STP

The Nottingham and Nottinghamshire
Sustainability and Transformation Partnership

Connecting care in Nottingham and Nottinghamshire

Annual Report 2017-2018

FOREWORD

Welcome to this first annual report of the Nottingham and Nottinghamshire Sustainability and Transformation Partnership. The organisations that have come together across the city and county believe that this partnership approach is the best way to sustain and improve NHS and social care.

Our aims for improvement are wide-ranging – from prevention of ill-health through to services that people receive in hospital. Through much of our work we are looking to re-design services in the community to help people to be treated and cared for at home, or as close to home, as much as possible.

Our first 12 months in partnership have been characterised by innovation and there have been many local groundbreaking initiatives that have attracted national attention. We now need to ensure that this cutting edge approach spreads throughout Nottinghamshire. NHS England has recognised our work to date by allowing us to become one of the first areas in the country to evolve into an Integrated Care System.

We face immediate significant challenges, particularly financial, but we have already made substantial progress as shown in the case studies of this annual report. The partnership organisations collectively oversee a budget of approximately £3.3 billion. In our first 12 months we have gone a long way to meeting the required £182 million savings target while protecting services where we can.

As we tackle today's pressures being experienced by health and care services, we must also be ambitious for the future and explore more efficient and effective ways of delivering care.

Our population is growing and getting older, with more complex needs. When the NHS was founded, average life expectancy was 64 years across the country. Nowadays someone living in Nottinghamshire can expect to live to 81 on average (for a man). While living longer is a cause for celebration, we must ensure that services, care and support are always there throughout a person's life. We must also ensure that we reduce the differences in life expectancy across our area.

OUR VISION IS TO ACHIEVE SUSTAINABLE, JOINED-UP HIGH QUALITY HEALTH AND SOCIAL CARE SERVICES THAT MAXIMISE THE HEALTH AND WELLBEING OF THE LOCAL POPULATION

We need to co-ordinate care around the needs of the individual, connecting services wherever we can. We need to make sure that the levels of quality care in one part of our county are equally as good as elsewhere. We need to make the best use of public money against this ever-increasing need.

Great progress has been made over the past year and I would like to congratulate staff from all partner organisations, both statutory and the community and voluntary sector, for the tremendous work they have done for our health and care. Their dedication has never been more apparent.

I would also like to thank all the members of public, patients and carers who have provided vital input into our plans to date. We held several engagement events in 2017 which produced some challenging and thought-provoking discussions. Their voice has been heard and we are acting on it. An update to the Partnership's plan as a result and updates about the Partnership's activities are available on our website **www.stpnotts.org.uk**

Thank you for taking the time to read this annual report.

David Pearson

Lead for the Nottingham and Nottinghamshire Sustainability and Transformation Partnership

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INTRODUCTION

The NHS is one of Britain's proudest achievements and this year celebrates its 70th anniversary. Our staff do a superb job treating record numbers of patients and service users. There has also been an unprecedented increase in the need for people requiring social care services. The health and care service has had to constantly adapt as our health and care needs have changed. We are now able to treat people with new drugs and treatments that were not available in the past. As life expectancy increases, so do the ailments of old age and there are now more people living with long-term conditions.

There are big opportunities in Nottingham and Nottinghamshire, as there are nationally, to improve care by making practical changes to how the NHS and social care work. Improvements that matter to people, like making it easier to see a health or care professional, getting a faster diagnosis, and offering help quicker to people with mental ill health.

This is why the NHS and local councils came together locally to develop proposals to improve health and care. A new partnership was formed – known as a Sustainability and Transformation Partnership (STP) – to plan jointly for the next few years.

The work of the STP has been progressed by focusing on two areas. In the city and the south of the county this has been based around the Greater Nottingham Transformation Partnership. In the middle of the county, the areas covered by Mansfield and Ashfield, and Newark and Sherwood, this has involved the Better Together Alliance Partnership.

Nottinghamshire has been chosen by NHS England as one of the first areas in the country to set up an integrated care system. In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. The fundamental principles of the NHS will remain the same.

Responding to the views of people and patients, skilled staff, and the insights and support of the community and voluntary sector, the Nottingham and Nottinghamshire Sustainability and Transformation Partnership has just completed its first year. This annual report reviews what we set out to achieve, the progress made so far, and looks at how we might best meet the challenges still to come.

We have made progress on a number of the challenges that are facing health and care communities across the country such as finances and avoiding admissions into hospital. We know we need to do more, particularly in the area of the high numbers of people attending emergency departments.

Personal health budgets are one way to give people with long-term health conditions and disabilities more choice and control over the money spent on meeting their health and wellbeing needs.

June 2017 to March 2018:

NOTTINGHAM

334 → 364

The number of personal health budgets in Nottingham increased from 334 to 364.

NOTTINGHAMSHIRE

874 → 1,743

In Nottinghamshire they increased from 874 to 1,743

97%

of patient records have been placed on a shared database where patients have given their permission

This helps provide seamless care between different organisations

There are nearly

20,000 ADULTS

in Nottinghamshire who have a learning disability

We have just over a million people living in Nottinghamshire.

