Integrated Care System
Nottingham & Nottinghamshire

ICS Board Meeting
13 February 2020
Item 6. Enc. D3

South Nottinghamshire Integrated Care Partnership

Our journey and progress so far

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South Notts ICP Convenor

South Notts – our 'place'

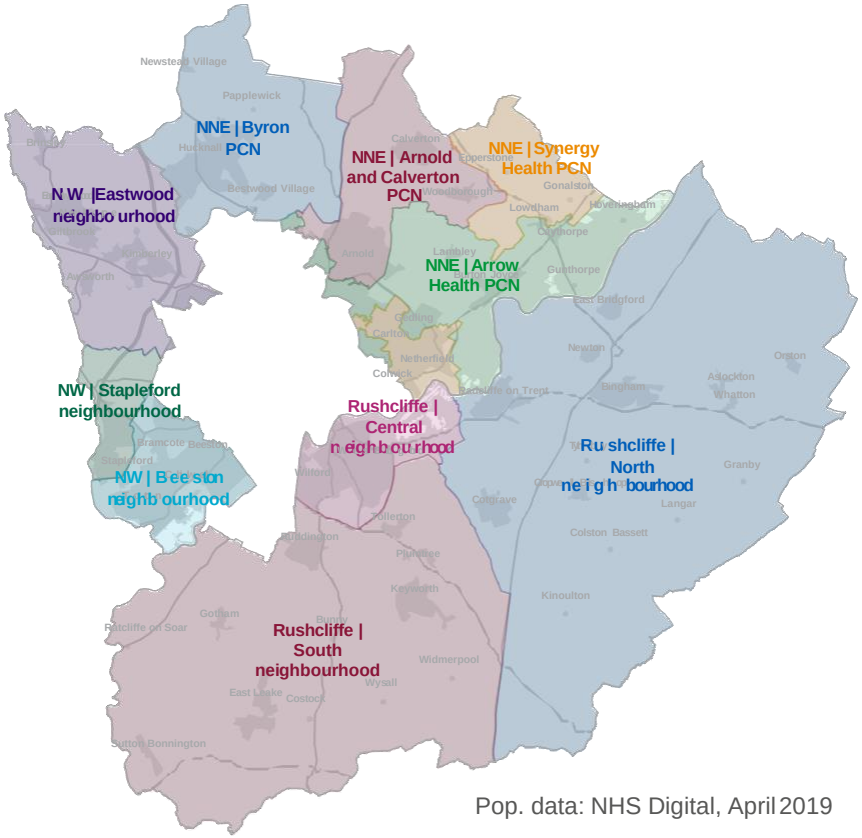
Three localities, population: c375k

Nottingham North & East – 4 PCNs
- Total registered population: 141,257

Nottingham West – 1 PCN
- Total registered population: 106,562

Rushcliffe – 1 PCN
- Total registered population: 128,524

- 1 County Council
- 4 District/Borough Councils
- 1 Acute Trust (NUH)
- 1 Community and MH provider (NHCT)
- 2 GP Federations/Partnerships



Pop. data: NHS Digital, April 2019

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Purpose:	The South Notts Integrated Care Partnership (ICP) brings together providers of health and social care, with commissioning support, to improve quality, cost and outcomes of care for the local population served through delivery of a comprehensive approach to population health management.

The ICP has responsibility for:

Delivery of outcomes for a defined population, deciding how those outcomes will be delivered, incentivising co-ordination and integration, undertaking resource allocation decisions, including supply chain management. The ICP's scope includes health, social care and wider determinants of health.

The ICP's functions include:

Care design, Care co-ordination, Care delivery, Technical infrastructure, Population health management, Financial and contractual management, Stakeholder engagement and management.

Expectations of ICP are:

In time, the ICP will hold outcomes-based contracts for specific populations with elements of capitation and the ICP providers can pool and share risks and benefits.

