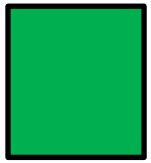
Mid-Nottinghamshire
Integrated Care Partnership

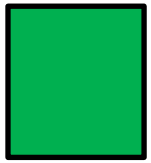
Our vision is simple:
To create happier, healthier communities with the goal of reducing differences in healthy life expectancy (the number of years that people live in good general health) by three years.

The Mid Notts ICP



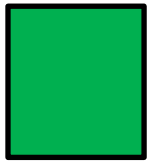
The MN ICP brings together heath, social care, voluntary, community organisations and members of the public to agree, address and deliver on shared priorities which serve our vision. Our focus must be on those areas where the collective endeavor and collaboration add value over and above the work of single unitary bodies or organisations: where the whole is worth more than the sum of its parts.

Our breakthrough objectives for 2020/21 must



- Include the issues which are important to all of us eg to give every child the best start in life
- Include the issues which we are also expected to deliver on eg best value
- **Be SMART (Specific, Measurable, Attainable, Relevant, and Time-Bound)**
- Represent the views of all partners and bind health and care together
- Continue to build trust and provide assurance
- Underpin the conversations at the ICP Board
- Be simple enough for everyone to understand
- Demonstrate our consideration of the planning of services across Mid Notts
- Reflect the overarching aims and objectives of the Nottinghamshire ICS and CCG.

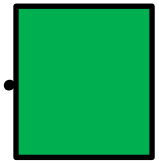
Foundation principles running through each priority



- Partnership working/ shared democracy and ownership
- Establish and strengthen focus on areas of place/ neighbourhoods with specific need AND whole ICP focus
- Culture and inclusion
- Informed by our residents
- Outcomes and financial delivery
- Alignment with recovery and restoration
- Where appropriate, clinically led
- A combination of quick wins and longer term focus.

Response from health and care partners - our 5 priority themes and recommended 19 breakthrough objectives

Our five previously agreed priority themes – a reminder…



1. To give every child the best start in life
2. To promote and encourage healthy choices, improved resilience and social connection
3. To support our population to age well and reduce the gap in healthy life expectancy
4. To maximise opportunities to develop our built environment into healthy places
5. To tackle physical inactivity, by developing our understanding of barriers and motivations.

Overall themes from responses

1. To give every child the best start in life (this will include work on breastfeeding, smoking during pregnancy, domestic abuse, school readiness, healthy eating)

1. Reduce smoking in teenage pregnant girls
2. Increase breastfeeding
3. Increase school readiness
4. Improve mental health access for pregnant women and young families

Full responses (1/3)

1. To give every child the best start in life

- Deliver continuity of care for X% of women in mid notts by March 21
- Increase smoking cessation in pregnancy by 10%
- Increase breastfeeding initiation rates by 10%
- Develop a local maternity programme that reflects the ICS ambition and meets the needs of local families – to include key metrics and outcomes measures that are agreed and monitored as part of a whole system programme
- Increase the uptake of the vaccination programme of pre-school (0 – 5)
- Reduce the number of women smoking during pregnancy (in partnership with your Health, Your Way)
- Support young children with parents requiring support from Link Workers/Social Prescribers to achieve school readiness
- Increase support for victims of domestic abuse. (i.e. provide refuge accommodation)

Full responses (2/3)

1. To give every child the best start in life

- Reduce smoking in pregnancy. Ambition should be to eliminate altogether. This is a main indicator of health inequality. As a SMART objective agree on a percentage reduction from baseline (this data is available in eHealthscope) (MN worse than England average 25.7% v 10.6%)
- Improve rates of breast feeding in Mid Notts. Public awareness, education campaigns and support to mums (MN worse than England average 42.2% v 67.4%)
- Improve access to mental health services (CAMHS). M&A comparatively worse to England average in hospital admissions with self-harm in 10-24 age group.
- Continue the work of Connected Nottinghamshire on digital inclusion (in progress). - Metrics: Number of calls to the Get Connected helpline / number of contacts at digital support hubs / number of digital ambassadors
- Introduce a 'healthier families' recognition and reward initiative – for families to upload their progress in line with a challenge map towards healthier choices in life (rewards: discounts, vouchers, awards etc.
- Provide a localised evidence based offer to those affected by DA
- Introduce a family buddy scheme – families to learn from each other and support each other – can be done within a bubble.

