accountable GP and for those that need it to have a comprehensive and co-ordinated package of care. GP personalised care will be underpinned by the integrated primary care team working with community services (part of the Bassetlaw Five Year Strategic plan and referenced in BCF scheme Q). This integrated care approach will be extended in the future to patients with long term conditions and chronic disease over the next few years.

In 14/15 CCGs are mandated to support practices in transforming the care of patients aged 75 and over in reducing avoidable admissions by providing funding to commission additional services which practices individually or collectively will use to support the accountable GP in improving the quality of care for older people. Funding of £5 per head of population is required which broadly equates to £50 per patient over the age of 75.

The CCG has committed this level of investment for GP practices and discussions are underway regarding practice plans to implement changes to clinical pathways, processes and the development of new services to improve care for the elderly in Bassetlaw.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on the Integrated Care Board who are listed below:

- Commissioner – Bassetlaw CCG
- Providers – Doncaster and Bassetlaw hospitals FT; Bassetlaw Health Partnerships; East Midlands Ambulance Service; Nottinghamshire Healthcare Trust; Nottinghamshire County Council; Bassetlaw District Council

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The GMS contract requirements for over 75s care set out specific requirements for practices to ensure there is a named, accountable GP assigned to each patient aged 75 and over. Practices must contact each patient and inform them they have been allocated a named accountable GP, who it is and invite them for a review and develop a care plan for the patient. The national Directed Enhanced Service for admissions avoidance will also be part of the personalised approach to patient care.

The named accountable GP will take lead responsibility for ensuring that all appropriate services required under the contract are delivered to each of their patients aged 75 and over, where required (based on the clinical judgement of the named accountable GP) they will:

- Work with relevant associated health and social care professionals (integrated primary care teams) to deliver a multi-disciplinary care package that meets the needs of the patient
- Ensure that the physical and psychological needs of the patient are recognised and responded to by the relevant clinician in the practice
- Ensure the patient aged 75 years and over has access to a health check

The introduction of named clinicians for vulnerable patients offers an opportunity to redevelop primary care teams, integrated with health and social care, mental health and the voluntary sector built around the patient's needs and with enhanced cooperation, communication and co-ordination between the patient's GP and community services seven days a week, including out of hours' services.

In the development of each scheme, we are working closely with the Nottinghamshire Public Health department to implement evidence based practice.

Interdependencies

GP-led co-ordinated care is closely linked with risk stratification of patients and patients identified through these processes will be given a care plan, and will be managed by a multi-disciplinary team. This approach to proactive care planning will reduce emergency admissions and improve proactive health and social care planning around a patient's needs. All practices hold regular multi-disciplinary team meetings with their community nursing teams to discuss the ongoing care of patients with long term conditions who are at risk of hospital admission. We will develop this collaborative team working into integrated primary care teams and a virtual ward community services model during the next year.

Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan. Please provide any further information about anticipated outcomes that is not captured in headline metrics below.
As a result of this scheme over the next 5 years we expect to reduce admissions, A&E attendances and GP visits.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
This is a joint priority with our partners on the Bassetlaw Integrated Care Board. Personalised care for patients is firmly aligned with the CCG's strategic plan and the national direction of travel. In North Nottinghamshire, review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group (e.g. Integrated Care Board / System Resilience Group) for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies, and the use of specialist analytical software where appropriate.
What are the key success factors for implementation of this scheme?
The key success factor for this scheme is the commitment from GP practices. All Bassetlaw practices are committed to implementing GP led co-ordinated care and multi-disciplinary care planning. All are currently establishing processes and pathways for their patients to facilitate this.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
T
Scheme name
Reablement Schemes
What is the strategic objective of this scheme?
The vision for North Nottinghamshire (NHS Bassetlaw CCG - "A Community of Care and Support") was co-created by local clinical leaders and local managers from both health and social care. It was based around delivering improved outcomes for patients and identifying what improvements local people can expect to see over the next few years. These were identified as being: Better care for our frail and the elderly population; more and better care provided locally; a high quality local Hospital with 7 day working, easy access, and essential services, such as 24 hour Emergency Department, and consultant-led maternity unit; same day GP led care, with access to the right health care professional; more support for independent living with enhanced sheltered housing choices; patients with a mental health condition to receive improved care through teams, professionals and services working more closely together; care homes to be an integral part of our local community; our local organisation to take joint responsibility for improving care and support; integrated delivery of care and support through team working; organisations to work across boundaries; professions to work together in teams with our patients at the centre of their care, and; organisations to openly share and pool resources where it will benefit the patient. To deliver on our vision we believe we need to focus on five specific areas of health and social care in Bassetlaw. They have been classified as our strategic programmes into which all our Better care Fund Schemes fit, and are as follows: - **Supporting People after Acute Illness** – Helping people to become independent after leaving hospital, providing more reablement and rehabilitation support at home and in the community. - **Care for the elderly -** Improving the pathway of care and integrating local services for people aged over 65. - **Care Homes** – Health and social care working together to improve the quality of care and standards and in care homes across Bassetlaw. - **Mental Health** – Improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on hospital / acute based mental healthcare. - **Urgent Same Day Care** - Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including

the GP out of hours service.

These programmes are supplemented by three key cross-programme requirements, namely the need to increase our 7 day services in hospital, the community and Primary Care and in Hospital; continue with our clinically-led philosophy, and; retain our relentless focus on quality, safety and patient experience.

This scheme is aligned to the Care for the Elderly, Urgent Same Day Care and Care Homes strategic priorities with particular aspects of the scheme targeted at different priorities (e.g. the Community Matron in A&E supports Urgent Same Day Care while patients are in A&E, and then Care for the Elderly once patients return to the community to provide a seamless service to patients, see below).

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The schemes identified below were implemented as part of the Department of Health winter monies December 2010 and then the additional monies for reablement and reducing hospital admissions for people that are frail, elderly or have one or multiple long term conditions. All the schemes were implemented on a temporary basis and then following a robust evaluation process were implemented into the Bassetlaw Health Partnership contract for 2014/15. All the schemes were able to demonstrate that they provided positive outcomes for patients and a reduction in hospital admissions for the targeted cohort.

All the services were developed as part of a multiagency approach with the local health and social care community, which led to the development of strong partnership working arrangements and Bassetlaw Integrated Care Board.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on the Integrated Care Board who are listed below:

- Commissioner – Bassetlaw CCG
- Providers – Doncaster and Bassetlaw Hospitals NHS Foundation Trust; Bassetlaw Health Partnerships; East Midlands Ambulance Service; Nottinghamshire Healthcare Trust; Nottinghamshire County Council; Bassetlaw District Council

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The following schemes were piloted as part of the Reablement monies 2010. Following independent evaluation the following schemes were incorporated in to the Bassetlaw Health Partnership Contract

- Tissue viability services in to care homes to enhance Tissue viability support, advice and training.
- A registered nurse into the fall team to provide nursing advice, assessment and support to patients.
- Occupational Therapy post into the Integrated Discharge Team to provide OT assessment and facilitate early discharge.
- A community Matron in A and E to facilitate early discharges directly from A and E back into community services
- Registered nurse support for the Respiratory service and heart failure matrons to provide follow visit and monitor patients less complex needs
- An increased investment into Rapid Response to increase the hours to 9pm and to increase it from a 5 day to 7 day service
- Community physiotherapy service as patients who needed additional physiotherapy following discharge and to maximise the rehabilitation of these patients.
- Respiratory Physiotherapist to support the COPD Nurses and implement a Pulmonary Rehabilitation service in Bassetlaw
- 5 Assessment beds to support the discharge to assess model
- An increased investment into the community matron service to provide a service over the weekends to make it a 7 day service.

In the development of each scheme, we are working closely with the Nottinghamshire Public Health department to implement evidence based practice.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

These schemes have been embedded into community services during 2014/15 as mainstream services. By 2016 these services will have been redesigned, if appropriate, to support new pathways and processes as part of the strategic priorities. At this point in time it is difficult to articulate what this will be as the 5 areas are currently be implemented.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This is a joint priority with our partners on the Bassetlaw Integrated Care Board.