This is predicted to rise by:

7.1% by 2030

– with more older people living with one or more long-term conditions.

6.7%

REDUCTION IN HOSPITAL EMERGENCY ADMISSIONS

in Mid-Nottinghamshire this year – learning from this is now being spread further across the county

An enhanced support package has been provided to care home residents in Rushcliffe. This included having a named GP for each care home, enhanced support from community nurses and advocacy support for residents from Age UK.

The initiative saw a 23% reduction in emergency admissions to hospital for care home residents

Technology can help people better look after themselves at home. In the city and county (March 2018) there were:

1,649

people using the Flo telehealth system, receiving text messages on their phones about their health

60%

There has been a 60% increase over the past year in Nottingham in sending pictures of skin conditions for diagnosis (teledermatology)

OUR FOCUS:
Promoting wellbeing, prevention, independence and self-care

THE CHALLENGE

Our aim is to maximise independence, good health and wellbeing throughout people's lives. We want local people to feel empowered to make healthier choices that support their own health and wellbeing. We want to ensure that the increasing number of people living with a disability or long-term condition can live as well as possible through access to the right advice, treatment, care and support. 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.

PROGRESS MADE

- We have been mapping out what support and services are available and where they are. From this we can also see the gaps in support
- We have reviewed local workplace wellbeing schemes. These help local businesses to support the health and wellbeing of their workforce. Both employees and businesses benefit by staff living healthier lifestyles. The scheme is being re-launched through Notts Help Yourself
- 'Social prescribing' schemes have been advanced in Rushcliffe and Nottingham, referring people to activities likes walking groups or friendship groups rather than traditional clinical services
- Health and social care professionals are being supported to ensure they have the skills and confidence to have more 'person-centred' conversations. This approach focuses on what would best improve an individual's quality of life, health and maximise their independence

NEXT STEPS

- Build up a managed network of health and social care professionals who can take this work forward
- Link in with 'expert patients' to introduce more ways for patients to best manage their long-term breathing illnesses
- Complete a pilot programme assessing 'patient activation measures' – looking at how we can improve people's confidence in managing their own conditions

OUR FOCUS: Improving access to GPs, primary care and social care, and improving quality of life for people with long-term conditions

THE CHALLENGE

We need to strengthen primary, community, social care and carer services. 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.

PROGRESS MADE

- We are working to integrate, improve and standardise access to health and care, thereby reducing the need for care in hospital
- Opening times have been extended at all of our GP practices since 2016 with greater availability of evening and weekend appointments
- Clinical pharmacists have been introduced into GP practices, helping people receive expert advice on their medication
- A policy has been established to help people 'self-care'

NEXT STEPS

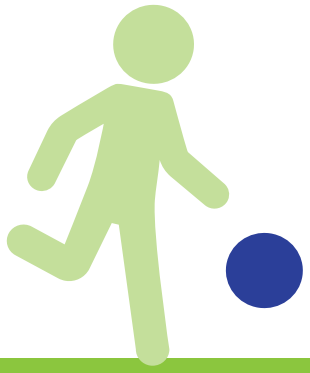
- We want to further expand access to care in GP practices and services in the community
- Implement patient and care co-ordinators to streamline care management for out and in hospital care
- Analyse our population to understand demographic needs, underpinned by a robust and proactive approach to health and care risk management
- Roll out e-booking services so patients can more easily book appointments online
- Support GP practices in working together, meeting the needs of all their patients across a wider area

CASE STUDY: CLINICIANS WORKING TOGETHER

In GP practices across Nottingham and Nottinghamshire, teams of district nurses, physiotherapists, occupational health therapists, social care workers are coming together with GPs and other colleagues to discuss the needs of individual patients. This means their whole needs are considered rather than specific conditions or problems. These multi-disciplinary team meetings are a vital way of joining up health and care services for patients who may suffer from one or more complex condition. Dr James Mills, who leads the meeting at Mansfield's Orchard Medical Practice, said: ''These meetings allow us to pool our knowledge to support patients to recover more quickly, or to give them the best end-of-life care possible.''

CASE STUDY: IMPROVED PATIENT CARE

A new service has been created to streamline healthcare for patients with stomach, nutrition and liver diseases. The 'Nottingham Digestive Diseases Interface', involving Nottingham University Hospitals and local NHS commissioners and GPs, has combined day case and outpatient appointments. It has also increased the number of nurse-led clinic appointments. Patients who need to attend hospital are seen by the correct specialist. GPs have been provided with the resources to treat patients who do not need to attend hospital. Furthermore, the average time from referral to first clinic appointment has been reduced.



OUR FOCUS: Making it simpler to access urgent and emergency care

THE CHALLENGE

When people have urgent or emergency care needs, we need to be able to direct them to the appropriate support or services. This may be in the community or in hospital. For those who need more intensive or specialist care that can only be provided in hospital, we need to ensure they can receive high quality and timely health care in hospital. When they are ready to leave, appropriate services or support in the community need to be in place to enable them to do this in a timely way. At the moment, this is not always the case. Despite the best efforts of staff, the winter of 2017-18 was difficult in terms of waiting times to be seen in the emergency department and in moving people out of hospital beds once their condition had sufficiently improved.

