Nottinghamshire County Council

Nottingham City Council

NHS

STP

The Nottingham and Nottinghamshire
Sustainability and Transformation Partnership

Responding to public feedback

An Update to our five-year Plan for health and social care

July 2017

Contents

1. Foreword

We published our five year Plan for health, social care - and wider services that contribute to the health wellbeing of our communities - in November 2016. The Plan identified how we can best meet the needs of our changing population and work differently to join-up services and make the best use of the public purse.

We met with members of the public and interested organisations and asked for people's thoughts and comments on the Plan. This has helped us to revise our thinking and our Plan, particularly in areas that need greater progress.

This Update to our Plan therefore includes more detail on the specific areas and key themes people told us were most important to them. You can find a full breakdown of the feedback received and our response to individual comments, as well as a summary report, on our website at www.stpnotts.org.uk

Since we published our Plan, we have also been given national support from NHS England to explore the potential for greater integration of organisations and services in our area, with an early focus on Greater Nottingham. This gives us an opportunity to learn from some of the most successful health and care systems around working as one system rather than individual organisations. More information about this can be found on page 23.

As we move into a phase of refining areas of the Plan and early implementation of some of the planned changes, we continue to share a collective commitment to partnership working. Only through collaboration across organisational boundaries can we deliver the treatment, care and support that people need now, whilst making sure services are more sustainable in the future.

David Pearson
STP Lead

The Nottingham and Nottinghamshire
Sustainability and Transformation Partnership

2. Introduction

The Nottingham and Nottinghamshire STP was submitted to NHS England in October and published on 24 November 2016. This was a draft Plan, produced and supported by all partner organisations.

The Plan built on existing service improvement work and drew on information that we had gathered from conversations with local people as part of this. The draft Plan set new, ambitious goals to renew and strengthen our commitment to working together as a health and care system.

Since the publication of the draft Plan, we have sought further feedback and comments from citizens, patients, carers, service-users, staff and organisations, providing a number of ways for people to feed in their views over a three-month period.

Feedback on the Plan did not suggest we needed to change our overall priorities or strategic direction. However, concerns were raised about how ambitious the Plan is, how we will deliver it and how we will bring about the required culture change in the way we work together as individuals and organisations to provide joined up health and social care services. The feedback also highlighted aspects of care for individuals or groups of people that did not have enough focus, for example children and young people, those with mental health problems and carers.

The Update to the STP restates our challenges and provides additional detail on how we intend to respond to these. The Appendix provides more detailed information on the delivery of our Plan, with a specific focus on what will change and feel different for staff and the public during 2017/2018.

This Update also includes additional sections on mental health, children and young people and carers, and how we will communicate with and involve local people and staff in response to feedback on the draft Plan. Finally, there is news on the development of 'Accountable Care Systems' (ACS) and how this will be taken forward locally.

For more information, including the draft Plan published in November, visit our website: www.stpnotts.org.uk

3. Our challenges

A rising birth rate combined with many people living longer into old age means more demand for health and care services than ever before – putting unprecedented pressure on social care, general practice, mental health services, community health services and our local hospitals.

We have a diverse population with a wide range of changing needs. It is fantastic that we are living longer and can contribute to our families and communities, but how long we live depends on where we live – with those in more deprived areas generally having a lower life expectancy. The number of years we live in good health ('health life expectancy') is lower in Nottinghamshire than in many other parts of England. The type of healthcare and support that individuals and communities need is also changing:

- Many people (of all ages and throughout life) are living with one or more long-term conditions such as diabetes, heart disease, respiratory illness or mental health problems. They need support to manage their condition at home so that they can maintain their independence and quality of life as much as possible, and avoid unnecessary admissions to hospital.

- People are living longer into old age and many have multiple complicated medical conditions, including frailty, disability and mental health problems. They may also be vulnerable due to the social or housing situation they live in. Our current system is not organised in the best way to provide complex care packages to people with such complex needs.

The care that we provide does not always match the expectations of local people who have told us that they want support to stay well and independent for as long as possible, they want more services at or close to home and joined-up, rather than fragmented care. People sometimes have to wait too long to get access to services and, based on externally assessed quality ratings, we know there is variation in the quality delivered by different care providers.

The costs of delivering health care are rising. With new technology and medical innovations, more sophisticated treatments and interventions become available, which many people want to take advantage of. Yet, there are only small funding increases for the NHS, and local authority funding faces a further significant decrease following several years of reductions.

Funding is not at a level which keeps pace with the projected increase in need and demand for health and care services. We know that there are ways in which we can improve the response to those needs and make better use of the public purse. If we do not make changes to the system now, we are forecasting an overall financial shortfall of £628m by 2020/21.

In our draft Plan we explain these challenges more fully using the NHS England description of the 'three gaps' faced by all healthcare systems in this country:

- Health and wellbeing
- Care and quality
- Finance and efficiency

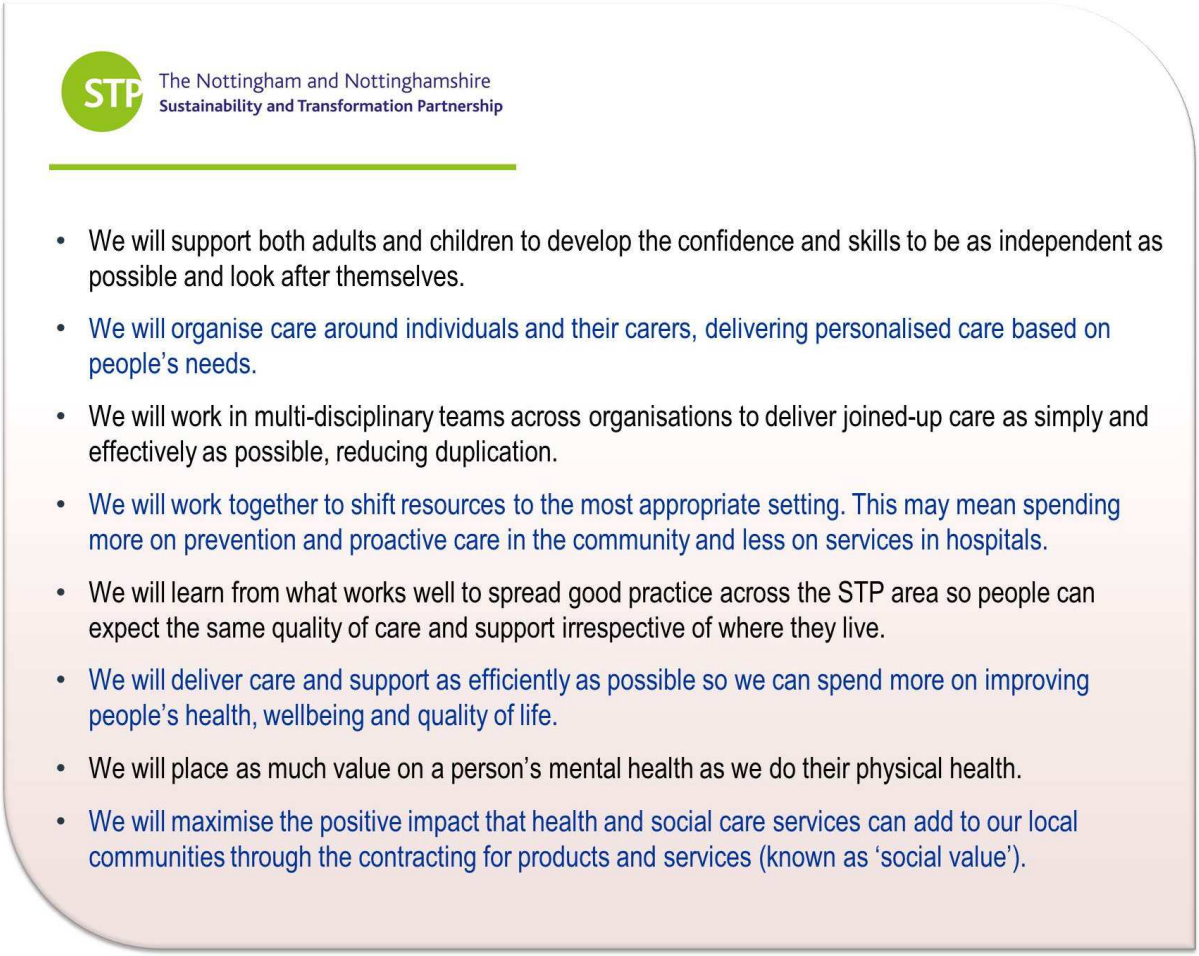
4. Our approach to delivery

We are now making the transition from planning to implementation as the Nottingham and Nottinghamshire Sustainability and Transformation Partnership.

As part of the feedback process we were asked to provide more detail on how we will organise ourselves effectively as a system to implement the Plan and give more information on how we will deliver on our priority areas and meet the financial challenge. The following information builds on that already contained within our draft Plan and outlines our approach to delivery and implementation in 2017/18 and beyond.

4.1 Principles

The STP partners have agreed to use the following principles to underpin and guide ongoing planning and the delivery of our Plan:



4.2 Changing how we deliver care to meet the needs of local people

The significant challenges faced by the NHS and local authorities, mean we can no longer work as individual elements of a larger health and care system. We have no option but to change if we are to be able to deliver sustainable and joined-up care for the people of Nottingham and Nottinghamshire, and meet their diverse and ever-increasing needs. Our five priority areas are a reflection of our rationale for meeting these challenges.

Our first priority (**Promote wellbeing, prevention, independence and self-care**) is in some ways our most radical as it aims to empower local people to make healthier choices that support their own health and wellbeing. By enabling communities to support people to have a healthy lifestyle, with support from local services to do this, we aim to help people to manage their own health and wellbeing, alongside health and social care services if required.

We aim to challenge the traditional NHS culture of trying to fix people. Instead we want to tap into skills and resources in people and places to help people lead as independent and well a life as possible. Instead of asking "what services or treatment do they need from health and social care?", we need to explore first "what can they do for themselves?" and "what help do they need to tap into community resources to improve their health and wellbeing?" We need to shift our skills and resources to become part of a 'health enabling' community as well as a 'treating illness' service for those who need it.

Promoting prevention, independence and self-care is a key philosophy that underpins the rest of the Plan. We will work with the public, local community groups and voluntary and community sector organisations to put this into practice through promoting healthier choices, reducing isolation and encouraging people to support each other.

Strengthening primary, community, social care and carer services (Priority 2) is also a vital part of our Plan. These services, which will mostly be developed around groups of GP practices working together, are the backbone of how we provide care and support to most people, most of the time.

Valuing and developing these services by building teams of professionals around general practice will enable us to provide proactive, joined up care as close to home as possible. It is important that we have enough capacity, quality and choice in the provision of social care and community health services. We know these services make a huge difference to peoples' lives.

When people have **urgent or emergency care** needs, we will direct them to the appropriate support or services which may be in the community (instead of hospital). For those who need more intensive or specialist care that can only be provided in hospital, we will direct them to hospital where they will receive high quality and timely health care. When they are ready to leave, appropriate services or support in the community will be in place to enable them to do this in a timely way (Priority 3: Simplify urgent and emergency care).

Where possible and appropriate, we will deliver services that do not need to be provided in a hospital setting in different ways. By redesigning pathways for **non-urgent care** we can ensure that patients receive the right care in the right place for their level of need. This may include delivering more outpatient care in the community and increasing the use of technology, for example for the self-monitoring of long-term conditions. This will free up space within hospitals to meet the increasing demand for specialist and emergency care. We will also develop consistent ways of delivering care across the STP area so that pathways are effective and people do not receive different types of care depending on where they live (Priority 5: Ensure consistent and evidence-based pathways in planned care).

All of this will be underpinned by an **increased use of technology** (Priority 4: Deliver technology-enabled care) in order to provide more support for people to live independently. We will explore and use assistive technology solutions where appropriate to enable people to manage their own care, and those that they care for, and to improve their health and wellbeing. This will enable us to deliver more care in the community and people's homes.

A recurring, and understandable, concern raised in the feedback people provided on the Plan was around the ambition to remove up to 200 inpatient beds from our local hospitals by 2018/19. With people supported to take more responsibility for their own health, and with stronger services in the community, we will be able to use our hospitals for the patients who need the specialist care that they provide or for when it is most the effective or efficient option. This will mean we can move to a position, over time, where we can consider reducing some services provided in the hospital and in turn, the number of inpatient beds required.

NHS England has set out very clear requirements that we need to meet before we can consider reducing current bed numbers in our hospitals. Only when we can demonstrate that there is at least the equivalent, appropriate capacity available in the community and there is confidence that this new model of care can deliver, will reducing hospital beds be considered. We will also need to be able to demonstrate that the required workforce and alternative resources are in place to deliver it.[1]

Some of the 'new models of care' that we are currently testing are already allowing us to move some services out of hospital, where it is safe and appropriate to do so. An example of how this has worked in recent years can be seen at Sherwood Forest Hospitals.

The development of local Integrated Community Teams in Mid-Nottinghamshire means we can provide more care closer to home, prevent hospital admissions and avoid delays to discharge. Over the last two years we have co-ordinated and integrated care between NHS and social care providers which has meant that Sherwood Forest Hospitals has been able to:

- Reduce its bed base by 60 and the length of stay for patients by almost two days. Improved flow through and out of the hospital has delivered annual savings of £6m to the system.
- Become one of the country's strongest performing Trusts for the four-hour emergency access standard (to treat and discharge or admit 95% of Emergency Department attendances within four hours). This is against a backdrop of a 15% rise in the number of people using the Emergency Department.