All of the above schemes will be included in the work of all work streams and will be developed or redesigned as appropriate to support new patient pathways.

In North Nottinghamshire, review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group (e.g. Integrated Care Board / System Resilience Group) for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies, and the use of specialist analytical software where appropriate.

What are the key success factors for implementation of this scheme?

Key success factors for the scheme include:

- Partnership working – our local health and social care community are working together through the Bassetlaw Integrated Care Board.
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes. Where there are multi-disciplinary cross agency teams, a partnership approach has been taken.
- Market management – through the steering group we are working with local providers to ensure that the future needs of our population can be met.

All of the work streams have been embedded into main stream services as part of the core Bassetlaw Health Partnership Contract and ongoing monitoring is via the contractual route

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
U
Scheme name
Discharge/Assessment and Intermediate Care
What is the strategic objective of this scheme?
The vision for North Nottinghamshire (NHS Bassetlaw CCG - "A Community of Care and Support") was co-created by local clinical leaders and local managers from both health and social care. It was based around delivering improved outcomes for patients and identifying what improvements local people can expect to see over the next few years. These were identified as being: Better care for our frail and the elderly population; more and better care provided locally; a high quality local Hospital with 7 day working, easy access, and essential services, such as 24 hour Emergency Department, and consultant-led maternity unit; same day GP-led care, with access to the right health care professional; more support for independent living with enhanced sheltered housing choices; patients with a mental health condition to receive improved care through teams, professionals and services working more closely together; care homes to be an integral part of our local community; our local organisation to take joint responsibility for improving care and support; integrated delivery of care and support through team working; organisations to work across boundaries; professions to work together in teams with our patients at the centre of their care, and; organisations to openly share and pool resources where it will benefit the patient. To deliver on our vision we believe we need to focus on five specific areas of health and social care in Bassetlaw. They have been classified as our strategic programmes into which all our Better care Fund Schemes fit, and are as follows: - **Supporting People after Acute Illness** – Helping people to become independent after leaving hospital, providing more reablement and rehabilitation support at home and in the community. - **Care for the elderly -** Improving the pathway of care and integrating local services for people aged over 65. - **Care Homes** – Health and social care working together to improve the quality of care and standards and in care homes across Bassetlaw. - **Mental Health** – Improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on hospital / acute based mental healthcare. - **Urgent Same Day Care** - Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including the GP

out of hours service.

This scheme is aligned to the Supporting People after Acute Illness and Care for the Elderly strategic priorities to improve access to intermediate care services.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The current intermediate care service in Bassetlaw is a partly integrated model of step down care delivered across a number of health and social care providers for people requiring additional support, rehabilitation and reablement following an acute illness such as the frail elderly or surgery. The intermediate care beds currently used are based in a number of care homes across Bassetlaw and the intermediate care pathway is supported by the following services: a multi-disciplinary rapid response (crisis) team working in the acute hospital (Doncaster and Bassetlaw Hospitals NHS Foundation Trust) and in the community supporting patients during and after hospital discharge, a community falls prevention service, a community intermediate care service (providing step down / step up bed based care and domiciliary reablement support), primary care GP led support and a community based Mental Health Intermediate Care Team. Nottinghamshire County Council provides all social care support to patients discharged from hospital and across the Bassetlaw district.

This new discharge process and intermediate care model will bring all these services together to work as multi-disciplinary teams across health and social care and the voluntary sector focused on the needs of patients and their families.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on the Integrated Care Board.

- Commissioner – Bassetlaw CCG
- Providers specifically involved
    - Bassetlaw CCG
    - Nottinghamshire Healthcare NHS Trust
    - Bassetlaw Health Partnerships (Nottinghamshire Healthcare NHS Trust)
    - Nottinghamshire County Council

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Bassetlaw CCG's 2014-2019 Strategic Plan outlines five strategic priorities being taken forward over the next five years to improve and sustain local services and improve patient outcomes. The five priorities are:

- Care of the elderly
- Care homes
- Mental Health
- Supporting people out-of-hospital
- Urgent / same day care

Integrating intermediate care with health and social care is a key part of the supporting people out-of-hospital and the care of the elderly strategic programmes. A review of the current intermediate care service and pathways is underway with local health and social care partners through the Bassetlaw Integrated Care Board; the service is also part of a national intermediate care benchmark exercise with the National Audit Office (NAO).

The aim is to establish a more integrated model that meets the care and support needs for the future (particularly the growing demand on services due to demographic changes of people living longer) and improving access by providing a seamless patient-focussed and efficient service supporting and reabling more people in their own homes to regain independence quickly or moved to an alternative place of care such as short or long term residential care home. Patient care will be co-ordinated and case managed through multi-disciplinary working within primary care neighbourhood teams.

There is limited published evidence to support whether integration reduces hospital % usage. However, a King's Fund study looking at the relationship between emergency bed use in older patients found that areas that have well-developed, integrated services for older people have lower rates of emergency bed use and lower re-admission rates. Interestingly, areas with higher proportions of older people also have lower bed use and this may be due to these areas prioritising the needs of older people and therefore putting a stronger emphasis on providing integrated services (Imison, 2012).

The MACE model (Mobile Acute Care of the Elderly) developed in Canada, which integrates primary and secondary care by utilising a multi-disciplinary team working both in hospital and out in the community has improved outcomes for patients and reduced hospital costs and LOS (Farber et al, 2011).

In the development of each scheme, we are working closely with the Nottinghamshire Public Health department to implement evidence-based practice.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

This programme of work will provide the infrastructure and pathways to ensure that planning of a patient's discharge starts at the point of admission and they are discharged as soon as their acute episode has ended and they are medically fit to leave hospital. Over the next 3-5 years our expectation is that integrated intermediate care model will provide patients with a range of different levels of support and care which will be provided over one site fully integrated into the wider health and social care system.

This more co-ordinated approach will improve the quality of care and patient experience, reduce the length of stay in hospital, reduced admissions and re-admissions. It will enable more patients to be given reablement and support in their own homes promoting independence with less reliance on short and longer-term residential care.

Specific data on performance, efficiency and quality outcomes are currently being worked up as part of the programme and are not yet available.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Integrating intermediate care is a strategic priority for all partners of the Bassetlaw Integrated Care Board and the local voluntary sector. The intention of the Integrated Care Board is to sustain local services around the Bassetlaw 'place' for the benefit of the people in Bassetlaw.

In North Nottinghamshire, review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group (e.g. Integrated Care Board / System Resilience Group) for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies, and the use of specialist analytical software where appropriate.

What are the key success factors for implementation of this scheme?

Key success factors for the scheme include:

- Partnership working – our local health and social care community are working together through the Bassetlaw Integrated Care Board.
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes. Where there are multi-disciplinary cross agency teams, a partnership approach has been taken.
- Market management – through the steering group we are working with local providers to ensure that the future needs of our population can be met.