PROGRESS MADE

- Planning for people's urgent and emergency care needs is increasingly taking place on a county-wide basis – rather than on district basis
- All areas of the county are progressing their 'discharge to assess' schemes – ensuring that patients are assessed for their ongoing care needs in the right place and can leave hospital in a timely manner
- Technology is helping staff at Nottingham University Hospitals manage their beds in real time
- In Mid-Nottinghamshire a new scheme is helping patients at the end of their life be cared for away from hospital where appropriate

NEXT STEPS

- Review what services are available so we can reduce the number of people waiting in hospital for a bed or support back home in the community
- Review how services support people at risk of falls and admission into hospital
- Advance plans to replace current services with new Urgent Treatment Centres in Newark and Nottingham providing services according to a national standard

CASE STUDY: ENSURING PATIENTS RECEIVE THE MOST APPROPRIATE SERVICE

We all know that not everyone who attends an emergency department needs emergency care. King's Mill Hospital in Sutton-in-Ashfield operates a 'single front door policy'. When patients visit the emergency department, they are triaged by a qualified specialist who decides whether they need acute care (given to patients who are seriously ill) or primary care (treatment for less serious conditions). Based on this assessment, patients are directed to an appropriate medical professional within the hospital. For the six months up to October 2017, 66,481 patients attended King's Mill single front door, with 14,366 being streamed to the primary care service.

CASE STUDY: 999 RESPONSE ACCORDING TO NEED

The ambulance service focuses on providing the right response to the right patient based on their clinical need. Not every 999 patient needs to go to hospital and many patients are offered alternative options for treatment to avoid an unnecessary visit to A&E.

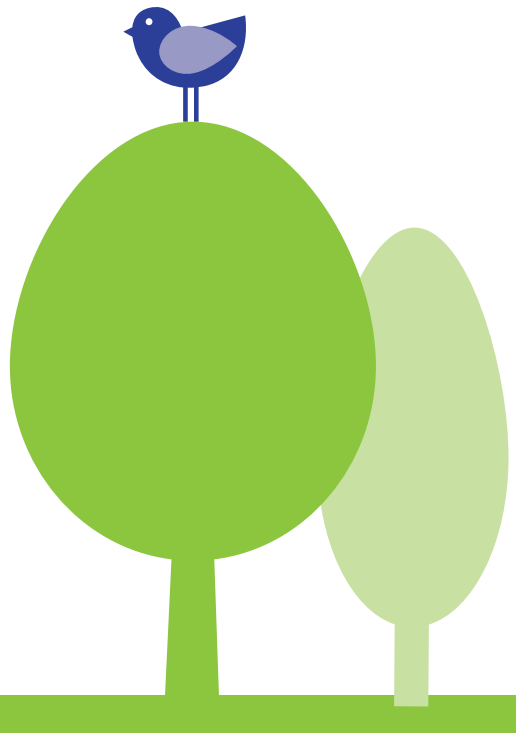
To reduce the number of ambulance patients admitted to hospital, we are working together to analyse data about which alternative services are available and which patients are being taken to them. This is helping us to identify and develop new services.

This focused approach is also unblocking issues to ensure the right services are open and available to meet patients' needs. The aim is to achieve a three per cent reduction in the number of ambulance patients taken to hospital.

CASE STUDY: AVOIDING HOSPITAL ADMISSIONS

A Call for Care service, based at Ashfield Health and Wellbeing Centre, is helping health and social care professionals make best use of the various local services available to patients. By calling a single telephone number, professionals are able to access urgent and crisis support for those at risk of admission to hospital for physical healthcare needs. This means that more people can be supported in their own homes, often within two hours, where a full assessment of their ongoing needs can be established and a comprehensive care plan put in place. The Call for Care service is also available to health professionals in hospital to get the right support for people to help them return home. Dr Thilan Bartholomeuz, a GP and clinical chair of Newark and Sherwood CCG said: "Call for Care is a vital means of co-ordinating responses so that patients get the care they need without automatically being sent to hospital."

This focused approach is also unblocking issues to ensure the right services are open and available to meet patients' needs. The aim is to achieve a three per cent reduction in the number of ambulance patients taken to hospital.



OUR FOCUS: Helping people manage their own care by using technology

THE CHALLENGE

Technology plays a useful role in helping some people look after themselves, managing their own health and care. We are looking to 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. We are working to make sure IT systems across different NHS organisations and local authorities can better communicate with each other. This will help ensure the right information is available, for the right purpose at the right time. There are also many other opportunities to embrace technology such as in making better use of digital services such as health and wellbeing apps on people's phones.

