The Nottingham and Nottinghamshire
Sustainability and Transformation Partnership

Feedback Summary

June 2017

INTRODUCTION FROM DAVID PEARSON

In November 2016, we published our draft five year plan for health and social care in Nottingham and Nottinghamshire. Since then we have been out and about listening to the views of local people and staff and reading and reflecting on your written feedback.

I would like to thank those who took time to write to us with their views or attend one of our four public events which 395 people came to. A further 80 people attended the voluntary and community sector event. We received 69 written responses.

This is a summary of what you told us about the draft Plan and how we will act on your helpful feedback. A full and more detailed feedback report is available as an appendix to this summary on our website at www.stpnotts.org.uk.

This summary also includes a number of case studies, based on real patient and carer stories, where we are able to show how we are already working differently to further improve services for the people of Nottingham and Nottinghamshire.

BACKGROUND – WHAT IS THE STP?

The Sustainability and Transformation Plan (STP) is the five year plan for health and social care in Nottingham and Nottinghamshire. We will refer to it from now in this summary document as 'the Plan'.

The draft Plan looks at how we can best improve the quality of care and the health and wellbeing of local people. Local health and social care services want to work even more closely together to make this happen. Demand is growing for these services and we need to deliver them differently so that we can achieve our aims based on what is affordable.

We set out five priority areas where we will focus our efforts over the next five years:

1. Promote wellbeing, prevention, independence and self-care
2. Strengthen primary, community, social care and carer services
3. Simplify urgent and emergency care
4. Deliver technology-enabled care
5. Ensure consistent and evidence-based pathways in planned care

Other key aspects of the plan include opportunities to improve housing and the environment, strengthen acute services, and make services more efficient and effective. We also want to make sure that we have the right workforce in place to deliver this plan and that staff are properly trained and developed to deliver services in the future. We want to make sure we are using our buildings in the best way and want to talk to local people about how we take some of these changes forward to make the necessary improvements happen.

The following documents can be found on our website www.stpnotts.org.uk. To request hard copies or alternative formats please contact us using the details on the back page of this report.

- **Full Sustainability and Transformation Plan (STP) for Nottingham and Nottinghamshire**
- **STP Summary Guide**
- **Appendix to this summary - Full Feedback Report**

LISTENING TO YOUR VIEWS

Our draft Plan was based on previous conversations with local people, including those who developed the Health and Wellbeing strategies for Nottingham City and Nottinghamshire County, and work already underway via specific initiatives such as our NHS Vanguard programmes, which are helping us to try out new ways of working and delivering care.

From November 2016 to February 2017 we have been talking to local people about the draft Plan, listening to your views and collecting feedback.
We have done this by:

- Publishing our summary Plan, the full Plan and appendices on our website
- Holding four public events at a range of venues and times across the City and County which have been hosted by Healthwatch
- Inviting written comments by letter or e-mail.

We have also shared the draft Plan at a range of other local events, such as a Nottingham University Hospitals NHS Trust public Members' event and an event for voluntary and community sector organisations. Their comments are also included in this report. We have also been talking to staff who work for the NHS, social care and the voluntary and community sector in Nottingham and Nottinghamshire to capture their views. Many staff attended the public meetings.

SUMMARY OF YOUR FEEDBACK

a) What did you like about the plan?

Many of you endorsed the overall direction of the plan:

'It's very good, and the right direction of travel. The plan has good aims.'

'We are unanimously in support of the STP.'

You agreed with many aspects of the plan, for example the focus on prevention and self-care, with people taking more responsibility for their own wellbeing. You want care closer to home and you want services to be joined up across health and social care:

'It would be wonderful if organisations actually worked together in partnership.'

You agreed with the focus on using technology to improve the way that we work:

'There should be support for IT – Skype, telemedicine etc. but this needs to enhance not replace conventional care.'

You were supportive of our workforce, including our commitment to provide 'adequate numbers of appropriately trained staff for new models' and to reduce our use of agency staff.

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 care link workers now make up a crucial part of the multi-disciplinary teams in the City's eight Care Delivery Groups (CDGs). 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 social care link 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 link 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."

b) What did you feel that we had left out of the plan?

You said that there were some areas of care and groups of people that we did not cover sufficiently in our plan, in particular:

Missing from the Plan	Our response
People with mental health problems, including those with dementia	We acknowledge there is insufficient focus on mental health in our Plan. We intended to include mental health and wellbeing in all parts of the Plan rather than create an artificial separation between physical and mental health, but accept this has resulted in mental health not being sufficiently prominent as a priority. Our focus will be on meeting the ambitions set out in NHS England's Mental Health Forward View. Mental health is an integral part of this plan.
Children and young people	The Plan is for all ages. We will include a specific section on children and young people and their needs, in particular around prevention, self-care and mental health.
Carers	We recognise the role of unpaid carers and acknowledge that the detailed plans to support them needs to be more explicit within the Plan. We will work closely with carers to develop how they can contribute to the delivery of improved services.
Specific groups of the population, for example the homeless, the deaf community, LGBT groups	We will consider the needs of specific groups of the population as part of our detailed delivery plans. This will then be taken forward by health and social care partners, working with the voluntary and community sector.
Voluntary and community sector	We have started to talk to the community and voluntary sector and plan to continue to work with them to maximise their contribution to the delivery and awareness of the Plan.

c) What were your comments on the content of the plan?