The proposed integrated intermediate care model will build on the existing partially integrated service. Included in the programme of work over the next year is the following actions / pathways:

2014

- Improve the multi-agency integrated discharge team (IDT) and processes at DBH. The team will include community services, acute, social care and primary care and the voluntary sector. A discharge process protocol will be followed for all complex patients. This team will have trusted assessors (and also on the wards at Bassetlaw Hospital) to assess the needs, establish health and social care packages (including continuing health care and fast track) and manage all complex patient discharges into the community (intermediate care) or to home. Ongoing care and support needs will be identified and included in the patients care plan led by their named GP and integrated neighbourhood team
- Analysis of integrated care demand (beds and home support) develop pathway and scope new facilities for a transfer to social care assessment pathway and identify the future intermediate care beds need

2015

- Implement new transfer to social care assessment pathway and changes to intermediate care bed capacity
- Consider longer term location and facilities for intermediate care via an independence and reablement unit (IRU) in Bassetlaw
- End of 2015/16 new model of IRU integrated intermediate care in place

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
V
Scheme name
Respite Services and Carers support
What is the strategic objective of this scheme?
The vision for North Nottinghamshire (NHS Bassetlaw CCG - "A Community of Care and Support") was co-created by local clinical leaders and local managers from both health and social care. It was based around delivering improved outcomes for patients and identifying what improvements local people can expect to see over the next few years. These were identified as being: Better care for our frail and the elderly population; more and better care provided locally; a high quality local Hospital with 7 day working, easy access, and essential services, such as 24 hour Emergency Department, and consultant-led maternity unit; same day GP led care, with access to the right health care professional; more support for independent living with enhanced sheltered housing choices; patients with a mental health condition to receive improved care through teams, professionals and services working more closely together; care homes to be an integral part of our local community; our local organisation to take joint responsibility for improving care and support; integrated delivery of care and support through team working; organisations to work across boundaries; professions to work together in teams with our patients at the centre of their care, and; organisations to openly share and pool resources where it will benefit the patient. To deliver on our vision we believe we need to focus on five specific areas of health and social care in Bassetlaw. They have been classified as our strategic programmes into which all our Better care Fund Schemes fit, and are as follows: - **Supporting People after Acute Illness** – Helping people to become independent after leaving hospital, providing more reablement and rehabilitation support at home and in the community. - **Care for the elderly -** Improving the pathway of care and integrating local services for people aged over 65. - **Care Homes** – Health and social care working together to improve the quality of care and standards and in care homes across Bassetlaw. - **Mental Health** – Improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on hospital / acute based mental healthcare. - **Urgent Same Day Care** - Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including the GP out of

hours service.

These programmes are supplemented by three key cross-programme requirements, namely the need to increase our 7 day services in hospital, the community and Primary Care and in Hospital; continue with our clinically-led philosophy, and; retain our relentless focus on quality, safety and patient experience.

This BCF scheme is overarching and supports all five strategic priorities, with particular aspects of the scheme targeted at different priorities (e.g. Dementia Compass Workers are aligned to the Care for the elderly priority, see overview below).

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Rationale:

The Carers' Strategy was developed in response to local need and national drivers, and reflects the plans developed by the clinical commissioning groups. In addition, the strategy addresses the Carers' Survey 2012.

The 2011 Census report identified that there has been an increase in the number of carers in the last decade by 7,517 across Nottinghamshire (excluding Nottingham City). There are now 90,698 carers in the county; 57,426 carers are providing between 1-19 hours of care per week, and the number of carers now providing over 50 hours of care per week has reached 21,680.

From April 2013 to March 2014, the council assessed and reviewed 4,719 carers, of whom 3,470 received a service. Based on population data, the value of the support provided by informal carers in Nottinghamshire would be around £1,656 million. It is therefore both ethically and economically sound to support carers to continue in their caring role.

The Care Act 2014 emphasises the importance of supporting carers, parity of esteem for carers and the cared-for person, principles of wellbeing and personalisation, universal rights to information and advice and carers' rights to an assessment and services. The expectation is that the Act will increase demand for both provision of carers' assessments and also services.

Within this strategy the following schemes are supported by this fund:

1. **Dementia Compass Workers:** employ one Compass Worker for Bassetlaw, based in the Intermediate Mental Health Team. These are specialist workers to support carers of people with dementia, and especially working age dementia. These workers would work along similar lines to 'Admiral Nurses'; qualified mental health nurses who have additional qualifications and personal experience of dementia care. They will offer direct casework with family carers, assessment, signposting, psychological support, training for other professionals etc.

Outcomes: Earlier diagnosis, intervention and reablement mean that people and their

carers are less dependent on intensive services. Carers can balance their caring roles and maintain their desired quality of life.

2. **End of Life Carers Support Service:** a single point of contact for carers providing information, advice and signposting, training, bereavement support and a sitting service.

Outcomes: Carers can balance their caring roles and maintain their desired quality of life

3. **Memory Clinic support workers and CRISP courses:** provided by the Alzheimer's Society within Bassetlaw for carers of people with dementia. The CRISP course comprises of 6 sessions focussing on building carer's resilience.

Outcomes: Earlier diagnosis, intervention and reablement mean that people and their carers are less dependent on intensive services. Carers can balance their caring roles and maintain their desired quality of life

4. **Care and Support Centres:** in Bassetlaw we have two care homes that have been rebranded Care and Support Centres; St Michaels in Retford and James Hince Court in Carlton in Lindrick. The aim is to develop these centres as a community resource and include an outreach and/or crisis prevention service out of these services. The centres will offer:

- Reminiscence Therapy Workshops
- Community Link workers
- Carers' rooms
- Bathing service
- Ad hoc drop-in
- Outreach work
- Assistive Technology Equipment

Outcomes: Carers can balance their caring roles and maintain their desired quality of life. Carers can access support in their local area.

5. **Carers' Personal Budgets:** one-off budgets of £150 or £200 given to carers as a direct payment to support them in their caring role. We are also implementing Carers' Personal Health Budgets to provide respite care for Bassetlaw carers through a direct payment.

Outcomes: Carers can balance their caring roles and maintain their desired quality of life. Carers have choice and control over how they receive support.

6. **Training for carers:** courses to support carers' resilience whatever their caring role, there are two courses currently commissioned in the county: Caring with Confidence and Looking after Me.

Outcomes: Carers can balance their caring roles and maintain their desired quality of life.

7. **Evaluation:** working with public health to evaluate the current provision of carers' services in the county, in particular the carers' breaks and the triage service.

Outcomes: People know what choices are available to them locally, what they are entitled to, and who to contact when they need help

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on the Integrated Care Board; the Carers' Implementation Group and the Carers' Commissioning Forum (key commissioners from health and social care) lead the development of this scheme. The joint Carers' Implementation Group reports into the Older People's Integrated Commissioning Group and ultimately to the Health and Wellbeing Board.

Commissioner – all CCGs and Nottinghamshire County Council

Provider – various

- Nottinghamshire Healthcare NHS Trust
- Central Nottinghamshire Clinical Services (CNCS)
- Alzheimer's Society
- Carers Federation
- GP surgeries
- Nottinghamshire County Council

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence base:

Evidence shows that supporting carers has been demonstrated to be cost effective. The Department of Health "Impact Assessment" includes a number of aspects, such as improved support for carers and carers' assessments. It details the figures for funding for carers' assessments and provision of support, and also the savings that the Department of Health believe will arise from improved support for carers, which is recognised in the Care Act 2014.

A 2013 review of the evidence base for funding carers was commissioned from the Institute of Public Care for Nottinghamshire in order to inform the carers' strategy and review of existing services. This identified a number of critical factors of successful carers' support services:

- Early identification
- A focus on outcomes
- A focus on improving and measuring quality of life

Referenced documents:

- Nottinghamshire Joint Strategic Needs Assessment

- Carers at the heart of 21st Century Families and Communities; (Department of Health, 2008)
- Care and Support Legal Reform (Part 1 of the Care Bill) Impact Assessment (8 May 2013), Department of Health.
- Institute of Public Care, Oxford Brookes University: Evidence Base for Carer Support 2013
- Adult Social Care and Health Carers' Survey 2012
- Improving How Direct Payments work for People with Dementia – Final Project Report 2014

In the development of each scheme, we are working closely with the Nottinghamshire Public Health department to implement evidence based practice.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

The impact of the Integrated Carers Commissioning Strategy for Nottinghamshire is expected to be the following outcomes as summarised in the services above:

- People know what choices are available to them locally, what they are entitled to, and who to contact when they need help
- Carers can access support in their local area.
- Carers can balance their caring roles and maintain their desired quality of life
- Earlier diagnosis, intervention and reablement mean that people and their carers are less dependent on intensive services.
- Carers have choice and control over how they receive support.
- Carers feel that they are respected as equal partners throughout the care process.
- People who use social care and health services, and their carers, are satisfied with their experience of care and support

Each service specification is outcome-focused with relevant performance metrics and milestones included.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This is a joint priority with our partners on the Bassetlaw Integrated Care Board.