PROGRESS MADE

- We have developed a countywide assistive technology strategy and plan
- We have improved the ways in which organisations can share patient records – this has helped care co-ordinators in being able to take a 'whole' view of someone's care – rather than dealing with illnesses or conditions in isolation
- We have improved patient online access – all Nottinghamshire GPs now provide access to repeat prescribing, online appointment booking and access for patients to their record
- We have identified parts of the county where assistive technology solutions are working well – we now need to expand this coverage by learning from the success of others

NEXT STEPS

- We are exploring the options to hold online patient consultations
- We are exploring opportunities for patient-facing digital services
- We will be holding an event for local people to help identify what kind of online and digital services would be most useful, and obtain views on experiences of information sharing and technology across health and care
- We will roll out plans for more 'mobile working' – reducing the travel time for staff having to attend meetings

CASE STUDY: FUNDING BOOST TO DISCOVER TECH SOLUTIONS TO HELP WITH MENTAL HEALTH

The MindTech Healthcare Technology Co-operative, based at the Institute of Mental Health in Nottingham, has been awarded £1.3 million by the National Institute for Health Research to continue developing groundbreaking technology applications to help with people's mental health and wellbeing. MindTech is a national centre focused on the development, adoption and evaluation of new technologies for mental healthcare and dementia. It was established in 2013 and brings together healthcare professionals, researchers, industry and the public. It has helped develop a medical device that has been shown to improve the time to diagnosis for children with ADHD and has researched technology that can help treat adults with personality disorders and post-traumatic stress disorder.

OUR FOCUS: Having consistent standards of care and treatment across our area

THE CHALLENGE

We want to develop consistent ways of delivering care across the area so that services are effective and people do not receive different types of care depending on where they live. By re-designing non-urgent care services 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.

PROGRESS MADE

- From the first contact with NHS or social care, to the completion of treatment or support, we have been implementing new, more joined up ways in which people can receive their care, all based on the best evidence. These include services relating to bones, joints, eyes, skin and stomach conditions
- We want to ensure that services are standardised across the area wherever possible – for this reason we have been working with some GP practices that may have been making too few or too many patient referrals for certain types of treatment

NEXT STEPS

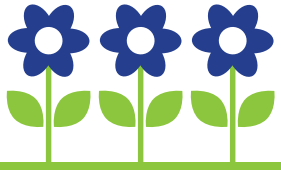
- We will be monitoring the impact of changes to the delivery of planned (non-emergency) care across the areas
- We will be reviewing how we deliver diabetes care across the area and whether this can be standardised and improved
- We will be reviewing how we can provide better conditions for patients before, during and after their operations

CASE STUDY: REFERRAL TO BREAST SERVICES IN NOTTINGHAM

We need to ensure that women with breast pain are treated appropriately and that they do not face the anxiety often created by a hospital referral and the inconvenience of travelling for a hospital appointment when not clinically required. For women in Nottingham and surrounding areas we have revised the two-week wait referral forms to ensure patients receive the right care at the right time in the right place. This has led to a decrease in initial outpatient attendances. We are monitoring services to ensure women continue to receive the right care and support.

CASE STUDY: COLLEAGUES WORKING TOGETHER ON THE BEST CARE APPROACH

A new way of caring in Mid-Nottinghamshire for patients having problems with muscles, bones and joints was set up in 2017. The 'MSK (musculoskeletal) Together' service has seen various health and care organisations team up to oversee GP referrals for services including orthopaedics, pain management, and physiotherapy. The referrals are triaged by specialist physiotherapists, with support from other specialists. This new way of working ensures patients are seen more quickly than a traditional referral into hospital care, with their care often taking place in the community or primary care. This has helped free up the time of secondary care experts to deal with patients who really need that specialist input. The new service has reduced the number of people needing referrals to orthopaedics and has helped save vital funds for reinvestment elsewhere.



OUR FOCUS: Improving cancer care

THE CHALLENGE

A cancer diagnosis can be devastating so we need to ensure we can prevent as many people as possible experiencing it in the first place. If someone is diagnosed with cancer, they should be able to live for as long and as well as is possible, regardless of their background or where they live. They should be diagnosed early, so that the most effective treatments are available to them, and they should get the highest quality care and support from the moment cancer is suspected. All our work is focused on increasing prevention, speeding up diagnosis, improving the experience for patients, and helping people living with and beyond the disease.

PROGRESS MADE

- Nottingham University Hospitals, Sherwood Forest, Nottinghamshire Healthcare and the local councils are smoke-free organisations. There are now patrols from community protection officers at King's Mill Hospital to enforce the smoking ban around the site
- Lung health checks are being piloted in Nottingham to improve early diagnosis rates of respiratory diseases. There are plans to expand this further across Nottinghamshire
- A range of tests have been made available to GPs to support earlier diagnoses of lung, brain and stomach cancers
- Macmillan funding is helping people affected by cancer with their self-management including adopting healthier lifestyles
- A pilot programme is offering access to an integrated psychological therapies service for people affected by cancer

NEXT STEPS

- We will be undertaking a major lung cancer awareness campaign in August 2018 with support from Public Health England. It will highlight the signs and symptoms of lung cancer and show that earlier diagnosis leads to improved outcomes
- We will be using national cancer funding to improve care for people diagnosed with lung, prostate and colorectal cancer. This will lead to faster diagnosis, improved waiting times for treatment and less visits to hospital for patients

CASE STUDY: HELPING PREVENT PEOPLE DYING FROM BOWEL CANCER

Bowel cancer is one of the most common types of cancer diagnosed in the UK. Most people diagnosed with it are over the age of 60. All men and women aged 60 to 74 nationally are invited to carry out a test using screening kits. Uptake of the screening has been relatively low among people living in Nottingham but a new telephone follow-up scheme has seen response rates increase by eight per cent in the people called.