ICP decision making:

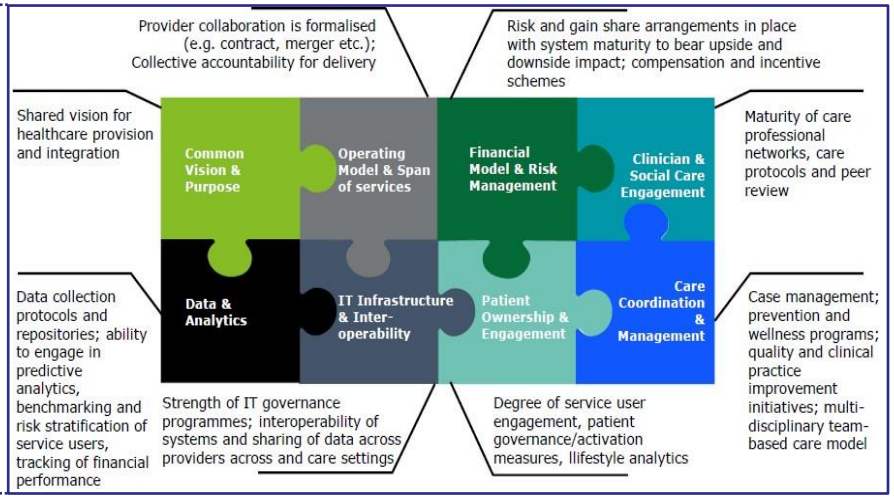
From a practical decision-making perspective, the ICP will decide how care at home, within communities and hospitals will be transformed; allocating resources accordingly, and putting in place a plan to deliver; receiving benefits if it delivers under budget but also bearing risk if targets are not delivered.

ICP Governance:

Governance could take a number of forms e.g. a lead provider or an alliance contract arrangement – it will be for the ICP to identify the appropriate form. The form will need to reflect and enable its role and functional responsibilities and be developed in consultation with the ICP's constituent members and the Strategic Commissioner.

ICP maturity:

Before any 'traditional' commissioner functions are transferred across to ICPs, a process will need to be put in place to assess ICP development and maturity. This will include the ability to sequence and synchronise population health and system improvement. A maturity framework has been confirmed (see figure right).



Information taken from the Nottm/Notts ICS Deloitte work (2018)

Our journey so far…

April 2019
ICP launched and Dr John Brewin appointed as ICP Convenor

July 2019
- First South Notts system-wide stakeholder meeting
- The PCN Directed Enhanced Service starts

July 2019
Six Primary Care Networks and Clinical Directors in place

August 2019
Transformational funding allocated to clinical priorities

November 2019
- Social prescribing starts
- Primary Care Psychological medicine service rolled out across South Notts

November 2019
Joint planning begun with ICP City ICP on the LTP

December 2019
Second system-wide stakeholder meeting – Frailty identified as a priority

January 2020
Dr Nicole Atkinson is announced as Clinical Lead

Our offer and achievements to date

We have improved and rolled out additional services across the ICP and ICS following local vanguard learning:

- **Use of transformational funding** to prioritise investment and roll out at pace
- **Integrated care teams putting the patient at the centre**
- **South Nottinghamshire social prescribing model**, with early plans to develop a Link Worker type role in ED
- **Primary Care Psychological Medicine**
- **GP Enhanced Services** to improve quality and standardisation across primary care using a Population Health Management approach.
- Supporting **PCN development and priority setting**

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Working across the ICPs

We are collaborating with our City ICP partners across the Greater Nottingham footprint to achieve the objectives of the NHS Long Term Plan through:

- Improving management of High Intensity Service Users
- Ensuring consistent and high quality end of life pathways and services across Greater Nottingham
- Developing the community bed model (review of the model and quantification of future bed numbers, and identify where revised care pathways are required)
- Opportunity to focus jointly on frailty (identification, care planning and falls)

Our Integrated Care Teams

- Developed an Integrated Care Teams specification
- Access to the health and care portal which enables greater information sharing across health and social care
- Social Care staff aligned to GP MDTs
- Testing ‘Huddles’ from NHSE Integrated Accelerator Pilot

Case study – Integrated team huddles

JP, a 96 year old female, frequent A&E and hospital attendance for falls

She had fractured her hip after a fall and was in hospital when **her case was brought to a huddle**

Options were discussed with the patient around support post-discharge, including health rehab beds and residential care

Professional opinions from a social care perspective ensured all possible options were explored

JP was well monitored, and the right services were put in place at the right time, despite, in this case, being residential care.