This work is part of a wider integrated commissioning strategy for carers which aligns with wider commissioning plans across health and social care. A regular Carers

Commissioning Forum brings together key commissioners from health and social care across the county to discuss the strategy. A Carers Implementation Group also meets quarterly and involves carers and other key stakeholders in the design and delivery of the strategy.

In North Nottinghamshire, review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group (e.g. Integrated Care Board / System Resilience Group) for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies, and the use of specialist analytical software where appropriate.

What are the key success factors for implementation of this scheme?

Key success factors for the scheme include:

- Partnership working – our local health and social care community are working together through the Bassetlaw Integrated Care Board.
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes. Where there are multi-disciplinary cross agency teams, a partnership approach has been taken.
- Market management – through the steering group we are working with local providers to ensure that the future needs of our population can be met.

Delivery timelines for schemes are shown below:

1. Dementia Compass Workers: evaluate the delivery of this service by March 2015.

2. End of Life Carers Support Service: evaluate the delivery of this service by March 2015.

3. Development of a new Carers Information Pack by October 2014.

4. Carers Roadshows across the county by December 2014.

5. Carers Support service: to recruit a Community Care Officer to liaise with Primary Care Teams to promote Carers Registers within General Practice by March 2015.

6. Carers' Personal Budgets: to offer 150 carers a Personal Health Budget for respite breaks, by March 2015.

7. Training for carers: to deliver 6 Caring with Confidence courses / Looking after Me courses by March 2015.

8. New, jointly commissioned Universal Services for Carers (including advice,

information, training and engagement) will be tendered, awarded and services due to start in April 2015.

9. Evaluation work: to complete an evaluation report by November 2014 to inform carers tendering process for the county.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
W
Scheme name
Improving Care Home Quality
What is the strategic objective of this scheme?
The vision for North Nottinghamshire (NHS Bassetlaw CCG - "A Community of Care and Support") was co-created by local clinical leaders and local managers from both health and social care. It was based around delivering improved outcomes for patients and identifying what improvements local people can expect to see over the next few years. These were identified as being: Better care for our frail and the elderly population; more and better care provided locally; a high quality local Hospital with 7 day working, easy access, and essential services, such as 24 hour Emergency Department, and consultant-led maternity unit; same day GP led care, with access to the right health care professional; more support for independent living with enhanced sheltered housing choices; patients with a mental health condition to receive improved care through teams, professionals and services working more closely together; care homes to be an integral part of our local community; our local organisation to take joint responsibility for improving care and support; integrated delivery of care and support through team working; organisations to work across boundaries; professions to work together in teams with our patients at the centre of their care, and; organisations to openly share and pool resources where it will benefit the patient. To deliver on our vision we believe we need to focus on five specific areas of health and social care in Bassetlaw. They have been classified as our strategic programmes into which all our Better care Fund Schemes fit, and are as follows: - **Supporting People after Acute Illness** – Helping people to become independent after leaving hospital, providing more reablement and rehabilitation support at home and in the community. - **Care for the elderly -** Improving the pathway of care and integrating local services for people aged over 65. - **Care Homes** – Health and social care working together to improve the quality of care and standards and in care homes across Bassetlaw. - **Mental Health** – Improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on hospital / acute based mental healthcare. - **Urgent Same Day Care** - Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including the GP out of

hours service.

Improving care home quality is aligned to the Care Homes strategic priority and is a key enabler to delivering the services that Bassetlaw's citizens need.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

During the last eighteen months the CCG has been working with Nottinghamshire County Council to develop a local understanding of the care home provision across Bassetlaw. In Bassetlaw there are currently 29 care homes of which 11 are nursing homes. The Nottinghamshire Strategic review of care homes identified the key areas of development for the local sectors for the next 5 years which includes adapting provision to meet the changing needs of the local population.

The vision is to develop and implement an accommodation strategy for older people, which will plan for future residential and nursing capacity, and improve the experience and quality of life of people in care homes.

The model of care will focus on the quality of care and quality standards being consistently implemented to ensure that frail elderly people in care homes are safeguarded against significant harm, while enabling them to live with manageable risk and to live an independent and fulfilled life as far as is possible.

A number of actions and tools have been developed by the CCG and partners to improve quality standards including a GP visit request template (to ensure GPs have the necessary information and observations about the patients illness prior to the visit) and a quality Barometer for nursing homes which is supported by a nursing network and through appointing 2 infection prevention and control nurses has raised the standards of cleanliness in the homes audited.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on the Integrated Care Board who are listed below:

- Commissioner – Bassetlaw CCG
- Providers – Doncaster and Bassetlaw Hospitals NHS Foundation Trust; Bassetlaw Health Partnerships; East Midlands Ambulance Service; Nottinghamshire Healthcare Trust; Nottinghamshire County Council; Bassetlaw District Council

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Due to the increasing growth of the older population it is vital that the CCG, LA and partners across Bassetlaw jointly plan the future needs, provision and affordability of long term care while also taking into account the impact and requirements of the Care Act 2014.

This work aims to reduce the reliance on long term care home placements by maximising independence and quality of life for local people that require residential / nursing care. By enhancing the quality of care, residents will receive the majority of their health and social care support in the care home setting, thereby reducing hospital admissions and unnecessary A and E visits.

The quality aspects of the programme will ensure that all local homes are providing high standards of care which is consistent across the locality and care that meets residents' needs.

Following a stakeholder event with local care providers to identify key areas of focus for the work stream, a steering group has been established with local providers contributing the development of the local schemes.

The proposed schemes include:

- End of life care which will support nursing homes and local care homes that provide fast track care to become accredited with the Gold Standards Framework for care homes and also to review palliative care support into homes to support the Chief Nursing Officers Priorities for the Dying Person launched on the 26th of June in the care home sectors.
- Medicines management support into local homes to support GP's to review residents with Poly pharmacy which impacts on the overall health and wellbeing of residents and their quality of life. Underpinned by the NICE guidance on Managing Medicines in Care Homes, this scheme will audit the whole process of administration of medicines and monitor medicine administration and storage practice to improve the quality of medicine administration across all homes. In addition there will be a programme of training for staff. There is local evidence that poor medicines management is often part of a wider indicator of poor quality of care.
- Reviewing and enhancing dietetic / nutrition services into care homes by providing additional resource into the current dietetic service. This enhanced service will provide support and training into local homes to identify residents at risk and support the implementation of actions to address low-level nutritional deficits. The enhancement will also allow for the development of a more robust referral process with local clinicians to ensure that nutritional support is timely and provides the best possible outcome for the resident.
- A development programme for care home managers is currently being explored to enhance the leadership skills with in homes to support them to develop practice

and to enhance the quality of care they provide. This programme is currently being scoped.

- It was recognised from the strategic review that retention of registered nurses is a key challenge across the care sector so the steering group is looking at the development of both the registered nurse and also the care staff in homes to ensure they are competent to perform their roles but also to provide them with a career pathway that will encourage them to continue to work locally.
- Embedding of the falls pathway into local homes to ensure that that the pathway is seamless and that appropriate multi agency assessment and management of falls is taking place. This will reduce falls and local A& E attendance.

In the development of each scheme, we are working closely with the Nottinghamshire Public Health department to implement evidence based practice.

Interdependencies

This work stream will work closely with the Bassetlaw strategic priorities mental health, and the care of the elderly strategic programme to improve the management of dementia, including people with dementia in Bassetlaw care homes. It will support the actions that have been identified from the Nottinghamshire care home strategic review in this locality. It will also support urgent care and hospital avoidance by reducing A and E attendances and hospital admissions.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

This programme of work will support the reduction in long term care homes placements by maximising independence and quality of life for the population that require residential care. By enhancing the quality of care residents should receive the majority of their health and social care in the care home setting reducing hospital admissions and unnecessary A&E visits.

