Mid-Nottinghamshire Integrated Care Partnership
Creating happier, healthier communities together

MID NOTTS ICP – OPERATING MODEL

Version 1.4

Author David Ainsworth

Co-author Sue Batty

Co-author Keeley Sheldon

An ICP Executive Discussion Paper – Infrastructure, Intelligence, Intervention

An Operating Model to Support Delivery

Introduction

If ICPs are to become delivery units for the single strategic leadership; we must go further than simply identifying our ICP priorities. We should shape the infrastructure to wrap around the identified priority 'places' and to meet the needs of our local communities. This paper sets out a proposed set of constituent parts for the proposed Mid Notts operational model.

The outcome we want is to co-ordinate targeted cohesive interventions at place level, drawing on asset based approaches within agreed priority communities and with consistent components which can be sensitive enough for local determination.

The diagram below sets out a high level vision for our system. The aim is for the majority of people to have their health, social and well-being needs met within their communities and at home where possible. Developing multi agency locality place based working is key to achieving this and making sure people have timely access to the right level of information, advice, preventative options, as well as care and support, to maintain their maximum health, well-being and independence.

This requires a whole system approach to place based working, with Integrated Community Health, Social Care and Housing Teams aligned to the same populations as Primary Care Networks. This core offer, will be the main way to pro-actively work with people who already have, or are at high risk of, developing needs relating to their health, social care or housing.

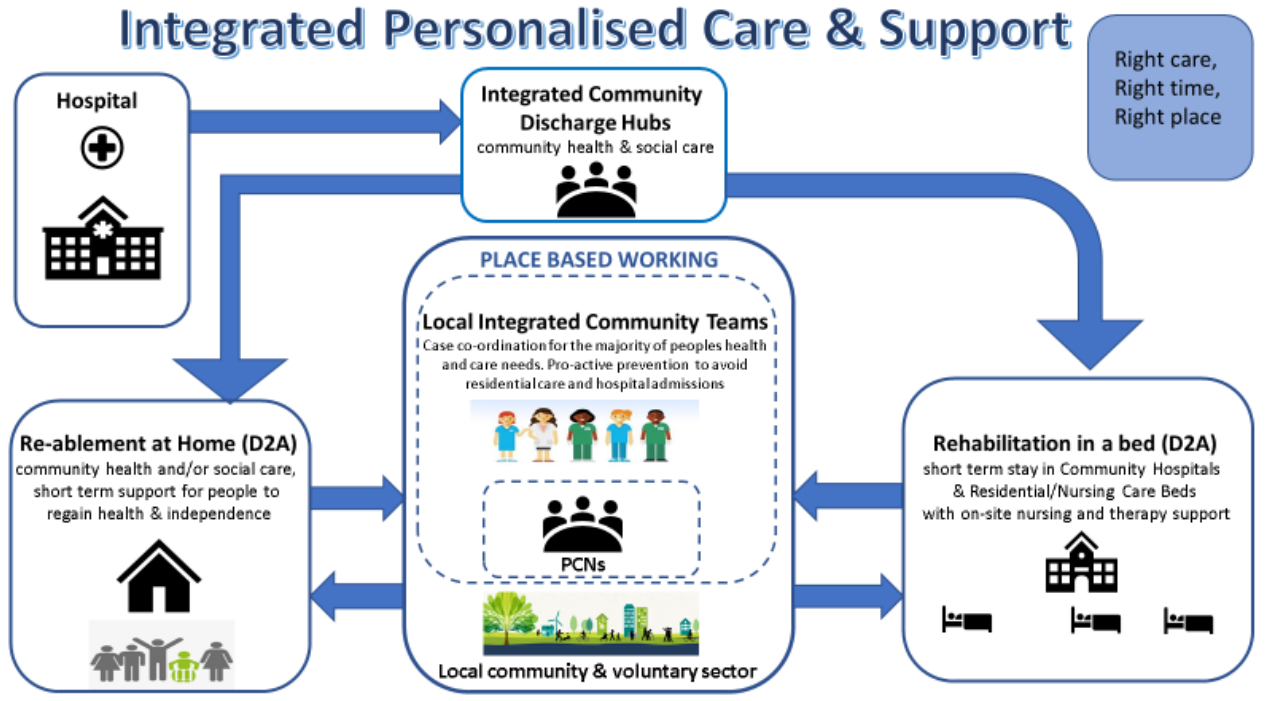
The Integrated Teams will be set within the wider local network of the whole community; local people and volunteers, as well as services. All system partners need to actively support methods of asset based community development to build this. The focus is on supporting people to be engaged citizens and to maximise their health and well-being as part of their day to day lives. People will be supported with the right information and advice to plan for later life and manage their health pro-actively. When people need support there will be clear referral routes into the Integrated Care teams.

Principles of place based working:

- There is no hierarchy, everyone is equal, egos are left at the front door
- All the organisations are linked up and networked. New ones are welcome. The system doesn't have a centre or revolve around one or two organisations.
- All have strengths to bring and challenges they face. Recognising this is key to developing a strong team
- We need to support each other to achieve shared objectives 'We win together, we lose together ethos'
- All organisations work with people and communities in ways that focus on their

strengths and empowers them to maximise their well-being and independence.

