Forward View into Action

Registering interest to join the new models of care programme

Q1. Who is making the application?

The ***Mid Nottinghamshire Better Together Programme (partnership) Board*** is the entity making the application. Membership comprises commissioners, local authority and major providers from the public and private sectors, together with representatives from the voluntary sector, general practice, citizens and Healthwatch. We are well placed to become a Vanguard site because we have mature system relationships that have withstood difficult discussions about the best means of achieving high quality and sustainable services in an organisationally agnostic manner. We have navigated many complexities associated with joint planning and the execution of joint plans. Year one of our strategy implementation has been successful – we have achieved our priorities, whilst maintaining a degree of flexibility to refine plans and to respond to emerging pressures or new evidence of impact.

The Mid Nottinghamshire Health and Social Care economy provides services to a population of circa 310,000 citizens. In 2013, leaders signed up to a system blueprint, setting out the services that will be needed in the future. This set the foundations for how commissioners and providers work together across organisational boundaries to best match and manage projected population demand. A clear shared vision has been adopted across the system, with detailed plans to implement transformational interventions that impact on whole system quality, cost of provision and sustainability.

An independently chaired Programme Board has been in operation in Mid-Nottinghamshire for 2 years now. This collaborative comprises senior leaders who are empowered to make decisions and drive forward change in their constituent organisations. The programme has significant delivery infrastructure and dedicated resource, which has been agreed for 2015/16.

Citizens are integral to the development of future strategies and are represented through a Citizen's Board. Healthwatch is also an active member and operate in their advocacy role.

Well-established partnership working arrangements exist with the voluntary sector in the localities. An intermediary has been appointed and the sector has agreed to come together create a Special Purpose Vehicle as a trading entity for a consortium open to all existing third sector providers.

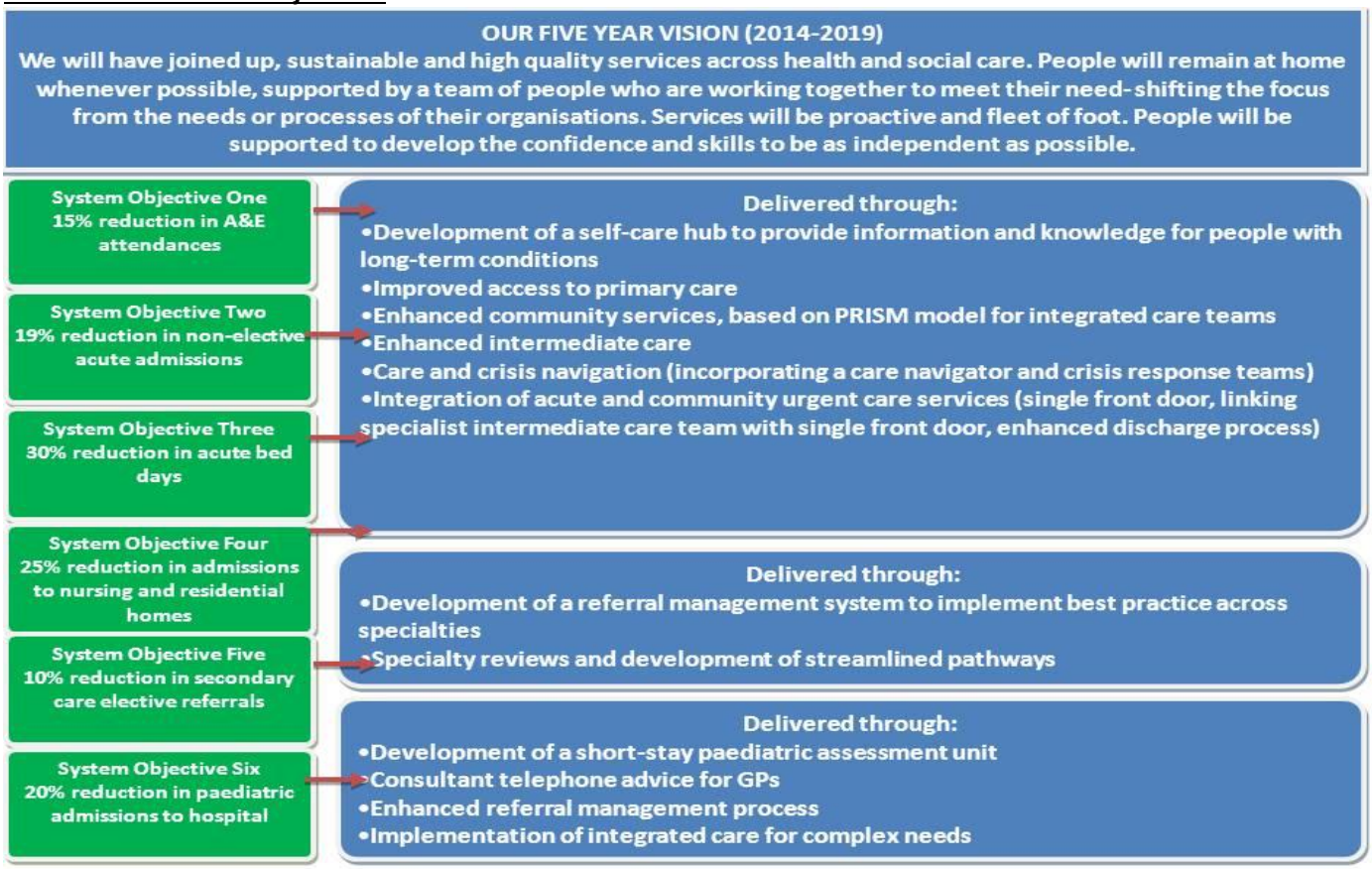
The main providers of acute, mental health, ambulance, out-of-hours and community services (public and private sectors from Mid Nottinghamshire and adjacent geographies)) have formed an alliance, governed by an agreed Memorandum of Understanding, to work together to deliver seamless services across sectors and care settings. This known as the coordinating providers group. From 2016/17, they will work within a capitation outcomes based contract as an accountable provider alliance to deliver integrated adult services (subject to 'most capable provider' procurement processes).