You said there were some areas of the Plan where specific challenges should be explored further:

	You said	Our response
Prevention, self-care and independence	We should do more to encourage the public to act responsibly and look after their own health	We agree that we need more focus on the responsibilities of the public in our Plan, but we need to support people to do this by making the 'right choice and the easy choice' wherever possible. We will look for ways of investing in local people as partners to increase responsibility and promote independence.
Primary care	You are worried about the increasing workload for GPs, whether we have enough GPs and whether practices will be merged.	We understand the big challenges facing general practice and the need to support them both locally and nationally. We will work as a system where appropriate but reflect the diverse needs of the area. We will develop services based around 'clusters' of practices working together, which may be supported by federations or alliances that will allow practices to achieve the benefits of operating together. Geographical clusters of GPs will be encouraged to work closely with other primary and community care providers, including sharing premises, to provide a more effective and efficient service. The aim is for teams to support these clusters in which mental health, social care, and community teams will be key members. By working in an integrated way we will improve services.

	You said	Our response
Workforce	You want to see a workforce and training plan that will enable us to deliver more care closer to home. You are particularly concerned that we may not have enough community staff trained in more specialised care and home care services to deliver the plan.	Redesigning our workforce is essential for the successful delivery of our Plan. Our Workforce and Organisational Development Strategy describes how we will bring our staffing information together so that we can plan the workforce that we need to meet the needs of local people in the most effective and efficient way. We will strengthen the current workforce by introducing new roles to support areas where there are staff shortages.
Technology	You are concerned that many people do not have access to computers or know how to use them	We know that not everyone has access to computers or smart phones. Where we feel there are benefits we will provide training and education to people on how to use technology to support their own health needs, in some cases providing the equipment. This may support them in their care, help them to live independently, monitor their condition or have access to information.

d) What were your comments on how we have communicated about the plan?

It was clear from the feedback that you wanted us to continue to communicate with the public and specific groups of people:

	You said	Our response
Communication with the public	You want an ongoing conversation with the public about the plan, using clear, understandable language. You provided some suggestions of how we could do this better in future.	We are committed to an ongoing conversation with local people using a variety of methods and using accessible language. We will use case studies and real stories from across all our partners to tell the story of how we are taking our plan forward. We will also talk to local people as we develop our detailed implementation plans ensuring changes to services are produced together.
Including all people in communication	You are concerned that there are many people who have not been part of the conversation so far, including seldom heard groups and the housebound.	We acknowledge that the people who attended the events do not represent the wider population and that there is more we need to do to hear the views of certain groups in our community. We commit to extending our communication to these groups, using existing networks and groups run by our own organisations and by the voluntary and community sector. We will also involve people in changes that directly impact on them.

	You said	Our response
Keeping you informed	You want to know how the public will be kept informed of progress.	As part of our commitment to an ongoing involvement with the community we will produce an annual report for the public, beginning with 2017/18, that will summarise what we have achieved in the last year (against what we said we would do) and plans for the following year. Our plan will update the public on the progress to date.
Communication with staff	You want us to make sure we involve all types of staff, including those from other sectors such as home care.	Frontline staff have been involved in the development of our Plan. With over 40,000 staff working in health, care and housing we have a great opportunity to get ideas from them but we also understand the challenge of ensuring we can involve and energise them in helping us to deliver our ambitious plan. We will use our current mechanisms for talking to and listening to staff. We will share consistent information about the Plan and give staff the opportunity to shape the detailed delivery plans.

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. 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."

e) What were your concerns about the plan?

You had concerns about the evidence and rationale for the plan, whether the plan is realistic and can be delivered, and questions about funding and finance:

You said	Our response
You want more information on the evidence that we have used to develop our plan	Most schemes in our plan are based on evidence or national guidance. Our Plan also contains schemes which Nottinghamshire is testing such as the innovative new models of care being developed through the national Vanguard programme. We have committed to spreading evidence-based learning across local organisations so that we can benefit from the emerging evidence. This means that everyone will benefit from improvements in one area.
You want confirmation that there will be investment in community services before hospital beds are closed	This concern has been recognised by NHS England and from April 2017 local NHS organisations will have to show that significant hospital bed closures meet one of three new conditions before NHS England will approve them to go ahead. One of these conditions is demonstrating that enough alternative services, such as having more GPs or community services, are being put in place alongside or ahead of hospital bed closures, and that the staff will be there to deliver them. Locally we have evidence that it is possible to improve patient experience and care, whilst reducing the number of hospital beds. This has been achieved in Mid Nottinghamshire through their approach to integrated care and the development of Local Integrated Community Teams which can provide more care closer to home and prevent hospital admissions or allow people to be discharged sooner.