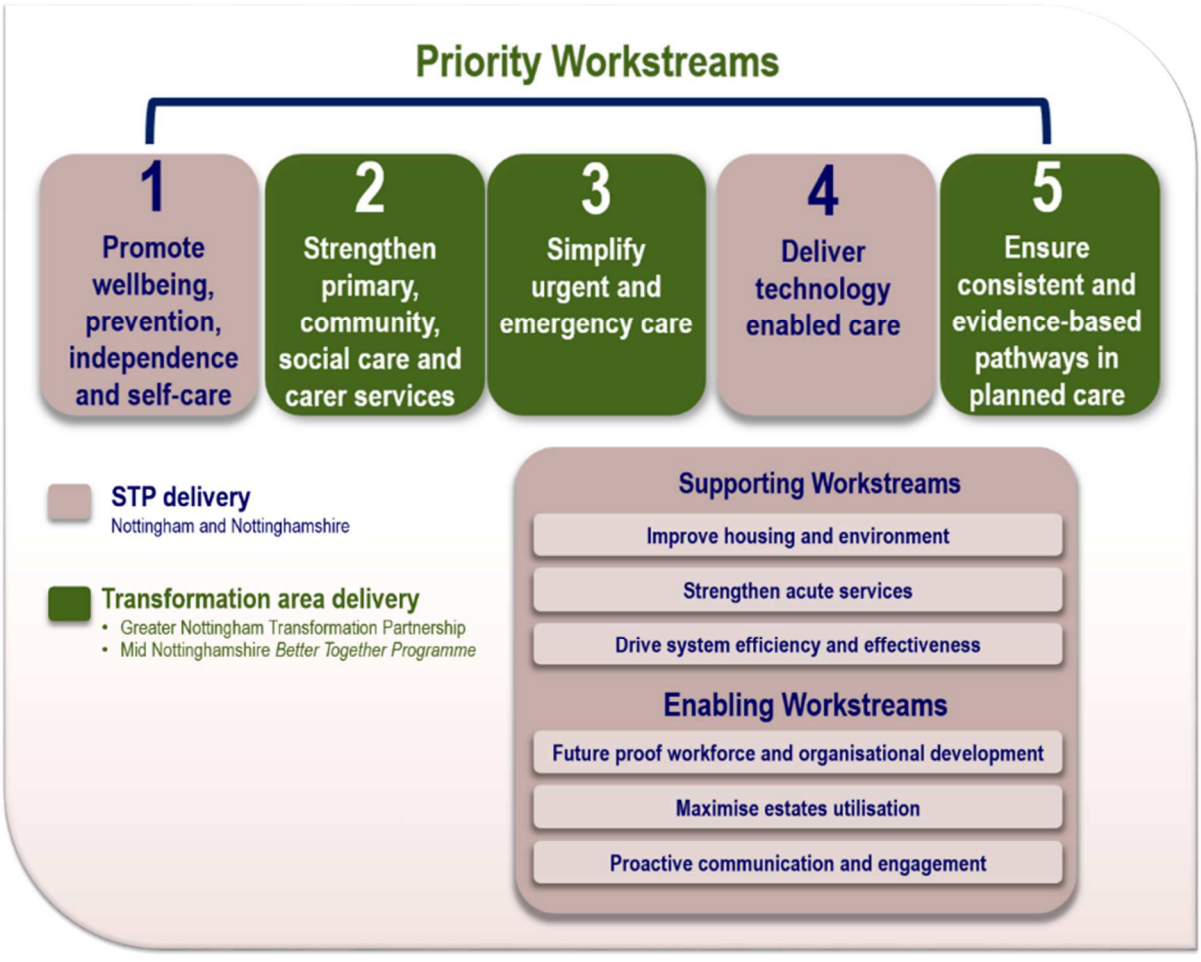
[1] https://www.england.nhs.uk/2017/03/new-patient-care-test/

We face challenges in transforming the way we deliver care to local people, with the health and care system being under pressure. Restraint on expenditure will have to be made in order to balance the books in the short term. These are the same challenges facing every health and social care system in the country, with changing and rising needs.

This is why over time we need to change what we do, building on the best, in health, care and wider services. We also need to invest in what is cost effective and we are already working together to find efficiencies as a system. We are determined to improve over time against the major priorities in the Plan and we will be transparent with the public about the successes and the challenges along the way.

4.3 Delivery through our workstreams

Our Plan is being delivered through the five priority workstreams explained in section 4.2, three supporting workstreams and three enabling workstreams. These workstreams bring together existing plans and new priorities and are explained in full in our Plan published in November and on our website at www.stpnotts.org.uk. Our STP 'plan on a page' has been revised as part of our update to the draft STP and is included in the Appendix to this Update.



Our STP area already has two established 'transformation areas' – the Mid-Nottinghamshire Better Together programme and the Greater Nottingham Transformation Partnership. Their work is aligned to the STP ambition and priorities.

These two transformation areas will take responsibility for delivering most of the service changes described in our Plan for their local area, although leaders will work across the STP to ensure a consistent and coherent approach. Whilst some of the workstreams will be led by the transformation areas, others will continue be delivered across the STP. The Appendix provides more information on what will be delivered in 2017/18. We also work with Bassetlaw, part of the South Yorkshire and Bassetlaw STP area, as an associate where it makes sense to do so due to patient flows and the geography of services provided.

Learning from innovations and new ways of working that are already being explored, the STP and its two transformation delivery areas will focus on spreading evidence-based best practice across the whole of our geographical area.

Some of the recent innovations have been tested through our NHS 'New Care Models' sites in Nottingham and Nottinghamshire which have been funded over the last three years from a national transformation budget. The national support for these programmes will end in March 2018 and the STP will become the vehicle to adopt proven schemes and tested ideas to ensure innovation is spread and sustained.

Examples of some of our local progress are provided below as case studies based on real patient and carer stories.

4.4 Case studies

Case Study

ROB'S STORY

Rob has been supporting his dad since he was discharged from hospital after an operation. He has been trying to set up home care for his dad and equipment to help him stay at home:

"I've been with dad every day since he came home and have spent hours on the phone to social services trying to get him some regular help. Dad isn't very good on his feet and he gets confused - he also forgets to eat and take his medication. They said he would need regular visits to his home to help him wash, dress and prepare meals but the process is so slow and I'm still waiting for the support and equipment he needs.

"I finally managed to get a walking frame for him but I wasn't there when they delivered it and he told them he didn't need it and sent them away. Now I have to start all over again with more phone calls. He's also lonely now he can't get out and about. I'm concerned he'll fade away and have to go into a home."

INTEGRATING HEALTH AND SOCIAL CARE

Social workers now make up a crucial part of the multi-disciplinary teams in the City's eight Care Delivery Groups (CDG). They work alongside GPs, community nurses and therapists and contribute to case reviews and care planning meetings. The team manager describes how this integrated health and social care approach is speeding up referrals and access to care for citizens:

"The CDG social workers provide vital insight and expertise regarding a patient's immediate and ongoing social care needs. This enables us to take a 'whole person' approach, spanning medical, physical and mental health needs as well as social care. They also provide advice on services which are free to access, such as friendship and activity groups, lunch clubs and voluntary organisations who can help.

"The social workers undertake social care assessments in conjunction with community nursing teams for patients who need support at home, including those recently discharged from hospital. Communication between agencies has been vastly improved - previously health teams may not have known about some of the social care support available and whether patients were eligible for referral to a service. People now get the right support much more quickly as we have more knowledge to support care planning."

Case Study

VERA'S STORY

Vera was taken to A&E by ambulance from her care home with suspected pneumonia. She remained on a trolley for more than nine hours. Her daughter describes their experience:

"I assumed that after all the tests had been done, she would be taken to a ward straight away. We asked how much longer we would have to wait, but no one could give us an answer. Mum was in pain, very uncomfortable and needed the toilet. A nurse helped us to the bathroom and I told her it was terrible that a 100-year old woman should be on a trolley for this long. The nurse seemed shocked at her age and how long we had been waiting. It wasn't long after that she was moved to a ward.

"She was given anti-biotics and finally put into a bed at 11.45pm, 13 hours after arriving at the hospital. She was exhausted and confused and I hated having to leave her in unfamiliar surroundings."

ENHANCED SUPPORT TO CARE HOMES

GPs in Rushcliffe have been working with care home staff, community nurses and therapists to deliver an enhanced model of support to nursing and residential homes. Since the initiative launched, residents are 23 per cent less likely to be taken to hospital by ambulance and 29 per cent less likely to attend A&E when compared with other, similar areas of the country. A care home manager describes how this is improving care:

"We now have a designated GP surgery for the home. They visit fortnightly to see the residents and review medication. This has helped build relationships and improved communication between the care home staff and health teams. If one of our residents has spent time in hospital, the community team follows up on their care within 48 hours of discharge. We are better informed about the support that person needs to recover properly which helps them avoid readmission to hospital.