The quality aspects of the programme will ensure that all local homes are providing high standards of care which is consistent across the locality and care that meets residents' needs.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This is a joint priority with our partners on the Bassetlaw Integrated Care Board. The care homes steering group will regularly monitor and develop the schemes within the programme to ensure that they are fit for purpose and be accountable to the Bassetlaw

Integrated Care Board.

In North Nottinghamshire, review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group (e.g. Integrated Care Board / System Resilience Group) for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies and the use of specialist analytical software where appropriate.

What are the key success factors for implementation of this scheme?

Key success factors for the scheme include:

- Partnership working – we are working in a new way with our local providers through the steering group, which will take time to embed fully. Partners are committed to supporting the development of local services with members from care homes, the local housing provider, voluntary sector, Bassetlaw District Council, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Bassetlaw Health Partnerships, Bassetlaw CCG and Nottinghamshire County Council. The steering group is co-chaired by a senior manager from Nottinghamshire County Council and a care home manager.
- Staff – as acknowledged above, the retention of registered nurses is a key challenge across the care sector. The steering group is looking at the development of both the registered nurse and also the care staff in homes to ensure they are competent to perform their roles but also to provide them with a career pathway that will encourage them to continue to work locally.
- Market management – through the steering group we are working with local providers to ensure that the future needs of our population can be met, e.g. enhanced provision for dementia and nursing patients, and more suitable lower level accommodation such as Extracare Housing.

The proposed time scales for the commencement of the schemes:

- During the remainder of 2014/15 – The schemes identified above will be implemented and a programme of audit and review will be commenced to evaluate their effectiveness
- 2015/16 – There will be a particular focus on dementia – the detail is to be decided - and plans for alternative long term care provision in the community (independent supported living) including support at home will be agreed by the partners of the Bassetlaw Integrated Care Board

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
X
Scheme name
Telehealth
What is the strategic objective of this scheme?
The vision for North Nottinghamshire (NHS Bassetlaw CCG - "A Community of Care and Support") was co-created by local clinical leaders and local managers from both health and social care. It was based around delivering improved outcomes for patients and identifying what improvements local people can expect to see over the next few years. These were identified as being: Better care for our frail and the elderly population; more and better care provided locally; a high quality local Hospital with 7 day working, easy access, and essential services, such as 24 hour Emergency Department, and consultant-led maternity unit; same day GP led care, with access to the right health care professional; more support for independent living with enhanced sheltered housing choices; patients with a mental health condition to receive improved care through teams, professionals and services working more closely together; care homes to be an integral part of our local community; our local organisation to take joint responsibility for improving care and support; integrated delivery of care and support through team working; organisations to work across boundaries; professions to work together in teams with our patients at the centre of their care, and; organisations to openly share and pool resources where it will benefit the patient. To deliver on our vision we believe we need to focus on five specific areas of health and social care in Bassetlaw. They have been classified as our strategic programmes into which all our Better care Fund Schemes fit, and are as follows: - **Supporting People after Acute Illness** – Helping people to become independent after leaving hospital, providing more reablement and rehabilitation support at home and in the community. - **Care for the elderly -** Improving the pathway of care and integrating local services for people aged over 65. - **Care Homes** – Health and social care working together to improve the quality of care and standards and in care homes across Bassetlaw. - **Mental Health** – Improving links and integration between physical health and mental health services with an increased emphasis on prevention and earlier intervention and less reliance on hospital / acute based mental healthcare. - **Urgent Same Day Care** - Providing equitable same day 24 hour urgent care services in Bassetlaw based on local population need and including the GP out of

hours service.

These programmes are supplemented by three key cross-programme requirements, namely the need to increase our 7 day services in hospital, the community and Primary Care and in Hospital; continue with our clinically-led philosophy, and; retain our relentless focus on quality, safety and patient experience.

This BCF scheme is aligned to the Care of the Elderly in the Community strategic priority.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Telehealth is used to improve case management for people with long term conditions through the provision of more timely information to support condition management. Patients use tele-health machines to take the readings related to their long term condition such as blood pressure, heart rate, oxygen saturation and weight in their own homes. These readings are then sent through a telephone line where they are monitored to detect any changes. Changes to vital signs which are outside individually set parameters are notified to appropriate case managers/health professionals using agreed pathways to prevent or reduce the impact of exacerbations in their condition.

Telehealth machines support clinicians in the community to case manage patients with established long term conditions. The introduction of a tele-health service in the community can to reduce the number of emergency hospital admissions, A&E attendances and reduce the number of community nursing visits for patients with long term conditions while improving their quality of life.

Life expectancy is set to increase in Bassetlaw; it rose by 1.1 years for men and 1.4 years for women with the average life expectancy being 77.7 years (male) and 81.3 years (female). This has an impact on the number of people with long term conditions as long term conditions prevalence increases with age. Therefore we expect to see a rise in Long Term Condition Prevalence in Bassetlaw over the same time period.

A pilot of 2 practices has been undertaken in Bassetlaw during the last 18 months using an established hub at Barnsley for daily monitoring by registered nurses who interface locally with the GP practice and Bassetlaw Health Partnerships community staff. There are 3 strands to the service available: vital sign monitoring, health coaching and care navigation:

Vital Sign Monitoring

This strand of the tele-health programme supports individuals with heart failure and or chronic obstructive airways disease who have frequent acute exacerbations and often been hospitalized or presented acutely to urgent care services. Patients take their vital signs daily through equipment in their home and the results are transmitted through the telephone line to Barnsley nurse hub that then monitor the results against the parameter set for each patient and also against the trend. Early signs of deterioration are identified and the local community matron informed. The equipment has an educational element to it helping patients understand the disease itself and the early signs of deterioration in

their condition. This approach allows the equipment to be withdrawn 6-9 months later in most cases.

Health Coaching

Alongside monitoring is also a health coaching service to support patients with long term conditions. Using motivational interviewing and behaviour change techniques via the telephone, patients are facilitated to achieve greater self -care. Telephone coaching is used to facilitate support and motivation to patients to achieve their own stated goals. Individuals are supported for 5 months and then reassessed.

Care Navigation

The third element of the service supports individuals who have a long term condition and at assessment stage do not have any personal health goals. As such they access the tele-health care service in order for them to receive advice, information and support to identify unmet needs. They are then signposted through the local single point of access at Retford to appropriate services to assist in the ongoing management of their long term condition. Patients who are suitable for 'navigation' support would be overseen by the hub for 12 weeks.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on the Integrated Care Board who are listed below:

- Commissioner – Bassetlaw CCG
- Providers – Doncaster and Bassetlaw hospitals FT; Bassetlaw Health Partnerships; EMAS; Nottinghamshire Healthcare Trust; Nottinghamshire County Council; Bassetlaw District Council

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

As well as the local pilot outlined above, in the UK there have been many small studies on tele-health. The Whole System Demonstrator (WSD) programme is the largest randomised control trial of tele-health and tele-care anywhere in the world. It was set up in 2008 to look at the clinical and cost effectiveness of tele-health and tele-care across three sites (Kent, Cornwall and Newham) involving 6,191 participants, and 238 GP practices. The tele-health part of the study focused on three diseases, COPD, diabetes and heart disease. Data was collected over a minimum of 12 months.

The headline findings from the Whole System Demonstrator (Dec 2011) were:

- 20% fall in emergency admissions
- 15% fewer visits to A&E

- 14% fewer elective admissions
- 14% fewer bed days
- 8% reduction in tariff costs

There are also significant reductions in mortality (up to 45%) however the demonstrator review highlights that the findings are subject to the implementation and service being delivered properly.

In the development of each scheme, we are working closely with the Nottinghamshire Public Health department to implement evidence based practice.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

The service has received very positive feedback from patients and carers, allowing them to have increased condition knowledge and confidence to manage their own conditions.