People want to have a life and not a service. 'Making It Real' (attached) is a national framework and set of statements that describe what good, people focused, personalised care and support look like from the point of view of people themselves. It is recommended that we adopt these statements and use them ourselves and with our staff, to inspire and motivate us to keep improving what we do.



Population health management and predictive analytics

Recommendation One: Establish an ICP specification to build on and grow the sharing of public sector data and how it will be used within place based networks and integrated care teams

ICP Executive Lead: TBC

GPRCC and e-healthscope information already exists at ICS level to create an intelligence hub for Nottinghamshire. Some primary care, social care and housing information is already being fed into this and analysed. This has been used extensively to identify key groups of people to contact during the Covid Crisis. The data is already available at ICP level as well as by GP practice, district etc.

Population health management will build on this and continue to provide, in new ways, local intelligence by population and communities. It is able to drill down to PCN, practice, disease register and individual person.

The task is to align the development of this information with how it will be used with the wider place based networks so that people get the right input they need at the right time.

There will be opportunities to bring public sector data together for:

- Identifying people in high risk groups to target for appropriate information, advice and social prescribing
- Identifying people much earlier and supporting them to plan for later life/to manage a new long term condition e.g. housing and well-being MOT
- Triggering earlier, more appropriate interventions with people who already have care needs to prevent a crisis
- Predictive modelling of future demand
- Influencing future models of service delivery
- Evidence that the desired outcomes for people are being achieved

Recommendation Two: Establish a virtual joint team and strategy for communication and engagement across the ICP

ICP Executive Lead: TBC

Overarching aim: is for place based networks and integrated care teams to be visible and accessible within their local communities. A joined up approach to communications and engagement is needed. This will cover:

- Communication of key messages locally
- Making it easy and quick to find the information and advice you need in an accessible format through a variety of media, including face-to-face/virtual
- Methods of having routine feedback from local people on their experience of services and for this to be sued to inform continuous improvement
- Engagement and co-production in the development of local communities and their services

Recommendation Three: Developing our Integrated Personalised Care and Support Systems and Teams

ICP Executive Lead: Sue Batty supported by David Ainsworth/Keeley Sheldon

Programme: Developing our Integrated Personalised Care and Support Systems

Overarching Aim – place based Health, Local Authority and community services will work together as a whole system to deliver joined up personalised health, care and community support services in the right place at the right time

Key Objectives

- To support the development of integrated systems where the benefits and outcomes can be evidenced
- To build system and community resilience through working together as integrated community teams and support networks

- To ensure that strength and asset based practice is fully understood and embedded across all local authorities and health services
- To ensure reablement and enablement is effective and available to all who would benefit
- To support people's independence and avoid unnecessary admissions to formal care settings such as care homes and hospital
- To continue the work to develop personalised integrated care and support options, including promotion of Direct Payments, Personal Health Budgets and Personal Assistants

We already have Local Integrated Care Teams (LICTs) in place for older adults health and social care community teams across the county. Broadening the existing integrated teams for Community Health and Ageing Well Community Services in social care to include Living Well social care teams, district councils and voluntary sector.

Existing integrated teams already map to PCNs but have different levels of maturity across Mid Notts and the county as a whole. Some teams have regular attendance from District Local Authority staff and voluntary sector representatives. Some teams are based together in the same office area so can talk to each other easily to build up trust and share information. There are a variety of referral mechanisms, some of which are over complicated. There is differing use of population health data, information to risk stratify people and early intervention/preventative approaches.

None of these arrangements, however, include social care Living Well staff who work with younger adults who have social care needs (learning disabilities, autism, mental health, physical and sensory disabilities). We need to support all these teams to have specialists available locally in each 'Place' and reach the most effective level of joined up working.

From previous evaluation work (Nottingham Trent Uni.) and our experience to date, we know that the best outcomes for people who have complex and multiple needs are delivered when local joined up care is built around individuals. This needs to be personalised and built on the person and their wider networks strengths and assets. There are benefits for people when community health, local authority staff and the voluntary sector work in close partnership with people and their communities. Research shows, however, that key conditions need to be in place to deliver effective integrated working including:

- Shared principles, values and objectives
- Co-location in the same physical space or close alignment so that staff have frequent contact and could have informal contact as well as formal contact in meetings
- High frequency of multi-agency discussions, decisions and when needed, assessment
- Shared access to information systems
- Regular multi-disciplinary team meetings where people can raise cases for discussion and take away actions
- The culture of the team supports people to work well together

For integrated working to be truly successful a culture is needed where:

- There is mutual understanding of roles, trust and respect between all staff
- There is a good understanding of what integration means and how to make decisions in a collective way, supporting each other to take and manage risks appropriately

- All staff involved are skilled, experienced and confident in their roles

Recommendation Four: Developing our local communities and networks

ICP Executive Lead: TBC

- Setting out our strategy for community asset development
- Establishing a wider network of support across; education, parks, police, faith groups, community volunteers etc.
- Establishing relationships across the community network, integrated care teams and PCNs
- Support the wider PCN place based meeting structure and conversations
- Develop the infrastructure under the transformation board to include a children's joint steering group, bringing together opportunities to explore joint commissioning and delivery approaches

Recommended next steps:

- Agree at ICS level a framework for shared objectives, values and common elements of place based integrated community teams
- Revise the Standard Operating Procedure in light of an all age approach and recent learning
- Develop ICP level implementation plans