"We also have better information about the urgent care services we can access as an alternative to calling an ambulance. Residents and their families are now proactively involved in discussions with staff about how they want to be cared for at the end of life. Many people would prefer to die in the place they call home rather than in the hospital we support this where possible."

Case Study

RICHARD'S STORY

After a fall downstairs Richard was left with chronic back pain. Following scans and x-rays he was diagnosed with osteoporosis at the age of 58. Richard describes living with bone fragility and his care and treatment since diagnosis:

"When I found out I had osteoporosis I was a little bit shocked. I had to have regular hospital appointments and was given tablets to strengthen my bones and reduce the risk of fractures. Taking the tablets was awful - once a week, early in the morning on an empty stomach with two glasses of water. I was then unable to lie down or eat/drink for a while and there were a number of painful side effects.

"I talked to the hospital consultant about this and she referred me to a new community service where they provide an alternative intravenous treatment instead. I had the IV treatment at my local health centre - it was such a positive experience. The drip lasts about half an hour and I only have to go every 18 months - much better than having to remember to take pills every week and going to the hospital."

MOVING SERVICES CLOSER TO HOME

The Fracture Liaison Service has now been rolled out across three areas in South Nottinghamshire with patients receiving the IV treatment they need at a local health centre or at home instead of the hospital. A specialist nurse from the service explains the benefits to both patients and the NHS:

"The service was designed by a local GP and a consultant at the hospital to improve patients' experience of treatment and reduce future fractures due to osteoporosis. Providing this new service in the community has also reduced costs by more than £100,000 in the first two years - through savings on drug and administration costs. We know that the treatment and care required following a single hip fracture costs the NHS around £20,000 per patient - as well as impacting on quality of life through the loss of mobility and independence. A hip fracture also leads to a greater risk of people not being able to manage at home and entering into residential or nursing care. If we treat more patients in this way and prevent future fractures then we can save the NHS a significant amount of money.

"This is thought to be the first service of its kind in the country and the response from patients has been incredibly positive, particularly around the compassionate and personalised care provided. They have described the service as being 'calm, friendly and kind' and say they are 'over the moon' at not having to travel to hospital."

Case Study

MABEL'S STORY

Mabel was enjoying life as an independent 92 year-old until the death of her husband. This affected her badly and she has since suffered from loneliness and been prescribed antidepressants. She also experiences chronic pain and her family explain how this has impacted on her quality of life:

"We contacted the GP as mum had significantly reduced mobility because of the pain she was suffering. The GP visited mum at home to assess her and contacted the 'Call for Care' service to discuss and arrange the most appropriate care for her. A Community Clinical Assessor and Assistant Practitioner came to talk to us about mum's needs and the support she might need. They assessed her health and wellbeing, discussing her symptoms and how she was controlling her pain. Mum also agreed to have a community physiotherapist visit to assess her mobility – this appointment was arranged for the next day at home. After all the assessments, we agreed a care plan which was communicated to the GP within two hours of the visit!

"We were also delighted that mum agreed to a visit from the local befriending service. This has been a real turning point for her. Since dad died she had been sad and become increasingly lonely. She has now regained some confidence and is planning to attend a social group they have recommended to her."

RIGHT CARE, RIGHT PLACE, RIGHT TIME

Call for Care is a new care navigator system that helps health and social care professionals across Mid-Nottinghamshire arrange quick and effective care for patients in need of urgent support. Mabel's GP describes the benefits it offers to patients, carers and families:

"Call for Care aims to provide or signpost to the support patients need to remain in their own homes, avoiding rapid deterioration or hospital admission. For some patients this is simply about gaining reassurance that they can stay living independently at home and that help is available if they need it.

"Through initiatives like Call for Care, we support patients and families to manage their own care and access the right services at the right time. This can prevent a crisis situation or emergency intervention. GPs, community nurses and other health professionals can all contact the Call for Care team to access a range of specialist support including the Falls Team, Physiotherapy and Community Matrons. Contact with the right professional at the right time can prevent deterioration and help people stay more independent into later life."

4.5 Communicating and working with our workforce and the voluntary sector

We remain committed to working closely with staff in NHS, social care, and other organisations that provide support and care, as we know that without them we cannot deliver our Plan. We will talk to our workforce about the reasons for change, listen to their views and involve them in designing and putting in place the operational changes needed to bring about improvements and efficiencies in care.

We know that NHS and social care staff are working in increasingly pressurised environments with staff shortages as we struggle to recruit to roles and retain staff. This understandably impacts on morale as people are being asked to do more with less against a backdrop of rising demand. That is why workforce planning is a crucial element of our Plan. We are looking at how we put in place a sustainable workforce that has all the required skills to meet people's needs.

We have been communicating with our frontline staff in our local health and care system throughout the development of our STP. With more than 40,000 local staff working in health, care and housing we have the opportunity to harness a wide range of innovative ideas, but also the challenge of ensuring that we involve and energise our workforce in delivering the Plan.

We will use existing communication mechanisms within individual organisations for talking and listening to staff. There will also be the opportunity for staff to get more directly involved through the transformation programmes and individual workstreams of the STP.

We have established an STP Advisory Group for communicating with those who provide care in our system but do not work for the statutory organisations, so that they are able to represent the views of their sector and contribute to the Plan. This group includes representatives from the Local Medical Committee and Royal College of General Practitioners (GPs), Nottingham CityCare, Circle Partnership, the voluntary and community sector, home care providers, care homes, carers support, community pharmacists and optometrists and Nottinghamshire Fire and Rescue.

4.6 Communicating with and involving local people

We are committed to an ongoing conversation with local people about our Plan. Building on a three month period of collecting public feedback on our Plan in early 2017, ongoing involvement with individuals and communities will be predominantly delivered through our two transformation programmes in Greater Nottingham and Mid-Nottinghamshire.

This will include a two-way conversation and seeking the views of specific groups in our communities that we have not reached so far. We will do this by working with groups run by local health organisations and local authorities, with the community and voluntary sector and with the support of Healthwatch. Together we will identify the people we need to talk to about specific issues and/or changes to services and seek the best way of doing this.

Communications and citizen involvement regarding the development of the ACS in Greater Nottingham will include quarterly public 'question and answer' sessions as well as written and face to face information giving. The Greater Nottingham Transformation Partnership will also work with an independent partner to deliver community engagement.

In Mid-Nottinghamshire, public engagement events and listening events will be planned throughout the year to ensure that people have the opportunity to be involved. Regular newsletters will be produced to ensure the public receive feedback and are informed about decisions made. We will work with our partners to ensure we gather rich information that can be used for future planning.

As an STP we will continue to provide news and information on our website (www.stpnotts.org.uk) and provide the two local Health and Wellbeing Boards with regular updates. We will also seek opportunities to keep people updated and involved at other relevant local council and community meetings.

We will continue to work with citizens in the development of any detailed plans or proposals, seeking representative input from across the communities we serve. This will be based on the national guidance 'Planning, assuring and delivering service change for patients' [2]. Any substantial changes to services will be subject to formal public consultation as per the statutory duty of a number of STP partner organisations.

We will also publish an annual report, starting at the end of the year 2017/18. This will give information to local people about the progress we have made on delivering our Plan and outline our STP priorities for the following year. The Plan will continue to evolve based on evaluations of local pilot projects, new evidence from elsewhere or changes in national policy as well as the information we receive from local people through our ongoing engagement activities.