Over the next 5 years we expect to see a reduction in A&E attendances, emergency admissions and primary care attendances for the patients on the scheme.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This is a joint priority with our partners on the Bassetlaw Integrated Care Board.

Telehealth enables people to better manage their condition and it is a key enabler of the 5 year plan supporting integrated primary and community care and reducing the unnecessary admissions and visits to hospital. It encourages independence and improved knowledge LTC for patients and families. Strategically, the programme is aligned with risk stratification, admissions avoidance, over 75s case management and the CCGs integrated care agenda. It also supports the CCG's urgent care strategic priority and the management of older frail or socially isolated individuals with long term conditions.

In North Nottinghamshire, review processes are already underway to inform commissioning decisions accordingly, and evaluation of specific services is presented to the relevant accountable group (e.g. Integrated Care Board / System Resilience Group) for the appropriate action to be taken. Patient, service user, and carer experience information is also monitored and reviewed regularly at a senior level. Further work is expected to evaluate existing services, and any new services will be subjected to

formative evaluation to inform development of the service. This work will be done across organisational boundaries, and drawing on the expertise of the Nottinghamshire Public Health department. A mixed methods approach will be adopted including both quantitative and qualitative methodologies, and the use of specialist analytical software where appropriate.

What are the key success factors for implementation of this scheme?

The key success factors are:

- Partnership working – our local health and social care community are working together through the Bassetlaw Integrated Care Board.
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes. Where there are multi-disciplinary cross agency teams, a partnership approach has been taken.
- Training - frontline staff in practices need to have the expertise to utilize equipment. This has been factored in to delivery plans.

The service is now being rolled out to all Bassetlaw practices during 2014/15. All practices are committed to offering tele-health to patients with COPD and HF and will be expanded to patients with other LTC and chronic disease later in the year

Evaluation has been undertaken throughout the pilot and as a minimum focus on patient's perceived improvement in health and understanding of their condition, efficiency gains in community and primary care and cost effectiveness.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Y
Scheme name
Social Care Capital (Living at Home Programme)
What is the strategic objective of this scheme?
To reduce the numbers of older adults being admitted in to long term residential care and develop alternative support services that will support people in their own home environment in local communities. Extra Care Housing is one of the alternative support services. This scheme is aligned with the ambitions in Nottinghamshire's Joint Health and Wellbeing Strategy (Living Well and Coping Well), and the visions for the three Transformation Boards.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The capital money is being used to part fund the following Extra Care schemes: - St Andrews House Gedling –Partnership with Gedling Homes - Jan 2015 - Brownlow Road Mansfield – Partnership with Mansfield District Council – open Nov 2015 - Walker Street Eastwood – Procured a strategic partner Kier/Ashley House – Autumn 2015 - Former Elizabethan School site Retford -Procured a strategic partner Kier/Ashley House – Autumn 2015 - Darlison Court Ashfield – Partnership with Ashfield District Council – open Dec 2015 Within each of the Extra Care schemes Nottinghamshire County Council will have nomination rights to a number of apartments and bungalows. This is typically 25% of the total number of units. The remaining units will be available to anyone over the age of 55 years. Each of the schemes are to be built to the specification of Nottinghamshire County Council including lifts, wide corridors, lots of light and sympathetically designed to support people with Dementia. At the Mansfield scheme there are 10 bungalows built

specifically for people with Dementia.

The schemes will also include flexible and communal space that older adults can use to develop their own networks. They can use the schemes for such things as well being clinics, fitness classes or simply meeting with family and friends for coffee.

Care support will be provided by Nottinghamshire County Council for the people assessed as eligible for the extra care service and this will be flexible in that people can have both planned care and support at different times dependent on their support needs.

The schemes are a real alternative to traditional residential care and will enable older adults to remain in their own home environment for as long as they wish to do so.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

This is a joint priority with our partners on Nottinghamshire's Transformation Boards. Nottinghamshire County Council is leading this scheme and working in partnership with the seven District and Borough Councils within Nottinghamshire and their respective housing providers. In addition to undertaking a procurement process that identified a consortium that will deliver two of the schemes. It has also had dialogue with health colleagues, which is continuing and it is hoped to work with them when the schemes are delivered so that they can use an extra care housing environment as opposed to a bed based service in a hospital or residential care home. Work is also continuing to look to deliver additional schemes across Nottinghamshire County.

Providers include:

- Mansfield District Council
- Ashfield District Council
- Gedling Homes
- Kier Construction Ltd and Ashley House Plc

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In the past Nottinghamshire County Council has admitted a higher proportion of older adults in to residential care than its comparator authorities and it is now working to provide a more diverse market so that people can be supported in their own home environment with appropriate support where needed.

In Nottinghamshire's Joint Strategic Needs Assessment (JSNA), updated in 2012, it is estimated that by 2025 there will be 196,600 people aged 65+ living in Nottinghamshire, 23% of the total population. The largest increase is expected for people aged 75-79 (approx. 16,000 increase) and females.

The numbers of people aged 85 and over with a limiting long-term illness are expected to double by 2030. Dementia is one of the main causes of disability in later life and the number of people with dementia is rising as the population ages. The prevalence of dementia is expected to rise across Nottinghamshire by 88% between 2010 and 2030 from 9,800 to 18,400 because of the ageing population. The rate of increase for Nottinghamshire is expected to be higher than for the East Midlands.

The increased prevalence of dementia related illness together with the enhanced requirements within the Care Act will create additional demands on older adults' and health services

Currently people tend to get in to a cycle of loneliness, isolation, periods of ill health etc. and often end up calling a GP or being admitted to hospital which puts unnecessary strain on already over stretched services. By providing suitable housing it is anticipated that this will enable people to live more independently without the need for more costly interventions.

The design of each of the schemes has been specified by Nottinghamshire County Council following significant research and using advice and guidance from the Department of Health - Housing LIN Extra Care Housing Toolkit, Stirling University - The Suffolk Extra Care Dementia design and management guide, Suffolk County Council - Extra Care Housing and People with Dementia and Housing and Dementia Research Consortium M Henwood 2009. There has also been direct input from Occupational Therapists from both Nottinghamshire County Council and local CCGs who have first-hand knowledge and expertise of how to support individuals appropriately and practically to support the selection and design of this scheme to drive assumptions about impact and outcomes.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

The impact of the programme is that more people will be supported to live in their own homes in local communities as opposed to permanently living in a residential institution.

Specific data on performance, efficiency and quality outcomes are currently being worked up as part of the programme and are not yet available.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

This scheme and admissions to long term residential care are being monitored as a part of the Living at Home Programme, which is a Nottinghamshire County Council

programme to further develop and test out a range of flexible and individually tailored care and support services to help older people to live at home. The programme board is made up of partners from health, social care and housing, and is accountable to the Adult Social Care and Health committee, and the Health and Wellbeing Board.

Nottinghamshire County Council's performance is also measured against local comparator authorities and national benchmarking data and reviewed by the Adult Social Care, Health and Public Protection Senior Leadership Team on a regular and ongoing basis.

What are the key success factors for implementation of this scheme?

Key success factors for the scheme include:

- Partnership working – our local health and social care community are working together through the Living at Home Programme Board.
- Market management – through the Living at Home Programme Board we are working with District / Borough councils and local providers to ensure that the future needs of our population can be met.