OUR FOCUS: Helping hospitals to work across different sites and in the community

THE CHALLENGE

Health and social care providers need to work together to manage the pressures and changes that are impacting on acute hospitals. Such challenges include balancing the books and recruiting to specialist roles where there are a national shortage of candidates. Our hospitals need to be reshaped in response to the changes brought about as we increasingly provide appropriate care in the community. This will help ensure the ongoing provision of clinically safe, high quality, acute and specialist care for the citizens of Nottingham and Nottinghamshire.

PROGRESS MADE

- Nottingham University Hospitals and Sherwood Forest Hospitals have established a Partnership Board to oversee areas of close collaboration and support
- The two hospital trusts have approved plans for joint working in the clinical areas of neurology and urology
- The two hospital trusts have agreed to develop a joint clinical strategy and collaborate in more areas where it is in the interests of patients

NEXT STEPS

- Nottingham University Hospitals and Sherwood Forest Hospitals are set to build on the significant progress already made between the two acute providers. They want to assess how the changes are working out in neurology and urology and consider other specialties where close co-operation will be for the benefit of all
- The development of a clinical services strategy for Nottinghamshire covering primary, community and acute services

CASE STUDY: A SERVICE BUILT AROUND THE NEEDS OF PATIENTS

Closer working between Nottingham University Hospitals and Sherwood Forest Hospitals is leading to improvements in care that is closer to home. Urology cancer patients that were being treated in Derby can now receive their treatment in Nottinghamshire. More joined-up services are also meaning that those patients are having to make less trips to hospital for diagnosis, treatment and after-care. An on-call rota developed between the two organisations has enabled patients to be seen immediately by a consultant during office hours or the next morning if admitted out of hours.

CASE STUDY: ASSESSING PATIENTS FOR LONGER-TERM CARE NEEDS

When it is safe and appropriate to do so, many people can continue their care and assessment out of hospital. The discharge to assess scheme in Greater Nottingham is helping to ensure that patients can be assessed for their longer-term needs in the right place. This may be via Home First, community beds, or continuing health care assessment. This scheme, run by Nottingham University Hospitals and local commissioners, is helping to reduce delayed transfers of care and thereby free up beds for people who need to be in hospital.

CASE STUDY: IMPROVEMENTS TO END-OF-LIFE CARE GIVES PATIENTS CHOICE TO REMAIN AT HOME

A new service has been launched to support end-of-life care for patients across Nottinghamshire whose preferred choice is to remain at home. An in-reach matron supports patients who are at end-of-life while in hospital, and co-ordinates the patients' discharge to home safely with the care of nursing teams from Nottinghamshire Healthcare, Macmillan and Carers Trust East Midlands. Since the start of the scheme, the service has improved patient care and enabled more than 95% of these patients to remain in their own homes. Dr James Hopkinson, clinical lead, Nottingham North and East CCG, said: "Many patients express a preference for remaining at home at the end of their lives, and this service gives patients that choice, where it is clinically possible, while also ensuring that they, their family and their carers' are supported throughout."

OUR FOCUS: Developing more efficient and effective services

THE CHALLENGE

We face challenges in transforming the way we deliver care to local people, with the health and care system being under pressure. We have the same challenges facing every health and social care system in the country, with changing and rising demands and we need to ensure that we are making the best use of the available resources for the people of Nottinghamshire.

This is why over time we need to change what we do, building on the best, in health, care and wider services. We need to invest in what is cost effective and we are already working together to find efficiencies as a system.

PROGRESS MADE

- We have focused our work on a number of key areas where we believe we can become more efficient in our work – and make important cost savings. An example of this approach is moving from prescribing 'branded' medicines to cheaper, generic ones. Other priority areas to make more efficient include continuing care, laboratory work on making diagnoses, use of agency staff, and corporate services (the way we run our organisations)

NEXT STEPS

- We will progress plans to develop an integrated care system in Nottinghamshire. Under this system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the local population
- Our priorities over the next year are based on advancing the work already under way – gaining efficiencies in our clinical and administrative work. This will help make our services better meet patient and public needs and become more efficient

CASE STUDY: RIGHT PLACE, RIGHT TIME

Feedback from people attending hospital outpatient appointments is that some would prefer to be seen in the community. A project run by Nottingham University Hospitals and local NHS commissioners has examined 17 different types of medical conditions, including breast cancer and stomach conditions, and identified a 10 per cent reduction in new outpatient appointments. This is not only helping save the NHS money but ensuring patients are being seen in the right place according to their needs.