[2] https://www.england.nhs.uk/wp-content/uploads/2015/10/plan-ass-deliv-serv-chge.pdf

5. How our Plan addresses the needs of local people

During the feedback process it was clear that people felt there were certain groups within our communities that had not received enough explicit focus within our draft Plan. In hindsight we could have been clearer that our Plan was intended to cover 'whole person' health and care, including both the physical and mental health needs of local people. We also assumed that the Plan applied to all age groups in the same way, without providing discrete detail about how we would address the needs of children and young people.

In this section we aim to respond to this feedback by providing more information regarding our ambitions and priorities for people with mental health conditions, young people and also carers.

This information is intended to provide the additional detail requested and is integral to this Update to our Plan.

5.1 Mental health

The challenges to providing good quality and timely care in the current system are particularly significant for mental health services which have had a lower profile and less funding than physical health services for many years. Outcomes are worse too – national figures show that people with a mental health condition are likely to die an average of 15 to 20 years earlier than others.

We recognise that physical and mental health and wellbeing are equally important and inter-dependent. Our aim is to take a holistic and person-centred approach to the delivery of care, and to improve outcomes for people with mental health problems. This will require significant changes in how we plan, deliver and fund services.

We recognise there are financial challenges that we will work through to achieve our ambitions for mental health. We have been successful in bidding for additional national funding in 2017/18, and more details of this are provided in the Appendix to this Update.

Two recent national reports have set out the national strategy for improving mental health services. *The Five Year Forward View for Mental Health*[3] sets a ten year, national plan to transform services for people with mental health issues and ill health. It builds on an earlier report called *Future in Mind*[4] that outlined what needs to be achieved to ensure that children and young people can access high quality mental health care when they need it.

3 The Five Year Forward View for Mental Health: A report from the independent Mental Health Taskforce to the NHS in England, Feb 2016

4 Future in Mind; promoting, protecting and improving our children and young people's mental health and wellbeing; Department of Health; March 2015

Our Plan will take forward these ambitions in our local area, with actions to improve mental health services being particularly important to the delivery of three of our STP priorities as outlined below.

One mechanism for this will be the continued delivery of the action plan for improving care for people in a mental health crisis that was developed by partners through the local Mental Health Crisis Care Concordat[5].

Mental health services for children and young people are covered in the next section of this report.

1. Promote wellbeing, prevention, independence and self care

- People with a mental health condition are less likely to attend a routine health screening. We will focus on increasing the uptake of screening for colon cancer and diabetic retinopathy and ensure we 'make every contact count' in promoting this and other prevention and healthy lifestyle programmes to vulnerable populations.
- We will refresh and implement our suicide prevention plan through the continued implementation of our local Mental Health Crisis Concordat action plan.
- We will work with the voluntary and community sector to develop self-care approaches with community groups. This will include a continued focus on using peer support networks - rather than treatment - to help people. By using an educational approach, people will be able to choose the courses best suited to help them be in control and manage their own lives.

2. Strengthen primary, community, social care and carer services

- We will develop an integrated mental and physical health approach across the health and care system, and support GPs and individuals to have improved access to evidence-based mental health services.
- Mental health teams will work with primary care to triage and support those with medically unexplained symptoms or chronic physical health conditions providing mental health/psychological input into planned care pathways through liaison psychiatry where appropriate. This will help to reduce the levels of unnecessary physical healthcare investigations and interventions that often get undertaken.
- We will embed the use of psychological therapies into the delivery of services for people with long-term conditions so that they are able to manage their condition and have the confidence to take more control.
- We will improve physical health and life expectancy for patients with serious mental illness, building on and learning from new models of care in Rushcliffe CCG.

5 Comprises Nottinghamshire Clinical Commissioning Groups, Nottinghamshire Police and Crime Commissioner, primary care, Nottinghamshire Healthcare NHS Trust, East Midlands Ambulance Service, Nottinghamshire Police, Nottingham City and Nottinghamshire County Councils and a number of third sector organisations.

- We will improve access to perinatal mental health care services through enhanced community teams and by investment in a new purpose built facility.
- We will deliver initial treatment for people experiencing a first episode of psychosis within two weeks.

3. Simplify urgent and emergency care

- We will pilot a mental health navigation service, incorporated within a single point of access, for clinician to clinician conversations. This will provide GPs with senior clinical advice and patients with urgent follow up locally.
- We will build our home treatment teams to enable people to stay well and reduce the demand on acute inpatient services and the need for out-of-area placements.
- We will work to ensure that crisis and intensive home treatment services are fit for purpose across all age groups and fully support alternatives to hospital-based care. We will continue to embed our Street Triage service and work to improve access to acute clinical assessments and Section 136 suites.
- We will expand our acute psychiatric liaison services across Nottinghamshire to make sure that services are in place 24 hours a day, seven days a week.

We will ensure that there are enough specialist inpatient beds in the system to meet the needs of local people while improving the support we give to people in their own home.

5.2 Children and young people

Behaviours leading to problems such as obesity, smoking, substance misuse, and poor sexual and mental health are commonly established in childhood and adolescence[6]. We know that healthy happy children are much more likely to become healthy adults and that providing the right support earlier in life can improve outcomes into later years.

We are already working in partnership to ensure our children and young people are healthy and to meet their physical, emotional and mental health needs as early as possible within the resources we have available to us. Further information can be found in two key plans: *The Nottingham City Children and Young People's Plan* and *The Nottinghamshire Children, Young People and Families Plan,* both available online.

This work will continue as part of the STP, and we will increase joint working across City and County to develop consistent approaches.

[6] Chief Medical Officer of the United Kingdom, *Our Children Deserve Better: Prevention Pays – Annual Report of the Chief Medical Officer 2012*, London, 2012. Retrieved from https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays

Action to improve services for children and young people is aligned to and supports the delivery of our STP priorities with key initiatives and areas of focus as follows.

1. Promote wellbeing, prevention, independence and self-care

We will work together across the STP to:

- Provide additional support to pregnant women and new mothers to reduce smoking in pregnancy, develop breast feeding-friendly public places and increase the uptake of Healthy Start vitamins in pregnancy and young children.
- Tackle childhood obesity by providing support to individual children and families where needed.
- Embed our *Healthy Families* and *Healthy Child* programmes across the City and County to empower children, young people and families to make healthy choices and reduce risk-taking behaviour.
- Improve the health and wellbeing of students and staff in our schools through the new *Schools Health Hub* in the County and the *Healthy Schools Programme* in the City.
- Improve the mental health and wellbeing of children and young people through the implementation of national policy, including *Future in Mind.* We will address the stigma associated with mental health and provide better information for children and families about self-help and where to go for support. Professionals working with children, young people and families will be trained to better understand and support people with emotional or mental health difficulties.
- Improve services for children and young people with learning disabilities, neuro-developmental disorders and children looked after by our care system.

2. Strengthen primary, community, social care and carer services

We will improve the local services available by:

- Continuing to develop the integrated Community Children and Young People's Service to join up and improve our services for families across the City and County
- Improving how we identify, assess and meet the needs of children and young people who have special educational needs and/or disabilities, including learning from and action on findings of the review of children's short breaks
- Continuing work to build resilient families and children, through the Family Service and Priority Families Services, targeted at vulnerable families with complex needs and problems.

3. Simplify urgent and emergency care

We will improve access for children and young people to crisis and urgent care mental health services and open a new, larger, inpatient child and adolescent mental services

(CAMHS) unit in Nottingham for children and young people, providing inpatient care closer to home. We are also working across the STP to increase capacity in CAMHS community services, including developing support for children and young people with eating disorders.