Timelines for implementation

- St Andrews House Gedling –Partnership with Gedling Homes - Jan 2015
- Brownlow Road Mansfield – Partnership with Mansfield District Council – open Nov 2015
- Walker Street Eastwood – Procured a strategic partner Kier/Ashley House – Autumn 2015
- Former Elizabethan School site Retford -Procured a strategic partner Kier/Ashley House – Autumn 2015
- Darlison Court Ashfield – Partnership with Ashfield District Council – open Dec 2015

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Z
Scheme name
Care Act implementation
What is the strategic objective of this scheme?
To enable the County Council to meet the statutory requirements of the Care Act Part 1 from April 2015, including closer integration with health commissioners, housing and providers.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which citizen cohorts are being targeted?
The Care Act provides a new legal framework for the whole of social care with new statutory regulations and guidance. This introduces new duties and extends existing responsibilities for social care and partners. It also provides a framework for closer integration with health and other health related services, such as housing. This framework includes the following areas: - Strategic commissioning and planning, including developing a diverse, sustainable and high quality market place to buy social care and health support - Access, assessment and planning for care and support, including integrated personal health budgets - Integrated advice and information across health, district councils and other partners - Joined up service delivery Detailed financial modelling and analysis is currently being undertaken to calculate the anticipated additional costs arising from implementation of the Care Act, both in relation to the social care reforms to be implemented from April 2015 and the funding reforms that are due to come into effect in April 2016. Initial modelling suggests that the funding earmarked in the BCF for the implementation of the Care Act may not be sufficient to meet the anticipated full costs of Part one of the Care Act, the social care reforms and the related new and extended duties. The Care Act applies to all citizens of Nottinghamshire with universal duties to promote wellbeing, provide universal information and advice, and proactively identify people who would benefit from preventive services that will prevent, delay or reduce the development of needs for care and support. A key requirement of the Care Act is provide universal and

comprehensive information and advice offer for all citizens of Nottinghamshire, including social care, housing, health and financial information and this must be in place by April 2015.

The Care Act also applies to service users and carers who have care and support needs. In 2013/14 social care provided a service to 15,833 citizens of Nottinghamshire. The Act introduces a new national framework for eligibility and these new criteria require local authorities to consider the physical, mental and emotional wellbeing of individuals in need of care. Nottinghamshire County Council has actively participated in national surveys to test the new eligibility threshold. Based on preliminary work carried out by the London School of Economics, the first draft of the proposed changes would have increased the numbers of 'definitely eligible' and 'probably eligible' by almost 20%. In response to these findings, the draft guidance and regulations were again revised and a further survey commissioned, which Nottinghamshire County Council participated in. The findings based on our very small sample indicate that more people will be eligible based on a lower threshold and further modelling will be informed with the release of the national report.

There is a new requirement to arrange an independent advocate to facilitate a person in the assessment, support planning and review if the person has substantial difficulty in being involved and there is no-one else appropriate to support them.

There are new requirements around continuity of care for people moving into the area until reassessment to ensure there is no gap in care provision.

A new responsibility for all local authorities is assessing and meeting eligible social care needs of adult prisoners (not just on discharge from prison, but also while they are in custody). This change in legislation will affect Nottinghamshire, which has a number of prisons and bail accommodation within its boundaries. Work is underway with contact to all the prison governors to scope the impact of this new responsibility and understand the numbers of prisoners who could be eligible for a social care assessment.

The Act gives carers the same rights as those of the person they look after and does away with the requirement that the carer must provide a substantial amount of care on a regular basis. It entitles a carer to services to meet their eligible needs, including ongoing services in their own right rather than services for the service user or respite services. It is estimated that in 2015/6 600 additional carers will request an assessment, support plan and review. The total cost of the new and extended responsibilities relating to new and existing carers is £1.1 million.

The Act provides a single framework for charging for care and support and some of these changes result in loss of income to the Authority. One example includes disregard of guaranteed income payments made to veterans.

From April 2016, the financial reforms extends the means tested threshold of £23,250 for residential care to £118,000 and introduces for the first time a cap on lifetime costs of £72,000 (this excludes living cost of £12,000 per annum). During 2015/16 it is anticipated that there will be a high demand for assessments from self-funders. Based on local data and an extensive survey carried out with care providers, estimates suggest current assessment activity could double from an approximate 6,000 assessments to between 13,000 and 15,000.

In response to these new and extended responsibilities, new models of access, assessment and service provision are being considered to meet these new demands in the most cost effective way, which will maximise the use of all available resources including online assessments, supported self assessment and working with partners in integrated assessments. These new requirements and the local response to meeting these new demands in the most cost effective way will require a fundamental change to our processes and systems, and training for staff in the new legal framework and ways of working.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

Nottinghamshire County Council has established a Care Act implementation team to enact the required changes. The requirements are split into the workstreams below, which are led by a named Manager(s). These workstreams feed back into the Programme, and the work is managed via the Care Act Programme Board, chaired by a senior officer from Nottinghamshire County Council. Workstreams 1-10 deal with specific areas while 11-14 are enabling/cross cutting workstreams.

Assessment, eligibility, and personalisation

We must undertake an assessment for any adult who appears to have any level of need for care and support, regardless of whether or not the Local Authority thinks the individual has eligible needs. Likewise, changes in the eligibility criteria based on principles of wellbeing and areas of need will mean more people are potentially eligible to receive funded care and support services. Local authorities are also to assume financial responsibility for self-funders including financial assessment, information, and signposting and financial monitoring. People will also be able to transfer their assessments between local authorities and have continuity of care and support ensured.

There is increased focus on integrated working between social care, health and other agencies, such as housing. The introduction of personal health budgets in health, similar to personal budgets in social care, will provide a powerful tool to enable integrated health and care provision.

Young people will also now have a legal entitlement to an assessment before they turn 18.

Advice, information, and advocacy

We will have an extended responsibility to provide access to comprehensive information and advice for the entire population of the Local Authority, not just those with care and support needs and/ or their carers. They will also have extended responsibility to support a market that delivers a wide range of high quality services so that people have choice.

The authority will have a responsibility to arrange an independent advocate to assist the involvement of a person in their assessment, the preparation of their care and support plan and in the review of their care plan, if the person would a) have substantial difficulty in being fully involved in these processes and b) there is no one appropriate available to support and represent the person's wishes.

Access to social care

Given that it appears likely that there will be an increased demand placed upon the front end as a result of the changed legislation, there will be a need to investigate alternative methods of providing service at the front end.

Paying/charging for support

There are currently different systems for determining charges to service users, depending on the type of care that is being provided - these are to be replaced by a single universal system.

The financial limit, known as the "upper capital limit" exists for the purposes of the financial assessment. This sets out at what point a person is entitled to access Local Authority support. The cap on care costs which a person pays over their lifetime is to be revised from £23,250 to £72,000 for those over retirement age. How a person progresses towards the cap will be based on what the cost of meeting their eligible needs would be to the Local Authority. We will need to ensure that the means testing framework and the deferred payment framework are compliant with the Care Act and the new cap.

Where a Local Authority is arranging a person's care, this will be provided through a personal budget. Where the person chooses not to have their needs met by the Local Authority, this will be provided with an "independent personal budget" (a statement recording how much of the adult's spending on care will count towards the cap).

Every person with assessed eligible needs will need to have a "care account". This will keep track of what they are paying, what the Local Authority is paying and what their progress is towards the cap. Local authorities will need to provide regular statements.

The financial support provided by the Local Authority will be extended, by raising the upper capital limit to £118,000 where someone's property is taken into account. This will mean that more people with modest assets are able to receive financial support to meet their eligible needs.

Law reform

We will need to review the current delayed discharges regulations and ensure we are legally compliant with any changes. We will work with Health to define a new system for fining/ reimbursement.

Local authorities must promote wellbeing when carrying out any care and support functions in respect of a person at any stage of the process from the provision of information and advice to reviewing a care and support plan. It applies equally to adults with care and support needs and their carers. It may also apply to children, their carers and to young carers when they are subject to transition assessments.

A new responsibility for all local authorities is assessing and meeting eligible social care needs of adult prisoners (not just on discharge from prison, but also while they are in custody).

Carers

Carers will have a legal entitlement to an assessment, and to information, advice and support. We will need to assess the impact of the new requirements on cost and demand. We will also need to consider the services offered to carers and charges.

Strategic market development

The Care Act places new duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area who need care and support, whether arranged or funded by the state, by the individual themselves, or in other ways. Promoting a local market that offers a choice of high quality services will include having regard to the needs of young people transferring from children's services after turning 18.

