CORE CITIES NETWORK

Case study

June 2018

NHS Clinical Commissioners

The independent collective voice of clinical commissioners

NHS Nottingham City Clinical Commissioning Group

NHS Nottingham North and East Clinical Commissioning Group

NHS Nottingham West Clinical Commissioning Group

NHS Rushcliffe Clinical Commissioning Group

The Greater Nottingham Transformation Partnership

Nottingham City CCG
Nottingham North & East CCG
Nottingham West CCG
Rushcliffe CCG

Key learning

- **The value of external analytical capacity to determine priorities and drive system transformation.**
- **The centrality of primary care to the delivery of integrated care systems.**
- **The importance of developing a financial approach that emphasises organisational viability.**

Introduction

The Greater Nottingham Transformation Partnership (GNTP) sits within the wider Nottingham and Nottinghamshire Sustainability and Transformation Partnership, covering a diverse population of 730,000 across Nottingham City and South of Nottinghamshire County.

The area has a £1.3 billion annual health and social care budget with a current projected funding gap of £314 million by 2020/21. The case for change centres on improving health and wellbeing given the low healthy life expectancy in some parts of the area; improving quality of care by addressing high mortality rates for patients with long-term conditions, variable outcomes for people with cancer and long lengths of hospital stay for the elderly and frail; and the need for a financially sustainable system of care.

Fig 1: The Greater Nottingham Transformation Partnership (GNTP)

What are the aims of the system?

Against the backdrop of this case for change, while the area has lots of examples of innovation, it has historically lacked an effective cross-organisational collaborative culture and overarching strategic direction to enable transformative system change to be delivered at scale and pace. The GNTP's ambition centres on:

- increasing accountability to service users and local people
- improving user and citizen experience
- supporting the maintenance and improvement of population health and outcomes
- providing integrated systems of care
- improving value (outcomes/cost)
- ensuring sustainability of service provision.

To achieve these ambitions, the GNTP needs more efficient joined-up working, fewer organisational barriers and duplication, to meet rising demand, and to support workforce development and sustainability.

What were the first steps?

Health and social care commissioners and providers first came together in 2013 to consider how best quality and sustainable care could be achieved.

The partners agreed to optimise current working while developing a new integrated care partnership, blending GP, community and acute trust capabilities in a single risk-bearing provider partnership with accountability for the entire care continuum and common resource.

However, in moving to a new integrated system of care, a fundamental change programme needed to be implemented and the organisations had no experience of what needed to be changed and no knowledge of what interventions would deliver the most value to patients while delivering financial savings. They sought help in 2015 from Centene Corporation, which had previously worked with the operator of the Alzira system in Spain and is experienced in developing public integrated care systems.

How was the framework developed?

The integration framework was developed over three phases.

Firstly, completion of a system-wide actuarial analysis provided an opportunity to understand patient activity and costs and identify opportunities to reshape the health and care system based on those patient and population groups with the biggest value opportunity. This benchmarked GNTP's system against best international standards. It confirmed it could create a financially sustainable system. This also provided the starting point for decisions to be informed by patient/population and system value, rather than organisational benefit.

Next, in phase two, a framework was designed based on a series of indirect enablers – one-off investments and regulatory/legal actions, and integration functions – which must continue to be performed on an on-going basis. The model is shown in fig 2 on page 3.

The framework is being developed with a focus on delivering improvements in three areas:

1. Best practice care – with an increasing focus on population health management, standardised pathways, patient flow (levels of care) and new models of cross-organisational working.
2. Optimal infrastructure – improved data management, reportable quality activity and cost data, and financial management undertaken on a whole population basis.
3. Operating/governance model – development of an integrated strategic commissioner and provider partnership, alongside wider system integration.

It is envisioned that as GNTP moves towards phase three, this will deliver net savings of £220–£280 million in four years if ALL indirect enablers and integration functions are effectively in place.