Building on social prescribing success

We've implemented a **fully integrated social** prescribing model across PCNs in South Notts based on learning from the Rushcliffe Let's Live Well model

Funding - PCN DES and TF

> *"It's one of the major big things that helped me to get better. I had never spoken to anyone on that level before or with someone who knows what it feels like."*

> *"Whenever my link worker left I would always feel massively better and like a weight had been lifted off my shoulders. It has taught me how to be compassionate to myself and look after myself."*

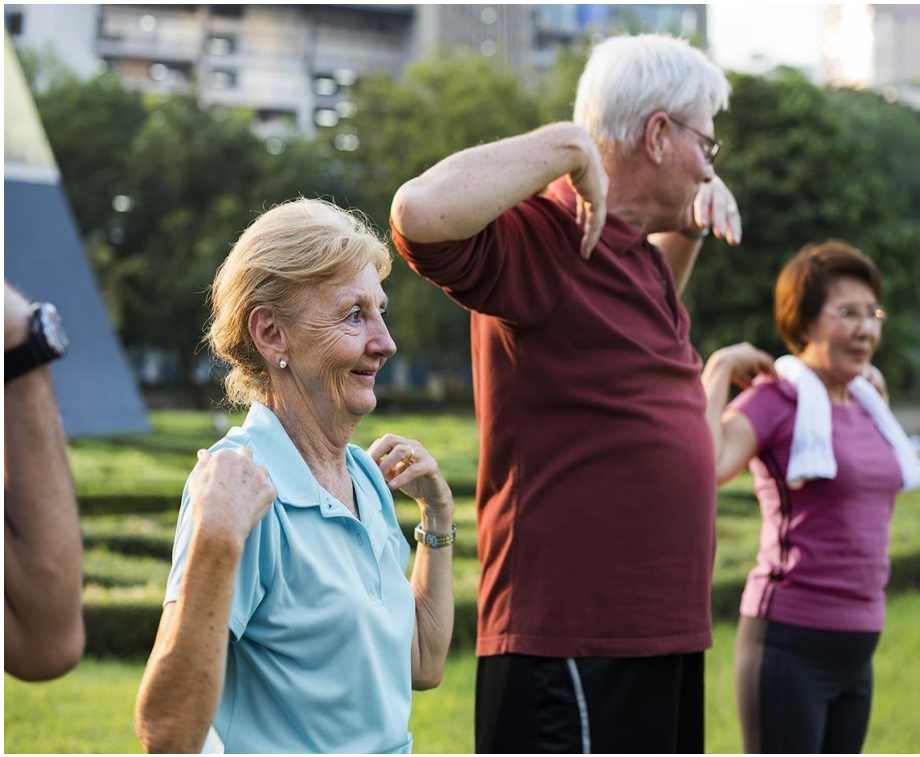
Our social prescribing set up

Building community assets

- Social prescribing Link Workers
- Co-production with local people
- Phased rollout - 100 referrals received

Engaging the community and voluntary sector

- Work with the Districts/Boroughs on community development
- Community involvement plans



Case study: social prescribing

When *Paul injured his knee, the pain was so bad he stopped being active and gained weight.

A knee operation wasn't possible until he lost weight and so his GP referred him to the social prescribing team for support.

They supported Paul to start a weight loss plan. Armed with a food diary and a personalised plan, he was signposted to a walking football group and started working out on a treadmill.

Result

Paul has currently lost just under a stone and a half and the swelling has reduced on his knee, meaning an operation may not even be required.