The ambition is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people who need care and support.

Local authorities should review the way they commission services, as this is a prime way to achieve effective market shaping and directly affects services for those whose needs are met by the Local Authority, including where funded wholly or partly by the state.

Prevention and housing

The Care Act requires local authorities to arrange preventative services, and to ensure a diverse range of quality providers of care and support in their local area. To meet the challenges of the future, it will be vital that the care and support system intervenes early to support individuals, helps people retain or regain their skills and confidence, and prevents need or delays deterioration wherever possible. The Local Authority's responsibilities for prevention apply to all adults, including: people who do not have any current needs for care and support; adults with needs for care and support, whether their needs are eligible and/ or met by the Local Authority or not; and carers, including those who may be about to take on a caring role or who do not currently have any needs for support, and those with needs for support which may not be being met by the Local Authority or other organisation.

Quality and risk

The possibility of interruptions to care and support services causes uncertainty and anxiety for the person receiving services, their carers, family and friends. The Care Act makes provision to ensure that, in such circumstances, the care and support needs of those receiving the service continue to be met by the Local Authority. We will have powers and duties when services are at risk of interruption in general and, in particular, when the interruption is because a provider's business has failed.

Safeguarding

There is a new legal framework for adult safeguarding, including establishing multi-agency Safeguarding Adults Boards and a requirement for an annual safeguarding plan. The Act establishes new thresholds for making safeguarding enquiries.

Workforce

We will need to ensure the authority has the appropriate capacity and skills within the workforce to deliver the requirements of the Care Act, both in the transitional period of increased activity and to sustain the delivery of requirements in the future.

ICT

This is an overarching workstream, which will link in with the other workstreams, as well as the departmental systems review, to ensure that all proposed changes are compliant

with the Care Act.

Communications and engagement

This enabling workstream will develop a communications plan and enable key stakeholders to engage in the design and delivery of the local implementation.

Finance modelling

Detailed financial modelling and analysis is currently being undertaken to calculate the anticipated additional costs arising from implementation of the Care Act, both in relation to the social care reforms to be implemented from April 2015 and the funding reforms that are due to come into effect in April 2016.

Health and social care commissioners

- Nottinghamshire County Council
- All Nottinghamshire CCGs

Providers

- Nottinghamshire County Council

The evidence base

Please reference the evidence base which you have drawn on:

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The evidence base for this scheme is underpinned by a number of initiatives, including:

- Dilnot Commission's recommendations on funding care and support to protect people from very high care costs
- Law Commission review of adult social care law to modernise the legislation and to replace over 65 years of piecemeal legislation into one single Act
- Failures at Mid-Staffordshire hospital
- The Caring for Our Future White Paper
- Department of Health Information Strategy
- Better Connected (SOCITM 2013)
- Digital by Default – Government Digital Service
- Department of Health Strategy – the power of information

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan.

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

All initiatives aim to deliver the following outcomes:

- To meet the statutory requirements of the Care Act by April 2015
- To implement the transition to the new legal framework during 2015-16
- To have an integrated approach to the design and delivery of social, housing and health care services

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Governance arrangements are in place and progress is being reported, via the Adult Social Care and Health Committee, to the Health and Wellbeing Board.

What are the key success factors for implementation of this scheme?

The key success factors are:

- Work-stream plans with a composite programme plan - key milestones will be set, with progress of delivery measured against planned activity
- Governance arrangements in place
- Partnership working – our local health and social care community are working together through the Health and Wellbeing Board
- Staff – frontline staff need to be fully engaged in the process to enable these changes to be driven forwards at the required scale and pace. Each organisation has engaged with their frontline staff, and will continue to do so throughout these changes. Where there are multi-disciplinary cross agency teams, a partnership approach has been taken

Key milestones for delivery are:

August 2014:

- Response to the national consultation on the Care Act
- Set up work-stream breakdown plans

September 2014:

- Composite programme plan
- Financial and demand modelling submitted to DH

- Workforce modelling complete
- Communications plan complete
- Charging paper complete

October 2014:

- Training requirements identified
- Stock-take submitted
- Proposals developed for alternative models of social care delivery

November 2014:

- Review plans against final guidance and regulations for social care

December 2014 – March 2015:

- Implementation of new requirements
- Communications to existing service users and general public on the changes
- Training the workforce

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Nottinghamshire Health and Wellbeing Board
Name of Provider organisation	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Name of Provider CEO	Mike Pinkerton
Signature (electronic or typed)	Mike Pinkerton

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	9181
	2014/15 Plan	9273 (+2% population growth, -1% efficiency)
	2015/16 Plan	8994 (+2% population growth, -5% efficiency)
	14/15 Change compared to 13/14 outturn	+1%
	15/16 Change compared to planned 14/15 outturn	-3%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	60
	How many non-elective admissions is the BCF planned to prevent in 15-16?	309

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Not as yet – please see statement below in Q2
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	The intended investment schemes are planned, over the next two years, to result in a reduction in admissions and A&E attendances at DBH. These investment schemes are being discussed with the CCG through their Integrated Care Board. A number are however, still in the planning stage and therefore, while in the CCG Plans and BCF Plan, there will not be a consistent replication in our Trust Plan's until completion of the detail behind each of the programmes of work. There is therefore a risk to savings, but as these are phased towards 15/16 rather than 14/15 this provides some element of mitigation. The potential savings have not yet been stress tested or quality assured so the clinical or financial risk to us as a provider is not yet fully understood. This work will continue into the autumn to ensure CCG plans are deliverable and the impact on the Trust fully understood.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Not as yet – please see statement above in Q2

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Nottinghamshire Health & Wellbeing Board
Name of Provider organisation	Sherwood Forest Hospitals NHS Foundation Trust
Name of Provider CEO	Paul O'Connor
Signature (electronic or typed)	Per pro Peter Wozencroft

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	Please Note: These are in line with NHSE planning trajectories which are in line with MAR activity definitions. **At SFHFT only** M&A = 21630 N&S = 8713
	2014/15 Plan	Please Note: These are in line with NHSE planning trajectories which are in line with MAR activity definitions. **At SFHFT only** M&A = 21197 N&S = 8539
	2015/16 Plan	Please Note: These are in line with NHSE planning trajectories which are in line with MAR activity definitions. **At SFHFT only** M&A = 18603 N&S = 7514
	14/15 Change compared to 13/14 outturn	**At SFHFT only** M&A = -433 (-2%) N&S = -174 (-2%)
	15/16 Change compared to planned 14/15 outturn	**At SFHFT only** M&A = -2594 (-12.2%) to 14/15 plan N&S = -1025 (-12%) to 14/15 plan
	How many non-elective admissions is the BCF planned to prevent in 14-15?	This is total non-elective admissions saved at SFHFT: M&A = 303 N&S = 214
	How many non-elective admissions is the BCF planned to prevent in 15-16?	This is total non-elective admissions saved at SFHFT: M&A = 1134 N&S = 701

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	N/A
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	The Sherwood Forest Hospitals strategic plan in predicated on reductions in non-elective demand greater than or equal to those quoted above and we will reduce our capacity in line with these reductions.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Nottinghamshire Health and Wellbeing Board
Name of Provider organisation	Nottingham University Hospitals NHS Trust
Name of Provider CEO	Peter Homa
Signature (electronic or typed)	Peter Homa

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	28,538
	2014/15 Plan	28,187
	2015/16 Plan	27,575
	14/15 Change compared to 13/14 outturn	-351
	15/16 Change compared to planned 14/15 outturn	-612
	How many non-elective admissions is the BCF planned to prevent in 14-15?	320
	How many non-elective admissions is the BCF planned to prevent in 15-16?	577

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes – We are part of the combined effort to maximise the impact of integrated care; at the same time we are concerned as to how risk will be managed if the schemes – which we support – do not deliver at the scale and pace required for us to reduce capacity and costs.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	N/A
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes – risk as above