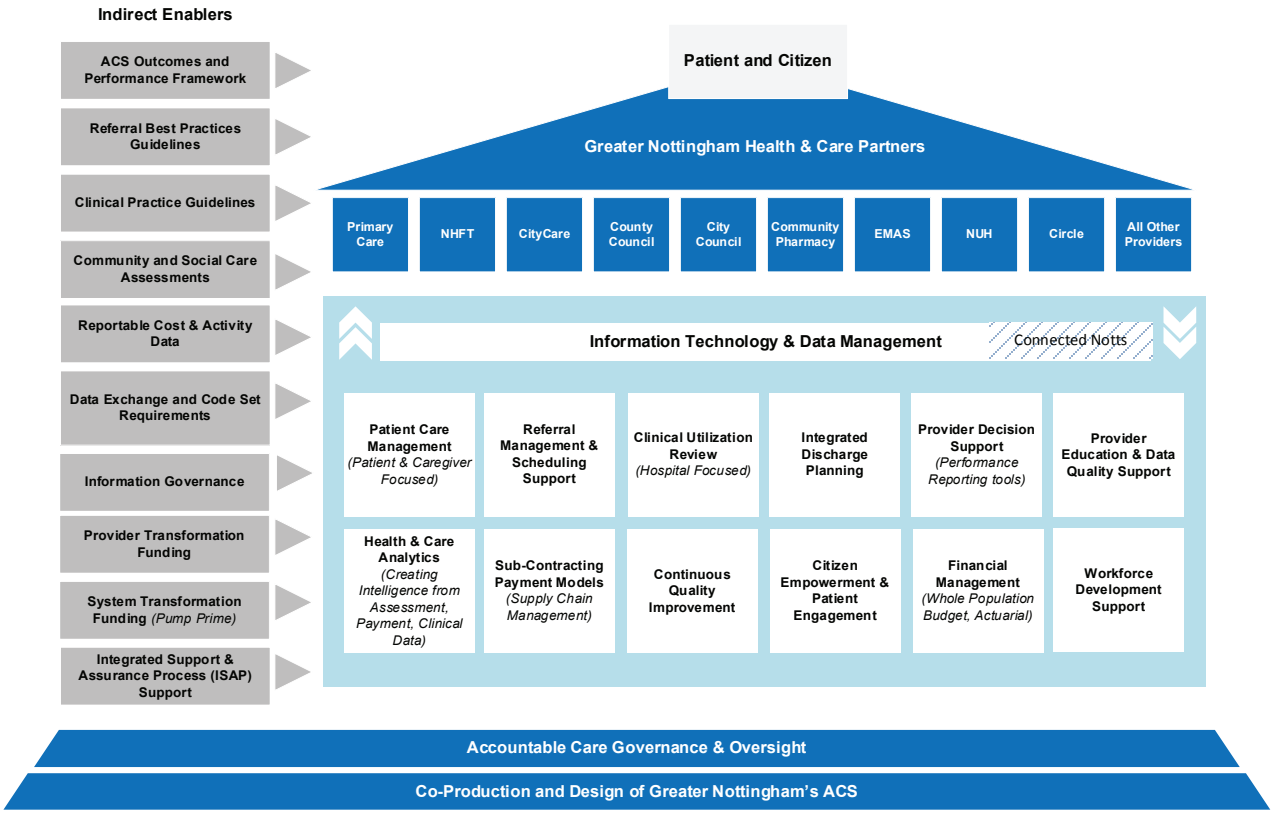

Fig 2: Phase two – Designing the integration framework

Governance structure – ICS/ICP

The system will operate with one strategic commissioner and regulator, the integrated care system (ICS), across two proposed integrated care provider partnerships (ICPs) as below. The outcomes required for all parts of the system will be aligned as far as possible to generate a collaborative culture and model across the whole system.