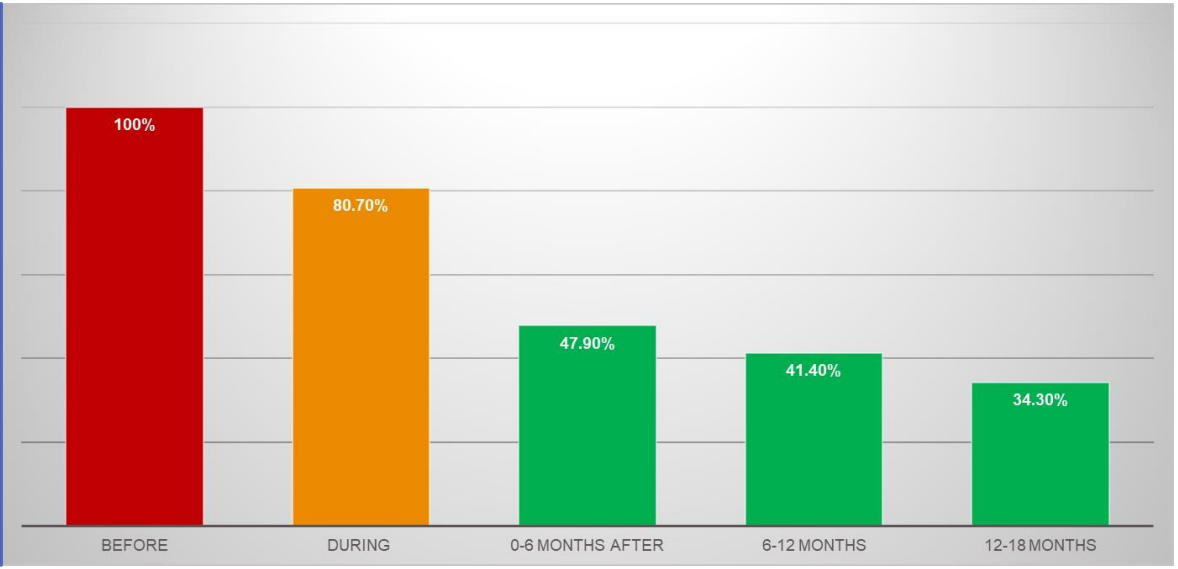
Primary Care Psychological Medicine

- Psychological interventions to people who have high levels of unexplained or persistent physical symptoms of illness. This can mean multiple GP appointments, outpatient visits and emergencies
- Now rolled out across South Nottinghamshire – proposal to extend further across the ICS footprint
- Has made significant impact on secondary care admissions and people's wellbeing.

PCPM: Impact on Secondary Care

- We know that the service has had a significant impact on secondary care with over 30% decrease across admissions, emergency admissions and ED attendance.

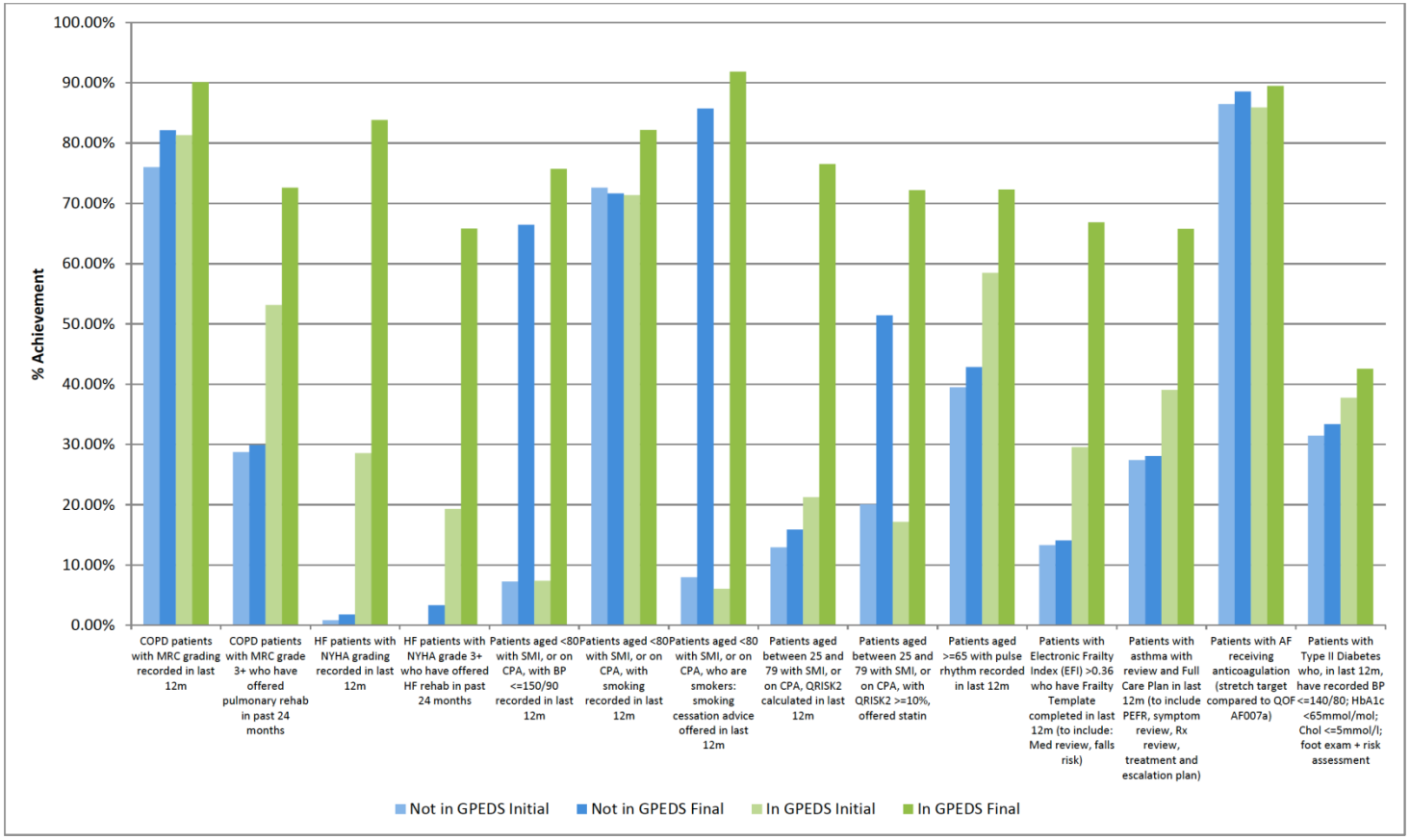
But the evidence also points to sustained impact of intervention for HRG4+ coded activity up to 18 month post discharge