4. Deliver technology enabled care

We will use technology to support the health and wellbeing of children and young people and to deliver care, building on services already in place, such as:

- Text and online services including Chathealth – a texting advice service provided by School Nurses for young people (07507 329952) and KOOTH – a free, safe, confidential on-line counselling service for young people. A new website www.healthforteens.co.uk, co-designed with local teenagers, will provide access to information on staying safe and healthy and a new young people's zone is planned within LiON (Local Information Online Nottingham).

- The Child Protection Information Sharing (CPIS) programme which allows effective information sharing and exchange of data between health professionals and children's social care professionals for children with child protection plans in place.

- Development of personal WIKIs for children and young people with additional needs, to improve communication between families and professionals - reducing the need to keep repeating their 'story'.

5. Ensure consistent and evidence-based pathways in planned care

We will develop new pathways for autism spectrum disorder conditions, continence and sleep issues - working with community health services, paediatricians and children's social care to ensure needs are met early and appropriately.

In addition, we are working to embed new guidelines for GPs for children who need specialist assessment or care to:

- Help GPs care for and treat more children, without needing to refer them to hospital
- Ensure that children who do need a specialist appointment are seen in a timely manner, in an appropriate clinic.

5.3 Carers

We recognise the role of unpaid carers and acknowledge that the detailed plans to support them need to be more explicit within the Plan. As part of the further development and implementation of our Plan, we are already working closely with carer groups and providing opportunities for them to help shape the delivery of improved services.

We know that carers play a critical role in supporting family members, friends and neighbours, with some providing many hours of care every week. Our aim is to support carers and to ensure their needs and experience are at the heart of service delivery and decisions about care, rather than expecting carers to fit around the services provided to those they look after.

All carers in Nottingham and Nottinghamshire can benefit from the support offered by the Carers Hub. This provides information, advice and support through a single phone number and website. Carers can contact the Hub for an assessment of their needs and for help in planning and accessing support. This support might include local carer support groups, practical support for a few hours a week from the befriending service, help in understanding more about local health and social care services, and free access to leisure centres.

The work of the Hub includes proactive outreach and promotion targeting carers from the black and ethnic minority communities. It also works with the Action for Young Carers service in Nottingham City to develop support for young adult carers. The Hub works proactively with GPs, and other health care and social care professionals, to increase understanding of the importance of supporting carers, and where to refer carers for support.

Additional services for carers are available for specific groups of people in some parts of the City and County, for example support services for carers of those with moderate or severe dementia and personal budgets for eligible carers and young carers to support them in caring and promote their wellbeing. We will seek to implement best practice across the whole STP area as resources allow.

We will also work closely with carers to listen to their views on how they can contribute to the delivery of improved services. Local Authorities and CCGs already use a variety of approaches to listen to carers, including through voluntary sector organisations. Our STP Advisory Group includes a carer representative who will seek and bring back the views of carers.

Our STP area has been chosen to be an early adopter of NHS England's Integrated Personal Commissioning (IPC). This will see Nottingham City and Nottinghamshire County leading the way in designing an increasingly personalised model of care for others to learn from. We will also use the provision of personal health budgets to support local people and those who care for them to take control of their own care needs.

IPC will mean health and social care staff working together to:

- Drive increased personalisation across health and social care
- Develop the system around the person
- Build community capacity and peer support
- Increase personalised support planning

- Increase integrated support plans and budgets
- Put people (and those who care for them) in control of their own care and give them choice on how to meet their needs.

Personal health budgets are provided to eligible patients with certain long-term conditions and disabilities to help them receive the care they need in a way that suits them. They enable people to take more responsibility for their own health and wellbeing with the support of local communities, their families, carers, friends and the organisations that provide services for them. With national support to drive IPC in our STP area, carers – as well as those they care for - will benefit from more personalised, tailored care.

6. Working as a single health and care system

We know that delivering a Plan of this scale and ambition is a major challenge and has not been done before. We need to move from behaving as individual organisations to working as a single health and social care system with a shared responsibility to meet the population's needs within the resources available.

This will require us to change the way we behave as leaders and organisations, collaborating across historic boundaries to deliver the best possible health and care for local people whilst also providing the best value to the system as a whole.

We will address these challenges both through developing an 'Accountable Care System', culture change and system-wide governance processes.

6.1 Developing an Accountable Care System (ACS)

Since we first published our Plan, we have been given national support from NHS England to explore the potential for an 'Accountable Aare System' (ACS) model across our STP area, with an early focus on developing this in the Greater Nottingham Transformation area.

This is an exciting step towards building an integrated health and social care system. It will enable us to explore how we can organise and fund services in a way that gives us a shared responsibility for a person's whole journey of care and the outcomes of the treatment and support they receive within a single budget. This is a new and ambitious way of working, but has been used successfully in other parts of the world.

The ACS development will transform the way in which we deliver care, strengthening our focus on preventative and proactive information and support. People will increasingly access health and social care services closer to home in their own community – with hospitals caring only for those who need to be there.

Developing an ACS will take time. We are committed to working with as many people as possible who are involved in delivering health and care to shape how this happens. The views of the public are crucial in this process. This work is being overseen by the Greater

Nottingham Transformation Partnership and involves all of the NHS organisations in Greater Nottingham working in close partnership with Nottingham City and Nottinghamshire County Councils. It also includes working with local care providers such as the Circle Partnership that runs the Nottingham Treatment Centre, and Nottingham CityCare Partnership that provides many of our community services.

Our initial focus will be to put the right systems in place to break down barriers between organisations and allow us to work closer together. Key 'enablers' to ACS development include the use of electronic information and technology and changing our current business model with a focus on new integrated governance arrangements and payment mechanisms.

Being selected as an ACS development site brings with it an element of freedom, some additional financial resource and more control over how we shape the future as a system. However, it also brings with it a level of responsibility and an expectation that we will deliver more quickly on the main 2017/18 national service improvement priorities for the NHS. These include meeting waiting time targets in the Emergency Department and in primary care and improving cancer services and mental health.[7]

The 'Better Together' programme in Mid-Nottinghamshire has already delivered some benefits to citizens using a similar approach - developing an alliance of key partners - which provides a firm foundation for future development of an ACS. We will review both these approaches to ensure that we share learning and adapt our development plans to benefit from what has been shown to work well.

There will be opportunities for citizens and staff to express their views and shape the development of the ACS model through planned feedback events and established engagement channels. For more information on the development of ACS models in England visit www.england.nhs.uk and search 'ACS'. News on our progress in Greater Nottingham will be shared through the STP website www.stpnotts.org.uk.

6.2 Finance and governance

In our draft Plan we set out the finances currently available across social care, public health and the local NHS until 2021. We are continually updating this information in line with national funding allocations and the development of our Plan. However, one of the common concerns from the feedback received was around how we will pay for the transformation of services and implementation of our Plan.

We are fortunate in Nottinghamshire as we have been successful in bidding for some short-term, additional funds from NHS England to support specific elements of our Plan, and details of this are contained within the Appendix. We have made additional bids for more short-term funding and capital funding (money to spend on buildings and facilities) and are

[7] P.12 Next Steps on the NHS Five Year Forward *[www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view]*

currently waiting to hear the outcome of these. Additional national resources will also be provided to support us in developing an ACS in Nottinghamshire.

Even with the investment outlined above, our financial position remains difficult. We will have to manage the funding we have been allocated very carefully to deliver core services whilst adequately supporting our transformation work. We will do this both as individual organisations and by working together as a system.