CASE STUDY: TREATMENT AT HOME, NOT HOSPITAL

The provision of intravenous (IV) therapy at home from Nottinghamshire Healthcare's Intensive Home Support team is helping people avoid weeks in hospital for treatment. Intensive Home Support is by referral only and accessed through the Call for Care system for patients in Mansfield and Ashfield. Derek Grice, 67, from Mansfield, has bronchiectasis, a disease causing inflammation and chronic infections in the lungs. He says: "Now I have my treatment at home it's a lot easier for me physically and I'm a lot happier mentally. I can now spend more quality time with my family and still receive the vital treatment I need. I finally have my life back."

OUR FOCUS: Improving mental health services

THE CHALLENGE

Mental health problems are the largest source of burden of disease in the UK, and there is a vast amount of unmet need among people of all ages with mental health problems. 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.

PROGRESS MADE

- We are working to ensure that our partnership achieves the aims of two national reports that have set out the national strategy for improving mental health services. The Five Year Forward View for Mental Health establishes a national plan to transform services for people with mental health issues and ill health. It builds on an earlier report, Future in Mind, 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
- We are committed to delivering 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

NEXT STEPS

- A key piece of work is to agree an overarching mental health strategy for this Partnership. This will be a strategy to care for people of all ages. It will seek to better integrate services around the needs of individuals and standardise the ways in which people can access services
- An Integrated Mental Health and Social Care Partnership Board is being established responsible for developing and implementing the mental health strategy. The Board will oversee the development of solutions across the health and care system to specific problems impacting on mental health services

CASE STUDY: TALKING THERAPIES IMPROVE LIVES OF LONG-TERM CONDITION PATIENTS

A talking therapies service to help people deal with the psychological effects of long term physical health conditions is now being provided by Nottinghamshire Healthcare. The Let's Talk Wellbeing service sees trained therapists use a range of talking therapies which aim to reduce the impact of the emotional distress caused by the patients' physical ill health, while helping them to better cope with their condition and manage symptoms.

CASE STUDY: INPATIENT MENTAL HEALTHCARE CLOSER TO HOME

A 16-bed ward has opened for adult mental health patients to ensure they can be treated closer to home. The beds were sub-contracted to Nottinghamshire Healthcare from Priory Healthcare and Partnerships in Care in a two year-deal and will be used by adults requiring inpatient mental health treatment. The Bestwood Ward at Calverton Hill in Arnold will allow families, friends and carers to have easier access when visiting their loved ones, ensuring their participation in their care and recovery.

OUR FOCUS: Improving housing and the environment

THE CHALLENGE

Good health starts at home. Safe, affordable and good quality housing is critical to meet the health and wellbeing needs of our residents, alongside the provision of appropriate housing support. Furthermore, a well-housed population helps to reduce and delay demand for heath and care services and allows patients to go home from hospital when they are clinically fit to do so.

The environment we live in can significantly impact on our health and wellbeing. By reducing air pollution and enabling good planning of the built environment, we can make our environment 'healthier' to live in.

PROGRESS MADE

- We have secured funding for a hospital discharge scheme in the south of the county to complement the offer in Mid-Nottinghamshire and Nottingham. This service will support the provision of timely, safe and supported home environments for people who are medically fit to leave hospital
- Through use of the Disabled Facilities Grant, councils have increased the numbers of people helped to live at home through measures including affordable warmth installations, adaptations and assistive technology
- A King's Fund report on 'Housing and Health' (March 2018)[1] said: "Nottingham and Nottinghamshire is widely acknowledged as having the most developed plan as regards housing, where it is a core theme, across the life-course."

NEXT STEPS

- We are seeking to expand the 'Warm Homes on Prescription' scheme, which will improve the thermal efficiency of homes for applicable residents
- We will continue to evaluate the hospital discharge scheme to support the development of services
- We continue to work to improve housing standards in the private sector and need to progress how health and social care can contribute to this issue
- We will identify more initiatives to increase the number of homes that are suitable for people with disabilities, helping people to remain at home
- We are looking at ways in which we can reduce air pollution and its impact on people's health
- We are looking at ways in which we can increase healthy eating options in takeaways

CASE STUDY: HELPING PEOPLE LIVE INDEPENDENTLY

Specialist apartments in Mansfield which offer care and support to older people to regain their independence after an illness or injury are helping to reduce the strain on hospitals. Nottinghamshire County Council has 12 short-term assessment and reablement apartments at the Poppy Fields Extra Care Scheme in Mansfield with more planned in a new extra care scheme being developed in Newark. The service is mainly for older people struggling to live independently or leaving hospital who previously would have been discharged straight into a care home or would have had to stay in hospital for longer.

In addition, a pioneering development providing much-needed housing for older people with additional support needs has also opened in Newark. Gladstone House has 60 purpose-built units over three levels, including 40 extra care apartments. Facilities include communal areas, rooms designated for activities, a sensory garden and commercial kitchen. Newark and Sherwood District Council, Nottinghamshire County Council, Newark and Sherwood Homes and Homes England worked in partnership to deliver the flagship £8.9million development. Social care and health partners were involved in the design of the project from the outset to co-locate social and health care services alongside quality accommodation.