General Practice providers have formed a GP Provider Cabinet, with support from the Local Medical Committee and local Primary Care Development Centre. This enables them to co-ordinate the activities of individual practices so as to ensure full engagement in shaping future care models and mobilise and deploy resources accordingly. Enhanced services will be included in the capitation model of commissioning for population outcomes, with the potential for core services to come into scope.

The contact for dealing with any queries in relation to the application is **Lucy Dadge, Director of Transformation, Mid-Nottinghamshire CCGs; lucy.dadge@mansfieldandashfieldccg.nhs.uk, 07775 942840, 01623 673140**

Q2. What are you trying to do?

Our Vision and Main Objectives



These objectives form the basis of the CCGs' five year strategy and are aligned with provider strategies and plans. The interventions are evidence-based and have been developed by clinical and care professionals, with significant public engagement to test and challenge ideas. Activity assumptions, efficiency gains and quality standards have been built into all interventions. They have also been mapped against the NHS Outcomes Framework.

Whole system integration of hospital, community, social and primary care is central to the vision because people tell us that services are currently too fragmented and difficult to navigate. We are moving from a model of predominantly reactive hospital-based care to one of home-based proactive care[1], eliminating hospital admissions as a default for people who are not acutely unwell but need help and support. Delays that do not confer added 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, whilst reinvigorating working relationships and dialogue between primary and secondary care clinicians.

We have undertaken very extensive engagement programmes in order to develop our service and contract model. Our citizens 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. We will help people to look after themselves and encourage the responsible use of services. We also inform people of the health and social care services available from statutory and voluntary sector organisations, linking in with the respective Health and Wellbeing Board Strategies. Further information about public feedback, proposed service models and new contract can be found at: http://www.bettertogethermidnotts.org.uk/

[1] Profiling risk, integrated care, self-management (PRISM) community teams are now in place and provide a platform from which a home-based system of care will continue to develop.

The most fundamental change in patients' experience will result from models of integration that make the journey through the system of care as simple as possible and encourage shared decision-making. The citizen'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 a multiplicity of individual suppliers with different incentives and objectives. Home will be the default care setting, rather than hospitals or institutional care.

The new ways of working will require the creation of a very different workforce, at pace, whilst smoothly managing the transition from traditional models of more fragmented care delivery. The creation of multi-disciplinary teams is a key staging post for more integrated ways of working, but we aim to go further than that and have already identified a number of key new roles. Together with new education programmes, we are designing competency-based development on the job, maximising the benefits of a blended learning approach. A Memorandum of Understanding has been developed between providers to begin cross-sector working and the further establishment of shared teams.

Q3. Which model(s) are you pursuing?

Primary and Acute Care System (PACS)

This model is best placed to achieve our system vision of integrated care across health and social care. It includes acute, community, voluntary and primary services. Our plans and ambitions are firmly grounded in evidence-based service models that have local public support and will meet the needs of our changing population demographics.

The model has been adapted in that we are proposing that we need an alliance of providers to come together to become a single contract holding party. Our vision is for service integration through partnership working and alliance, rather than vertical integration of acute and primary / community care. Home and community will be the default care settings, rather than an acute trust. The governance of the integrated care provider needs to reflect the critical and equal role that all sectors play in preventing crises and maximising health outcomes.

Q4. Where have you got to?

The Better Together Programme is well established, with a PMO approach, agreed resources, work stream infrastructure and robust governance arrangements.