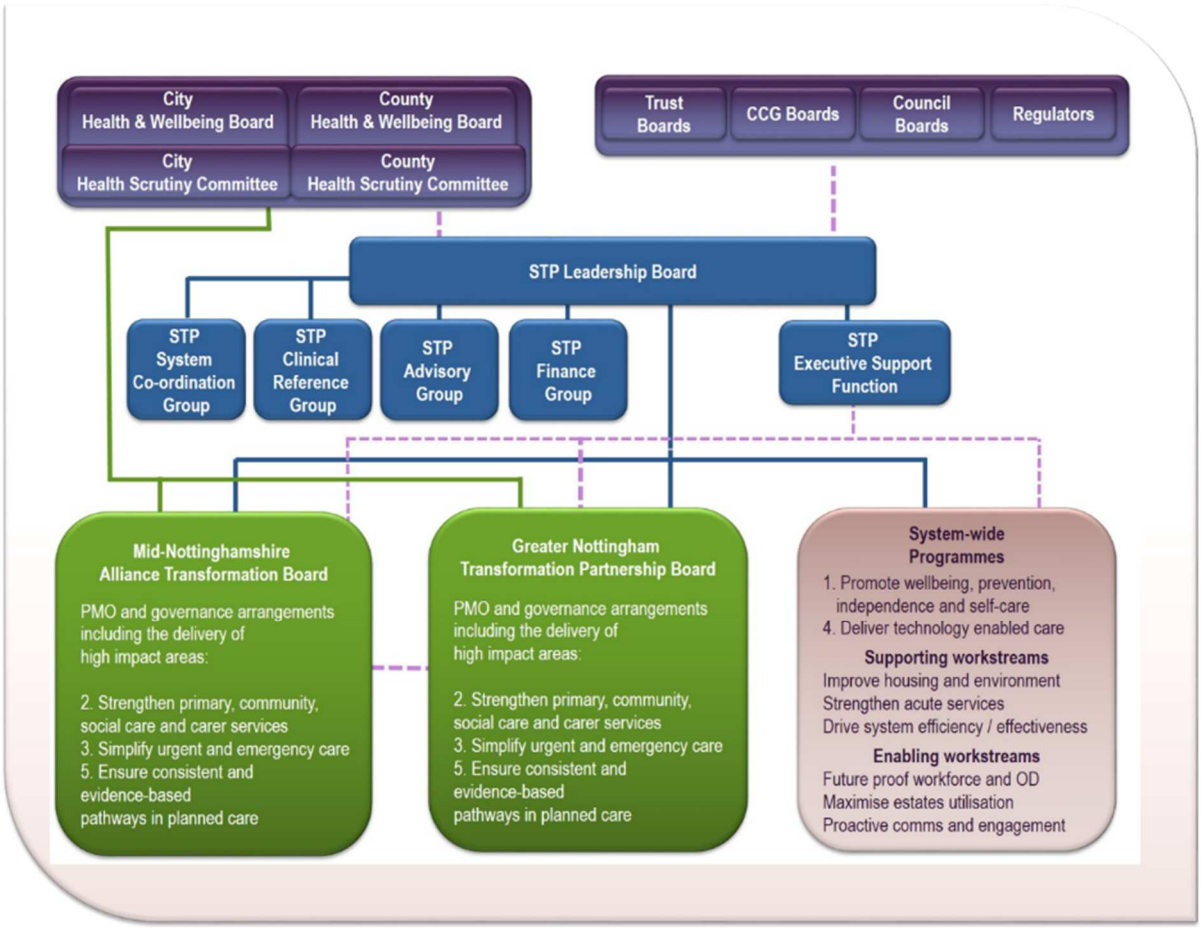
The STP Finance Group (comprising finance leads from our partner NHS organisations and local authorities) meets monthly to support the STP Leadership Board in delivering their objectives and ensuring that this aligns with the financial plans of individual organisations.

The STP Leadership Board has streamlined governance arrangements for the STP to improve the speed and consistency of decision-making, and will keep these arrangements under review for the duration of the Plan.

Through the STP governance arrangements we will:

- *Establish a mutually accountable system with independent challenge* - At the STP level, organisational leaders will be mutually accountable to each other as well as being mutually supportive. They will learn, share and provide independent challenge to each other. Leaders will be the interface between the STP Leadership Board and their own organisation's board or governing body.
- *Be clear on where risk is owned and managed* - Individual organisations and the two 'transformation boards' (areas of health and care planning covering Mid Nottinghamshire and Greater Nottingham) will continue to manage their own individual risks. Some of these risks may be managed at the STP level if that is in the best interests of the overall system. The STP Leadership Board will keep track of risks, key metrics and milestones.
- *Transform care through leaders working together* - The STP aims to ensure that where a citizen lives should not dictate the quality of service received or the impact on their health and wellbeing. We will act as one system for our population, providing evidence-based services and ensuring consistent outcomes.

Our governance is summarised in the diagram below and further details can be found on the STP website at www.stpnotts.org.uk



7. Summary and contact us

This Update has aimed to provide additional information to that contained in our STP five-year Plan for health and social care published in November 2016 – with a focus on the areas that people told us were important to them as part of the feedback process.

We have tried to use simple language where possible to explain more about our Plan and our approach to delivery. However, we acknowledge that we have had to use some terms that may be unfamiliar to people where it was difficult to find alternative terms to describe some of the changes planned.

The supporting Appendix to this Update includes:

- Appendix A – What we will deliver in 2017/18
- Appendix B – Additional national funding for 2017/18
- Appendix C – Our updated 'Plan on a page'

If you have any queries about the information in this Update or would like more details on any aspects of our plans, please visit the STP website at www.stpnotts.org.uk or contact us at:

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Printed copies and alternative formats of this document are available on request, using the contact details above.

Appendix A
What we will deliver in 2017/18

This Appendix describes the changes that members of the public and staff should 'see and feel' by the end of March 2018. These changes are listed below under the workstreams where changes will be most evident this year.

There will also be a significant amount of development work that will be going on behind the scenes to enable these changes to take place, and to prepare for changes that will be delivered in future years.

Priority 1: Promote wellbeing, prevention, self-care and independence

- A consistent approach to providing advice to citizens and patients across health and care services. This will include advice on how to learn about and manage their own health, in particular reducing smoking and the amount of alcohol they drink, and to make changes that will enable them to remain independent in their own homes for as long as possible.

Priority 2: Strengthen primary, community, social care and carer services

- Increased access to GP practices in the areas that are piloting extending the times and days of the week that patients can see a GP, and new ways for patients to seek advice from a GP in pilot areas. We will review and evaluate these approaches to determine how to roll this out after March 2018.
- More joined-up care through our ongoing work to integrate teams in the community around groups of GP practices. These teams bring together staff from primary care, community services, mental health services, social care and the voluntary sector to work together to support people with on-going / complex health and care needs.
- More people will be able to book GP appointments and get advice online and through telephone consultations.
- Better and more consistent care for residents of care homes through linked GP practices and improved use of technology. This will include electronic monitoring of the ordering and administration of medications to improve safety and video-conferencing for rapid clinical advice.

Priority 3: Simplify urgent and emergency care

- Better signposting to urgent and emergency care services through 111 and the new Clinical Hub. This will enable people to self-treat or find the most appropriate care quickly when they need urgent or emergency care.
- Improved discharge processes so that people who are admitted to hospital can return to the most appropriate place of care at the right time.

- A new mental health navigation service, incorporated within a single point of access, for clinician to clinician conversations. This will provide GPs with senior clinical advice on mental health and patients with urgent follow-up services locally. This is being piloted for one year and will be evaluated.
- Better access to acute psychiatric liaison services to provide psychiatric advice and support to patients and staff on wards and in the emergency department.