Full responses (3/3)

1. To give every child the best start in life

- Targeted intervention work in priority neighborhoods to improve parenting capacity
- Improve support for children who are receiving social care and/or community pediatric interventions to ensure a holistic and whole child/family approach
- Undertake screening in priority neighborhoods to identify Adverse Childhood Experiences and establish understanding and required interventions
- Children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams. As a system, it is 6,777 in 2019/20, 6,976 in 2020/21, and 7,151 in 2021/22. This needs to be modelled for the ICP.
- Increasing access to evidence-based care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis. There is a system target for 2022/23, but not broken down into individual years nor ICP but I am told, this can be done.

Overall themes from responses

2. To promote and encourage healthy choices, improved resilience and social connection (this will include work on smoking, alcohol, substance misuse, nutrition and healthy eating, sexual health, volunteering, wellbeing@work)

1. Increase access to prevention services (diabetes, alcohol etc)
2. Improve connection with voluntary sector
3. Improve connection with existing programmes (Your Health, Your Way/Wellbeing at Work)

Full responses (1/3)

2. To promote and encourage healthy choices, improved resilience and social connection

- Develop a plan to ensure physical and mental health needs can be met within a single care environment
- Work with voluntary sector to introduce ‘talking benches’
- Introduce farmer’s style markets across the ICP
- Develop and embed respiratory pathways to support health and rehabilitation underpinned by use of technology to enable self care
- Develop and embed effective diabetes pathways to focus on prevention and appropriate care
- Develop and embed MSK pathways focussing on prevention, self care and conservative management with timely access to appropriate care when needed
- Each partner organisation to achieve the next level of Wellbeing @ Work (for ADC from Gold to Platinum)
- Create a place based team, with clear terms of reference, in each identified priority place
- Agree key actions with Your Health, Your Way for delivery of outcomes related to alcohol, smoking, physical activity for 2020/21

Full responses (2/3)

2. To promote and encourage healthy choices, improved resilience and social connection

- Reduce teenage conception rates. Education and improving access to contraceptive services including long acting contraception in the community. Developing services outside traditional health estates. Teenage pregnancy rates are 3 times worse in M&A compared to England (1.9% v 0.6%)
- Improve uptake of National Diabetes Prevention Programme and NHS Health Checks in most deprived neighbourhoods and hard to reach communities.
- Improve access to alcohol and substance misuse treatment and rehab programmes. This would need to be done in conjunction with access to mental health services and linked to existing interventions eg High Volume Service Users.
- Find alternative support that keeps people well so that fewer people attend A&E. Building the effective integration of urgent care across our ICP. (In progress) - Metrics: 1.a. Reduction in A&E attendances with A&E serving the population that needs real emergency care, 1.b. Track demand against activity during the COVID Pandemic to ensure people requiring healthcare are receiving the right care in the right place
- Use population health management to identify which choices are most needed within key communities - Metrics: Increasing demand through community based services.
- Roll out Healthy Lung Check scheme (Due to launch Q4 2021 tbc) - Metrics: At least 50% of people aged between 55 and 74 who have ever smoked in Mansfield and Ashfield would have taken up the invite.
- Ensure all patients (with their permission) who live alone, discharged through the D2A hub are referred to a be-friending service - Metrics: Numbers of referrals and ongoing involvement.
- Start the development of a wellbeing and welfare offer across the ICP – core offer accessible to all partners and the community
- Establish a ‘We are the Community’ toolkit to support and encourage volunteering, social interactions and getting involved with services

Full responses (3/3)

2. To promote and encourage healthy choices, improved resilience and social connection

- Targeted health screening and vaccinations in communities most in need as identified by Mid Notts ICP priority neighborhoods
- Targeted support for those with the most complex needs in our communities including rough sleepers , prison release , care leavers
- Intervention and support for those in poverty including working poverty
- Additional adults and older adults will be able to access NICE-approved IAPT services. As a system, it is 24,119 in 2019/20, 28,434 in 2020/21, and 29,746 in 2021/22. This needs to be modelled for the ICP.