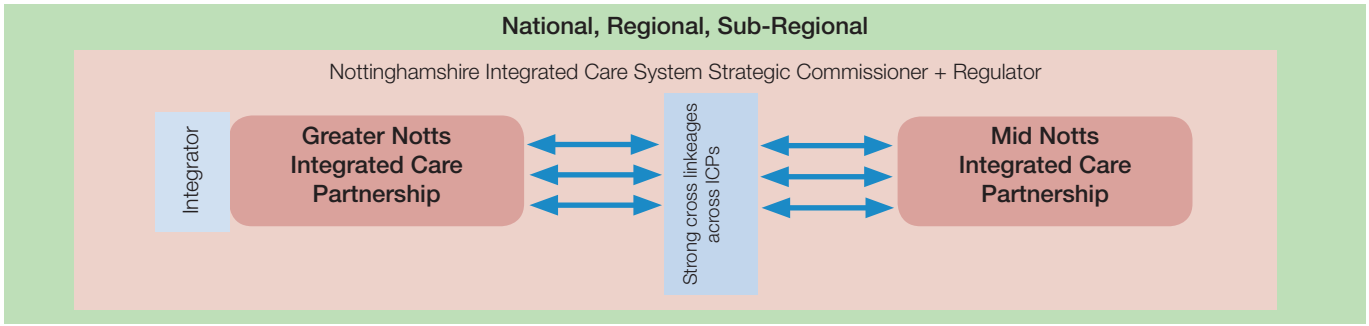

Fig 3: Governance structure for the Greater Nottingham integrated care partnership in relation to the Nottinghamshire integrated care system

What is the approach to financial management and funding?

Commissioners and providers are working to agree a system financial control total across the whole STP, in the first instance. Over time, work will be progressed on developing a population budget, which will take account of the different types of financial risk and where these are best managed, as well as supporting patient-centred care, collaborative working, innovation and financial sustainability.

Work is also underway to understand the cost of managing the integration functions on an ongoing basis, together with detailed work on the transformation funding requirements to both pump-prime and transition fund the acute provider.

The role of primary care

Care delivery groups have been developed based on multi-disciplinary teams serving localities of 30–50,000 people with general practice as the base component, but with social care as an integral part.

The most advanced area is across NHS Rushcliffe CCG. General practice has moved from multiple unconnected practices to accountable, community-based and integrated services at scale, forming 'Partners Health', a limited liability partnership (LLP). A similar LLP has been formed across 47 practices within the Nottingham City area.

To develop a culture of shared accountability, the local CCGs have extended the GP contracts and have been able to agree a contract with Partners Health, focussed on three tiers of service delivery – gateway, core quality and shared outcomes. The contract requires the organisation as a whole (rather than individual practices) to deliver improved management of outpatient demand and prescribing across the local area.

Primary care across Greater Nottingham is supported by 'F12', a comprehensive series of templates and guidelines built directly into primary care clinical IT systems to aid care navigation and pathfinding, provide clinical guidance, and allowing CCGs to monitor referrals. This standardises data inputs and outputs, reduces clinical variation and provides a reminder to clinicians of the up-to-date pathways. An associated database, E-healthscope, then enables practices and clinicians to look at activity down to individual practitioner level. Finally, this is supported by the Nottingham Care Navigator which supports managing urgent care issues and enabling easy communication between consultants and primary care across all specialities.

Acknowledgements

Many thanks to Dr Hugh Porter, chair of NHS Nottingham City CCG and his team for hosting a meeting of the NHSCC Core Cities network in March 2018 and presenting the work being undertaken across the system.

Many thanks also to Rebecca Larder, Greater Nottingham Transformation Programme Director for assistance in the production of this document.

Find out more about the Core Cities Network

The Core Cities Network, chaired by Dr Tim Moorhead, chair of NHS Sheffield CCG and NHSCC board member, is a peer-led network representing clinical commissioning groups from the eight core cities in England outside London – Nottingham, Leeds, Sheffield, Bristol, Newcastle, Birmingham, Liverpool and Manchester. The group meets on a quarterly basis with one purpose: to improve the health outcomes of populations that live in complex city environments.

The network has produced two publications on the role of clinical commissioning groups within the core cities. These can be downloaded from the NHSCC website: www.nhscc.org

- *Shaping healthy cities and economies: The role of clinical commissioning*. This report shows the positive contribution that clinical commissioners are making to their local economies.
- *Transforming healthcare in England's core cities*. This outlines how CCGs in England's core cities are taking up the challenge set out in the Five Year Forward View and transforming the way in which healthcare is delivered to the benefit of their local population.

For further information or to get in contact with the Core Cities Network, please email office@nhscc.org