You said	Our response
You are concerned that care closer to home may not be cheaper and that economies of scale may not be achieved	This is a difficult area and needs to be considered for each individual service. It is true for some services that outcomes and timeliness are improved if services are brought together at scale. However, for other services such as the care of the frail elderly and those with complex long-term conditions there is evidence that more co-ordinated support at home helps people to manage their care more effectively and reduces cost.
You consider the Plan to be very ambitious and optimistic, particularly in relation to the timescales and factors that are outside our control	The Plan is ambitious but as it is built from evidence from elsewhere we do not believe it is over-optimistic. The concerns expressed in the public feedback are mirrored in some of the national reports from independent research/policy organisations such as the King's Fund and Nuffield Trust. These highlight issues relating to the plans for integrated care but also how such change is planned and delivered. We will learn from these reports and ensure that we apply the learning from them and our Vanguards in how we develop and implement change, monitor progress and identify and manage the risks.
You want to know how we will work together to deliver the Plan, including dealing with cultural differences between organisations and managing risk	The next stage of development and implementation of the plan will now move to our two areas in Greater Nottingham and Mid Nottinghamshire, and to our City and County wide programmes. Our approach to dealing with cultural differences and managing risk is to develop proposals for Accountable Care Systems as we believe this model will help us to manage some of the challenges. This would enable us to work together in a new way to meet the needs of local people and reduce the focus on individual organisations. This approach has already delivered benefits in Mid Nottinghamshire through their 'Better Together' programme through its alliance of key partners.

You said	Our response
You want us to talk about the issues about national funding	As senior leaders we raise concerns about national funding levels as we feel appropriate. The recent national commitment to increase funding for adult social care will bring benefits to local people in Nottingham and Nottinghamshire. This has been as a direct result of senior leaders across social care and the NHS making a case to the Government. We have to live within our means, and this means spending only what we can afford and getting the best value for money. We believe the changes proposed in the Plan will improve care and health outcomes, either improving care at equal or lower cost, or delivering efficiencies from services and support functions.
You are concerned about the availability of pump-priming funding to support the double-running of services	We understand the concern from the public in relation to investing in alternative services before we reduce existing services (pump priming). This is a major challenge for the area and one which the STP Leadership Board will manage over the course of the five year plan. We are fortunate in Nottinghamshire as our Vanguards bring additional resources in 2017/18. We have also been awarded some additional central Transformation Funds for specific priority areas. However, there are areas where we don't have any easily identifiable resources and there is further work to do to fully address this challenge.

You said	Our response
You think that there should be a single budget for health and social care	There is a great deal of national debate on the advantages of creating a single budget for health and social care, but this would require legislation in Parliament and is not a decision that we can take locally. Our proposals for Accountable Care Systems will allow us to move away from focusing on single organisations and manage some of the blocks to doing the right thing such as the split between health and social care funding. We believe an Accountable Care System approach will enable us to work more flexibly and manage some of the risks raised by the public to deliver the changes required.
You are concerned that the STP will lead to more privatisation of health care	We do not believe the STP will either increase or decrease the use of the private sector to deliver health care. The NHS uses private partners where value for money, innovation and quality exceeds the service offered from the NHS. We will continue to do this as we must ensure we spend the money we have wisely. Some of the innovation we are looking for to support the development of services in Nottinghamshire may come from the private sector, both in technology and clinical services.

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."

WHAT WE WILL DO NEXT

The Full Feedback Report and including our response to comments received is included as an appendix to this report and available at www.stpnotts.org.uk

We will publish an update to the five-year Sustainability and Transformation Plan (STP) for Nottingham and Nottinghamshire in the form of a revised executive summary in response to public feedback.

This revised executive summary will be written in clear language and include additional information on:

- How our Plan addresses the needs of people with mental health problems, children and young people and carers
- How we will deliver our Plan, including the governance and organisation of delivery
- Principles for working with local people to develop our Plan
- Principles for working with staff, and the community and voluntary sector as we develop our Plan.

We will write a new appendix to the Plan to describe arrangements for delivery, finance and governance.

We will produce an STP annual report for local people (starting from 2017/18) which will outline the progress we have made, our priorities for the coming year and any changes we want to make to the Plan in the light of the progress and work we have undertaken.

We will update the STP website with links to the two local transformation areas - Better Together in Mid-Nottinghamshire and The Greater Nottingham Transformation Partnership - to provide the public with a single point of information about the STP and how it is being delivered.

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