Overall themes from responses

3. To support our population to age well and reduce the gap in healthy life expectancy (this will include work on Carers, housing for the elderly, social isolation, cancer, stroke, respiratory disease, dementia)

1. Improve Care home support including increasing physical activity
2. Improve Dementia support for people with the disease and their carers
3. Strengthen care co-ordination across PCNs
4. Improve frailty pathway and value for money
5. Improve access to cancer and outcomes

Full responses (1/3)

3. To support our population to age well and reduce the gap in healthy life expectancy

- Work with partners and patients to identify the drivers of health inequalities in our locality
- Develop a 3 year plan to address this
- Develop a package to support patient / public activation
- Cancer and elective care – enable early diagnosis, timely access to care and improve health outcomes
- Care homes - develop and sustain a comprehensive framework of support to care homes, to ensure the safety of staff and patients , and enable high quality community based care working across health and social care boundaries
- Develop and embed community based care based on end to end pathways that support our frail and vulnerable population to be cared for outside of the acute hospital– including all elements of 'frailty' and acute admission prevention
- Care Co-ordination: further develop pro-active MDT community health, social care and housing teams for adults and carers of all ages aligned to (and bridging) PCNs and the wider community/volunteer offer.
- Enhance support for Care homes and Homecare. Retain and build on the joint response during Covid and extend similar to homecare providers.
- Develop a joint plan for community asset development, (linked to recovery planning and retaining the benefits of the Community Volunteer Hubs we have via the HAG)
- Develop a Dementia focussed partnership in each District with agreed priorities and actions
- Ensure all older people entitled to flu vaccination are inoculated
- Deliver a programme of physical activity to 3 identified care/residential homes/sheltered accommodation.

Full responses (2/3)

3. To support our population to age well and reduce the gap in healthy life expectancy

- Increase uptake of flu vaccination – more pertinent given covid crisis. Specific interventions to target vulnerable individuals and neighbourhoods.
- Utilise PHM dashboards in PCN: Active case finding of care gaps in the community, being proactive and implementing interventions eg falls prevention, medication reviews, care plans, pulmonary rehab, frailty assessments. It may well be that we aim to identify one or two interventions per PCN based on PHM data.
- Be Clear on Cancer Campaign. As a ICP do we develop a Mid Notts campaign based on principles of national BCOCs?
- Improve frail/elderly pathways and value for money
- Introduce a single Integrated Care Home Model, that incorporates the Ageing Well programme, the national Enhanced Health in Care Homes programme and the Primary Care DES.(In progress) - Metrics: 1. a. Use findings and learning from the Enhanced Care Response Team (ECRT) established in response to the COVID Pandemic to determine the real impact to the residents, care providers and the homes themselves, 1b Evaluation of the impact with the Care Homes, Primary Care and Community Services.
- Expand our End of Life programme into its second phase, developing further a single pathway accessed by patients at any stages of End of Life (In progress) -Metrics: Fewer patients at end of life being supported by multiple providers.
- Embed integrated discharge processes to support rapid discharge so that those leaving hospital have the right care package around them (known as Home First and In progress) -Metrics: Reduction acute admissions and in length of stay, with the model supporting the discharge of patients back to their place of residence and Reduce readmissions.
- Ensure carers are referred to any known 'carer support' groups - Metrics: Numbers of referrals and on-going participation in groups.
- Ensure patients with dementia are referred to known dementia support groups - Metrics: Numbers of referrals and on-going participation in groups.
- Identify any gaps in provision for support for carers living with people with dementia -Metrics: Produce a report that identifies gaps and makes recommendations.
- Introduce a Mid Notts 'Improvement Partner' approach to transform services and our community (based on the new Sherwood initiative-citizens involved in improvement)
- Introduce a three strap line approach to community engagement during Covid-19: Think Welfare, Action Self-Care, Protect our Community

Full responses (3/3)

3. To support our population to age well and reduce the gap in healthy life expectancy

- Workplace health- within partner organisations and businesses.
- Ageing Active – programmes for over 50s, sheltered accommodation, community based groups, gardening with links to social subscribing for isolation – walk and talk etc
- Community Hubs – building on the partnerships that have developed through the work of the Community Hubs delivering support (food parcels, befriending, safe and well- checks etc. particularly in respect of volunteers.
- Hospital discharge and continuity of care in the community e.g activity, social inclusion and healthy choices.
- Develop and implement a community based (integrated neighbourhood care) model that supports our frail and vulnerable population to be cared for outside of the acute hospital – focused on acute admission prevention. Measures could be a reduction in the nights spent away from home in an alternative care setting in the last 12 months of life, a patient reported quality of life / wellbeing measure, Advanced Care Planning usage and achieving choice.
- Develop and implement a support framework to care homes, to be achieved through partnership working between Care Home, health and social care agencies. Measures could be the same as the above as well as a Staff reported wellbeing and training measures.
- Uptake of flu vaccination targeted at vulnerable individuals and neighbourhoods.