Priority 4: Technology enabled care

- Health and care professionals will use one system to give them essential information about their patient's health, through a new shared record. It will support better care and provide faster, up to date and secure access to information where and when it is needed.

Priority 5: Ensure consistent and evidence-based pathways in planned care

- More support for patients with stable glaucoma or ocular hypertension in the community through an expanded role for community optometrists.
- More care closer to home for patients in Greater Nottingham with gastrointestinal conditions. A clinical assessment by a consultant in the community will ensure that all relevant diagnostic tests are undertaken following referral, meaning that fewer people will need to travel to hospital for appointments.
- An improved pathway and better outcomes for people with musculo-skeletal problems in Mid-Nottinghamshire. This will integrate services and include a single visit for assessment, diagnosis and treatment or referral in a local setting, and full discussion with patients to help them to determine the most appropriate way to manage their condition.
- A diagnostic service in primary care for patients requiring a specialist dermatology opinion which will mean that fewer patients will have to attend for a hospital appointment.
- A new pathway for GPs to use for patients with vague symptoms such as weight loss or where the GP's gut instinct is that something is wrong and the patient could potentially have cancer. The patient will be assessed within two weeks by a specialist team in the hospital who will organise tests, give a rapid diagnosis and refer them onwards to the appropriate specialty if necessary.
- All patients diagnosed with cancer will receive an holistic needs assessment before and after treatment, and on transfer back to their GP. This will include a review of their physical, mental health and social needs, and will be shared with all staff involved in their care, as well as with the patient.

Improve housing and environment

- An increased number of fast food takeaways that offer healthier food options on their menu to help people have greater access to healthier choices.
- More people offered the 'warm homes on prescription' scheme to help them to more easily afford a warm home.

- Better support from housing providers to help people to be discharged from hospital safely at the right time by ensuring their accommodation and environment is safe and appropriate to return to.

Strengthen acute services

- More integrated and efficient acute health services between Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust, with partnership working between sites, starting in the specialities of Urology and Neurology.
- Development of other clinical services shared between these hospitals including cancer and vascular services.

Workforce

- New employment models to add flexibility in how staff can work across organisations to deliver joined-up patient care.
- More opportunities for staff to develop service and quality improvement skills and implement changes to their services that will improve the outcomes and experience of patients.

Proactive communication and engagement

- Public listening and engagement events in the Mid Nottinghamshire and Greater Nottingham transformation areas to keep people informed and involved in shaping health and care services. This will include engaging citizens and staff in the development of plans for redesigned services and pathways.
- An updated STP website that provides information for the public and staff, including details about the transformation programmes in Mid-Nottinghamshire and Greater Nottingham, and information about the development of the ACS.

Appendix B
Additional national funding for 2017/18

The table below outlines the areas where we have applied for national funding from NHS England and the amounts that we have been awarded as at 21st July 2017. These additional funds have been awarded to support specific elements of our Plan.

NHS England Funding Source	**2017/18 allocation to Nottingham and Nottinghamshire STP**
Cancer	£73,000
Mental health, including urgent and emergency care and Learning Disabilities	£1.73 million
GP Forward View	TBC
Diabetes	TBC
Maternity	TBC
STP capital funding	Between £5 million and £10 million
Development of the accountable care system (ACS)	TBC

We have made bids for more short-term funding and capital funding (money to spend on buildings and facilities) and are currently waiting to hear the outcome of these. From our first capital bids submitted in April, subject to meeting criteria, Nottinghamshire should receive between £5-10 million to develop capital projects in 2017/18. Additional national resources will also be provided to support us in developing an ACS.

In response to national widespread concerns and calls for action about the funding of adult social care, the Chancellor of the Exchequer announced additional funding of £2 billion in his budget statement of 8 March 2017 (part of the Improved Better Care Fund). In Nottinghamshire the grant will provide an additional £58m over two years - with £25m in 2017/18, and £33m in 2018/19. The additional money announced is temporary.

Appendix C

Our updated 'Plan on a page'

The Nottingham and Nottinghamshire Sustainability and Transformation Partnership

Our Vision: Sustainable, joined-up high quality health and social care services that maximise the health and wellbeing of the local population

Principles we will...

- Support people to develop the confidence and skills to be as independent as possible and look after themselves, both adults and children.
- Organise care around individuals and their carers, and deliver personalised care based on people's needs.
- Work in multi-disciplinary teams across organisations, delivering joined-up care as simply and effectively as possible, reducing duplication.
- Work together to shift resources to the most appropriate setting. This may mean spending more on prevention and proactive care in the community and less on services in hospitals.
- Learn from what works well to spread good practice across the STP area so people can expect the same quality of care and support irrespective of where they live.
- Deliver care and support as efficiently as possible so we can spend more on improving people's health, wellbeing and quality of life.
- Place as much value on a person's mental health as we do their physical health.
- Maximise the positive impact that health and social care services can add to our local communities through the contracting for products and services (known as 'social value')

Priority areas:

1. **Promote wellbeing, prevention, independence and self-care**: Increase healthy life expectancy by 3 years by 2020/21 with a focus on reducing the number of people who smoke or are obese in the first 2 years. Promote self-reliance and independence from services and make community support stronger to enhance the wellbeing of people who live there.
2. **Strengthen primary, community, social care and carer services**: Ensure people stay healthier for longer by increasing access and resilience in general practice and improve the quality of life for people with long-term conditions and their carers.
3. **Simplify urgent and emergency care**: Deliver the right advice or service at the right time including improving the urgent and emergency care pathway, and redesigning the system to enable reduction of 200 beds in acute hospitals.
4. **Deliver technology enabled care**: Help citizens to manage their own care; help clinicians and other staff to deliver more care more efficiently and use new technology to support independent living and care at home.
5. **Ensure consistent and evidence based pathways in planned care**: Standardise care pathways reducing variation; improve prevention, early diagnosis and recovery in cancer care.

Measured through the following success criteria:

- All within the health and care economy achieving financial balance by 2021
- Delivery of the agreed outcomes and targets that reflect our system values and citizen satisfaction: Improve Healthy Life Expectancy by 3 years
- High quality providers through regulatory outcomes

Supporting work-streams and enablers:

1. **Strengthen acute services**: Partnership working between Nottingham University Hospitals Trust and Sherwood Forest NHS Foundation Trust.
2. **Drive system efficiency and effectiveness**: Deliver individual organisational efficiencies and system efficiencies, developing a collaborative approach to gain best value for public money.
3. **Improve housing and environment**: Improve housing, housing-related support and the wider built environment so that communities are healthier and homes are appropriate, warm and safe to reduce demands on NHS and social care services.
4. **Future proof workforce and organisational development**: Make sure that we have the right workforce to deliver our plan and that staff are properly trained and developed to deliver services in the future.
5. **Maximise estates utilisation**: Make best use of our land, buildings and facilities and ensure they are fit for purpose and in the most appropriate location
6. **Proactive communication and engagement**: Engage staff, local people and other stakeholders to support the successful development and delivery of our plan.

Governance approach:

- Mid Notts and Greater Nottingham transformation areas oversee delivery of priorities 2, 3 and 5. Other workstreams have own Programme Boards, and come together under STP Co-ordination Group
- STP Leadership Board holds these to account, puts system before organisation, ensures services are consistent across the STP area, and shares best practice.
- Other STP groups advise, support and challenge – Advisory Group, Clinical Reference Group, Finance Directors Group