[1] https://www.kingsfund.org.uk/sites/default/files/2018-3/Housing_and_health_final_0.pdf

OUR FOCUS: Supporting our workforce in new ways of working

THE CHALLENGE

We must work collectively to provide care and support for the increasingly complex needs of our population. This requires us to re-think and re-organise the way that care and treatment is delivered. With 50,000 local staff working in health, care and housing, we need to make sure that we have the right workforce in place and that staff are properly trained and developed to deliver services in the future. No organisation can solve the problems we face on their own. To make a difference to local people, we need everyone to work together across professional and organisational boundaries.

PROGRESS MADE

- We have been working to support our workforce to promote healthy messages to citizens
- We have been progressing a partnership organisational development strategy
- We have completed modelling of our future workforce needs
- We have undertaken training in care homes and the community to enable diagnosis of certain conditions, helping prevent admissions to hospital

NEXT STEPS

- Plans are being progressed to establish a Nottinghamshire Talent Hub so we can meet our future workforce requirements
- We will be supporting leaders in developing their capability for working together to transform our health and care system
- We are developing workforce plans to help support GP practices and colleagues throughout primary care, with a focus on staff recruitment and retention
- We are developing innovative solutions for human resources (HR) to support staff working across organisations
- We are developing proposals for new roles to ensure we have the right skills and capabilities to deliver care

CASE STUDY: LEARNING IMPROVEMENT SKILLS

A programme to develop quality improvement skills among our workforce was launched in summer 2017. It is planned that 150 health and care staff will be trained in 'quality, service improvement and re-design' this year and a further 150 colleagues in 2019. Initial feedback from the first people to join the course has been very positive. The learning gained will help equip leaders with the tools and techniques they need to implement transformational change. Trainers on the programme are from Nottingham University Hospitals, Nottinghamshire Healthcare and Nottingham CityCare Partnership.

CASE STUDY: ADDRESSING RECRUITMENT AND RETENTION

Healthcare provision is constantly evolving, and the healthcare workforce must also evolve to meet changing needs. This involves ensuring staff numbers and skill mix keep pace with change and are adequate to maintain safe levels of care. Like many other NHS organisations, Sherwood Forest Hospitals wanted to address issues of staff recruitment and retention. The Trust formed a Medical Taskforce Programme with membership of the taskforce drawn from across the organisation. A review of job plans, rotas and career opportunities has seen medical vacancies halved in the last six months of 2017 and a significant reduction in spending on agency staff. This programme has been shortlisted in the Health Service Journal 2018 Value Awards for workforce efficiency.

CASE STUDY: TRAINING OUR URGENT CARE STAFF TO MEET NEW DEMANDS

A new partnership has been formed to train the urgent and emergency care workforce and create multi-skilled practitioners. The Nottinghamshire Urgent and Emergency Care Partnership, led by Nottingham CityCare, aims to provide high quality training opportunities, build career opportunities and support staff retention. Better skilled and equipped staff will be in a better position to provide excellent urgent and emergency care services. The partnership has been able to host training sessions locally, providing learning opportunities for many clinicians at a time, as well as obtain discounts on external training courses.

OUR FOCUS: Making best use of our land and buildings

THE CHALLENGE

Without investment in the land and buildings of the NHS and partner organisations, the buildings will deteriorate and become unfit for purpose, and we will not be able to deliver our aims to improve people's health and wellbeing. By using our estate in the most efficient and effective ways, and by having services and buildings located in the right places, we can help to provide the quality services that the public expects. It is vital that we ensure proper maintenance of our existing buildings and seek to invest in new facilities where appropriate and cost effective to do so.

PROGRESS MADE

- Our Partnership has brought organisations together to begin to consider their land and buildings from a county-wide perspective - rather than looking at their individual services and buildings in isolation. This is enabling us to properly consider the value of new potential developments and also where we might need to disinvest
- Additional national funding has been secured to develop two primary care centres

NEXT STEPS

- We are refreshing our estates strategy for the Partnership. This will be able to fully consider the financial implications of new schemes, the ongoing needs of the current estate, and how planning for the estate can best meet the needs of the Partnership's clinical strategy
- We are joining up with other partner agencies to make the best use of our estates and the available funding

CASE STUDY: REDUCING OUR ADMINISTRATIVE ESTATE

We continue to challenge our thinking to ensure that our estate provides the most cost effective and sustainable solution for both patients and workforce, by having services and buildings located in the right places and reducing needless space. As part of the ongoing review into our estate, we assessed the opportunities in reducing local health partners' administrative presence from two buildings into one in Mansfield. This has been successfully implemented, enabling better workforce integration and savings to the local health economy.

OUR FOCUS: Engaging with local people

THE CHALLENGE

We are very keen to hear the broadest possible range of views from local people. The Partnership will only be successful if we can ensure that local partner boards, councillors, staff, the voluntary and community sector, and citizens understand and are fully engaged in achieving its aims. It is essential that we harness our staff's energy and commitment to support us in developing the Partnership. We want to continually involve our citizens in designing how we transform our system to enable them to be more independent and to shape the ways in which we deliver health and care services to deliver outcomes that matter to them.