GP Enhanced Services

- Quality scheme for GPs that provides a standard offer and improves care for patients using a Population Health Management approach
- Services developed in South Nottinghamshire and with plans to roll out across the ICS.
- Patients have benefited from improved care management, e.g. for atrial fibrillation, heart failure, COPD and serious mental illness
- Significant potential to deliver care differently across the ICP, through use of data to target interventions at specific populations.

Proven effectiveness



Our PCN development in South Notts

- A South Notts CD network established and met for the first time in November
- PCN Practice Learning Time events held in NNE (Sept) and NW (Nov)
- PCN event for Rushcliffe scheduled for February 2020
- CCG Locality Team aligned to PCNs
- PCN plans on a page completed for all PCNs
- Mapping of community assets – first drafts completed
- Teamnet rolled out across all South Nottinghamshire Practices as enabler for communications and collaboration.
- PCN initial assessment against the maturity matrix completed and work plans in development to address key indicators.

PCN DES contract

DES Contractual Requirements Year 1 19/20	South Notts Status
Practices sign up to DES to enable 100% population coverage of requirements	All 41 practices signed and aligned to 6 PCNs
Clinical directors (CD) identified to lead each PCN	All CDs in place
Extended Hours (additional general practice hours required)	100% coverage achieved
Employment of additional workforce roles: • Social prescribers • Clinical pharmacists	 9 SPs in post 8.5 CPs in post

DES Contractual Requirements Year 2 20/21	South Notts Status
DES Contractual Requirements Year 2 20/21 • Additional roles – First Contact Physiotherapists and Associate Physicians • Service specifications • Impact and investment Fund	 In development Under review Detail awaited

Case study: NW PCN Pharmacists

- An elderly lady, with dementia, was referred to the PCN Pharmacist by a Care Co-Ordinator as she was having issues with medication.
- On review, they found the patient was taking the incorrect dose of their anti-hypertensive medication and their blood pressure wasn't controlled. The patient was taking medication that was no longer prescribed and had also stopped their antianginal and secondary prevention medication.
- The Pharmacist contacted the patient's GP and pharmacy and the prescription was changed. She also contacted the patient's son (carer) and informed him of the new changes.
- Two weeks later, her blood pressure is down and her GP decided to keep her on the same doses due to her age and frailty.

Involving our patients and local people

- South Nottinghamshire virtual groups
- Active GP Practice Patient Participation Groups across the South
- Patient PPG Forums in NNE and Rushcliffe
- Newly formed community engagement group in NW
- Maintain communication through an engagement database
- Engagement event May 2020
- Social media presence planned **@SouthNottsICP**

Case study: Community Engagement

- A patient group working across organisational boundaries by building community assets that will support the population in health, wellbeing and independence.
- Mixed group of individuals, from community leaders, voluntary sector, borough and county council and health representatives located within a PCN
- Aim to embed primary prevention across all service functions, encouraging people to take control of their own health and wellbeing
- Organic and community-led activity – the group have recently bid for places on a National Leadership Programme receive training to help them build better relationships with local communities and ensure that personalised care becomes part of the DNA of the NHS.

Resources to support the ICP

Resource Requirement	Progress	Support
ICP Clinical Lead and team – 7 sessions per week	Recruitment completed for Clinical Lead – additional clinical support recruitment underway	CCG/NHCT
ICP Programme Director	Recruitment under way	CCG/NHCT
ICP launch event - stakeholders	April 2020	All partners
ICP launch event – patients/citizens	May 2020	All partners
Communications and engagement support	On-going	NHCT
Development plan with timelines for implementation	Draft produced	All partners
Joint planning work with City ICP	Joint group established	All partners
South Notts Locality Team move to Trent Bridge House	Move date expected imminently	CCG