Commissioners have designed a commissioning approach that reconciles the desire to drive quality and value through open market competition with the stability, cost effectiveness and the delivery of near term benefits (e.g. QIPP and business as usual activity). The CCGs have developed a capability assessment process and identified a group of coordinating providers who they believe could be the 'most capable providers.' Key elements of work that are being completed in parallel are:

- Development of scope of services
- Agreement of the outcomes framework
- Identification of financial flows and apportionments
- Development of the commercial model to underpin the outcomes-based capitation approach to contracting

Approximately £340 million per annum is included within the scope of the new contract to enable whole system realignment.

Coordinating providers have come together very positively and are developing new joint ways of working, particularly around hospital discharge processes (transfer to assess) and admission avoidance. They are working with primary care and the voluntary sector to design integrated ways of working. Commissioners are agnostic as to the commercial model that may develop between coordinating providers and primary care providers. They may form part of a care delivery chain or may be represented as part of a partnership (or other commercial structure) as part of an accountable provider alliance.

Mid-Nottinghamshire is at the national forefront of optimising the opportunities offered by Flo Simple Telehealth. This uses mobile phone technology to remotely monitor and communicate with patients for a very wide range of

conditions. EMAHSN have funded a project manager to spread use across the acute setting and to help roll out and spread of good practice across the whole of the East Midlands as part of a wider TECS programme. Skype is already used for care home consultations and the use of technology to support clinical and cost effective delivery models will increase throughout the life of the programme. An IMT work stream is in place and is actively working to achieve an integrated record across the system.

Whilst whole system re-commissioning and the development of an accountable provider alliance continue, a number of key outputs and service changes were delivered during 2014/15. These include:

- Roll out of multi-professional community teams (PRISM) in Mansfield and Ashfield and extension of existing services to 7-day working in Newark and Sherwood
- Introduction of new hospital discharge processes and community services to prevent medically fit people being detained in hospital for assessments regarding their long-term care requirements (transfer to assess)
- Development of a self-care strategy (including how we will provide additional information and support for people to promote health and wellbeing and independence, advice and support for carers)
- Joint working between out-of-hours GPs and emergency care at Kings Mill A&E and Newark MIU, pilots of ways to change GP appointment systems and improve access to urgent care
- Standardised referral protocols trialled using the Map of Medicine
- Development of an estates strategy, including the acute hospital PFI

Q5. Where do you think you could get to by April 2016?

Our principal focus during 2015/16 will be to implement an outcomes based, capitated with a single accountable provider by April 2016. There will be concurrent provider development in anticipation that they will form an accountable provider alliance (subject to demonstration at the capability assessments that they comprise the 'most capable provider' solution). The contract will be awarded either to an alliance of the current most capable providers or to a new market entrant through a competitive process. In order to ensure system sustainability and NHS Constitution standards, the following tactical service changes will also have been implemented:

- Expansion of the current integrated community service to 7 day working by June 2015
- Integrated primary/secondary care triage and associated estate changes at the ED and MIU in the 2 main hospital sites by October 2015
- Roll out of the community based specialist intermediate care service by August 2015
- Standardised referral systems to be in place between all providers by May 2015
- Care Navigator roll out, supported by a patent facing self-care hub to access health and social care services from all providers including the third sector by June 2015.
- Launch of an Integrated Care Record (ICR) available to both health and social care professionals by September 2015

Q6. What do you want from a structured national programme?

There are a number of local challenges that the Better Together Programme can address if there is wider system working with regulators, NHS England and national advisors. Our planning assumptions forecast that the current proposals will close £35 million of our projected five year £70 million health and social care financial gap. Challenges to the clinical and financial sustainability of our medium-sized DGH are similar to many other areas, so there will be generalisable learning and solutions that the Better Together Programme can deliver. We are very keen to engage actively with partners and peers to share learning and information, as well as to learn from others.

Our acute trust (Sherwood Forest Hospitals NHS Foundation Trust) is in Special Measures and is subject to regulatory measures by Monitor and the Care Quality Commission. There is a large PFI. The mental health and community services provider (Nottinghamshire Healthcare Trust) is likely to be awarded Foundation Trust status in the near future. We would like to work with national teams and regulatory bodies to secure a sustainable health and social care solution. We are not looking to secure the future of any specific organisations, but we want to secure sustainable services for our local population. Developing organisational forms will have to support our service vision

and plans. Our vision is very closely aligned with the Five Year Forward View. It will improve the quality and clinical sustainability of services through efficiencies at the interface between services as well as within individual sectors.

We would also like support to enact our estates reconfiguration (in line with strategy) to enable new models of care across acute, community and primary care.

Our mature partnership arrangements have already resulted in an agreed approach to system alignment and service delivery. Vanguard site support would enable more rapid navigation of legal and regulatory requirements on our journey towards managing whole population health through an integrated provider supply chain and incentives based on outcomes.