PROGRESS MADE

- Over the last few years we have worked with public and patient representative groups across the area on the design of future services
- In 2017 we held a number of engagement events across Nottingham and Nottinghamshire. The conversations were very helpful in seeing how we could tailor our plans to meet local needs. We updated the Partnership's plan as a result of the feedback obtained. We made a commitment to produce this annual report as a result of feedback from the events
- Further public engagement events have been developed with patient groups in Greater Nottingham to build on the early conversations, with a particular focus on how we can continue to develop more joined-up care
- We have been communicating with our 50,000 frontline staff working in health, care and housing using existing communication mechanisms within individual organisations
- Updates on our work can be seen on the website www.stpnotts.org.uk

NEXT STEPS

- Through further meetings and events in 2018 and through other ways such as publications and the website, we will continue to involve staff, partners, public, patients and carers
- The organisations involved in the Partnership are speaking to the public and patients every day as part of delivering local services. We must ensure that we continue to refine our plans based on what the public, patients, partners and staff are telling us
- We will seek 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
- 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

KEY PRIORITIES FOR 2018-19

As we move to an Integrated Care System taking collective responsibility for managing resources, delivering NHS standards, and improving the health of our population, some of our key priorities include:

OUR PRIORITIES	KEY MILESTONES
IMPROVE ACCESS TO URGENT AND EMERGENCY CARE **(including the 4 hour waiting time target for A&E)**	• Implementing new care models and reviewing patient flow for urgent and emergency care • Review how services support people at risk of falls – and admission into hospital • Advance plans to replace current services with new Urgent Treatment Centres in Newark and Nottingham providing services according to a national standard
ENSURE TIMELY ACCESS TO CANCER DIAGNOSIS AND TREATMENT **(meeting national target times)**	• Redesigning pathways for cancer services to ensure that they are providing the best care possible • We will be using national cancer funding to improve care for people diagnosed with lung, prostate and colorectal cancer. This will lead to faster diagnosis, improved waiting times for treatment and less visits to hospital for patients
ENSURE THAT PROFESSIONALS ARE DEPLOYED IN THE RIGHT PARTS OF THE SYSTEM TO ACHIEVE THE VISION, SERVICE PERFORMANCE AND TRANSFORMATION THAT IS REQUIRED	• Developing a single clinical services strategy to deliver consistent, high quality and efficient clinical care, offering seamless care across Nottinghamshire • Building on the work to date in enhancing support for people living in care homes across Nottinghamshire. We want to ensure that care home residents are more involved in decisions about their care, improving their health and quality of life • Identifying opportunities for prevention across all work-streams, such as developing prevention toolkits and training for the workforce by January 2019 • Establishing a common framework and integrated process for personalised care and support planning by October 2018 • Developing a common approach to the care that is given before and after surgery, including implementing universal shared decision-making • Establishing a single agreed outpatient model across the STP • Identifying opportunities for common referral systems for assistive technology solutions with housing organisations
ACHIEVEMENT OF FINANCIAL TARGETS	• We will progress plans to develop an integrated care system in Nottinghamshire. Under this system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the local population • Our priorities over the next year are based on advancing the work already under way – gaining efficiencies in our clinical and administrative work. This will help make our services better meet patient and public needs and become more efficient
DEVELOP MENTAL HEALTH AND PRIMARY CARE SERVICES IN LINE WITH THE NATIONAL FORWARD VIEW STRATEGIES FOR THESE SECTORS	• Developing an all-age mental health strategy for the STP • Developing a standard approach to establishing primary care groups so that primary care can be delivered in a more effective way and is better integrated with community and social care services

PARTNER ORGANISATIONS

Our partnership for Nottingham and Nottinghamshire covers six NHS clinical commissioning group areas, eight local authorities and a population of slightly more than one million people. Bassetlaw is part of the South Yorkshire and Bassetlaw Sustainability and Transformation Partnership with close links between the two STPs.

STP LEADERSHIP BOARD MEMBERSHIP

- Mansfield and Ashfield CCG
- Newark and Sherwood CCG
- Nottingham City CCG
- Nottingham North East CCG
- Nottingham West CCG
- Rushcliffe CCG
- Nottingham City Council
- Nottinghamshire County Council
- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- Mansfield District Council on behalf of Nottinghamshire's other district councils
- NHS England

OTHER ORGANISATIONS WHICH ARE INVOLVED INCLUDE

- District councils throughout Nottinghamshire
- Healthwatch Nottingham & Nottinghamshire
- Nottingham CityCare Partnership
- Circle Nottingham Limited
- Voluntary and community sector organisations represented by Nottingham CVS, Nottinghamshire Together and Team
- Nottingham Emergency Medical Services
- East Midlands Ambulance Service NHS Trust

FURTHER INFORMATION

If you have any queries about the information in this Annual Report 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.