Overall themes from responses

4. To maximise opportunities to develop our built environment into healthy places (this will include work on improving housing, greener places, food environment, air quality)

1. Increase virtual consultations and more care in the community
2. Increase referrals to leisure centres
3. Improve utilisation of public estate
4. Improve social housing and access to greener spaces

Full responses (1/2)

4. To maximise opportunities to develop our built environment into healthy places

- Implement three actions that will make the locality a 'greener place to be'
  - Increase physical activity by achieving Green Flag award in % of our parks and open spaces
  - Achieve x standard in x% in the quality of our social housing (i.e. utilisation Better care fund, homelessness and rough sleeping strategy)
  - Develop a clear food environments action plan for each priority place
- Embed remote and virtual consultations as a default option in health services. Reducing congestion, air pollution and reducing carbon foot print. As a SMART measure we will have baseline activity data pre-covid and target a percentage point of all follow ups to be remote/ virtual circa 25-30%. Likewise adopt similar changes in primary care.
- Widen scope of GP Active Referral Scheme in our leisure centres. Open to referrals from other sources eg social care based on need
- Improve use, utilisation and sharing of public estate to reduce investment
- Ensure any care/treatment is provided in community settings rather than hospital settings, where appropriate - Metrics: Number of interactions undertaken outside the hospital setting.
- Climate Action Plan for Mid Notts – led by community CATs – Climate Action Teams.

Full responses (2/2)

4. To maximise opportunities to develop our built environment into healthy places

- Consider health and wellbeing in all planning applications with the aim to supporting good physical and mental health , reducing health inequalities and improving peoples wellbeing
- Engage with charities, community groups, volunteers to work to enhance the local environment
- Pursue funding opportunities that support green and clean.
- Priority areas review and enhance
- Maintain and further reduce congestion and air pollution, using the measure of pre and post COVID activity, by embedding remote and virtual consultations for health services. Pre-COVID was moving to a 30% reduction in face to face OPAs. Can we double this?
- New places – is there an opportunity to tackle a couple of estate / facility issues by identifying 'not fit for purpose' estate of any partner in the ICP and by working collaboratively integrate services into new premises that bring multiple services together on one site. Could this place-based intervention be co-designed with the local population to strengthen community bonds and eliminating poor estate simultaneously. An example of good stewardship?
- Stewardship – can we agree a local procurement strategy for services such as supply's, food, etc as part of becoming anchor institutions. This might be a longer term strategy discussion opposed to the next 12 months.

Overall themes from responses

5. To tackle physical inactivity, by developing our understanding of barriers and motivations (this will include work on leisure centre provision, sports clubs, childhood obesity)

1. Use existing campaigns (Feel Good Families, We Are Undefeatables and Your health, Your Way)
2. Increase physical activity in all breakthrough objectives
3. Better understand the barriers to physical activity

Full responses (1/2)

5. To tackle physical inactivity, by developing our understanding of barriers and motivations

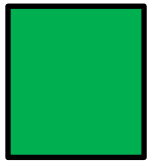
- SFH charity quarterly 5k family friendly series
- Free Virual health seminars / exercise sessions
- Complete the initial phase of physical inactivity behaviours work, understanding barriers to physical activity
- Deliver a programme of activity in each priority place to educate on physical activity and healthy eating to families (in partnership with Your health, Your Way – childhood obesity)
- Increase the take up of the Feel-good families initiative and Club Matters and Active Notts funding support to all sports clubs in Nottinghamshire.
- Physical education and sports in school – Implementing a programme such as 'The Daily Mile' in schools in Mid Notts. Childhood obesity is among worst when compared nationally – 29.5% v 20.1%
- Broaden scope and reach of 'We are Undefeatable' campaign
- Adopt a national programme such as 'Britain in Bloom' to get people active and develop community support

Full responses (2/2)

5. To tackle physical inactivity, by developing our understanding of barriers and motivations

- Focus on improving the physical activity levels of those with Long Term Conditions as part of the We Are Undefeatable campaign with Active Notts.(In progress) - Metrics: A reduction in the number of those who are physically inactive.
- Develop our MSK service into phase 2, an integrated service model across the ICP partners with a single payment model that ensure resources follow the patient. (In progress) - Metrics: Number of appropriate patients with an agreed exercise programme at discharge from the MSK and Have a single payment structure in place.
- Ensure all patients (and their carers) discharged via D2A have the opportunity to agree an activity programme Metrics: Number of patients with an agreed activity programme.
- Introduce a 'healthier families' recognition and reward initiative – for families to upload their progress in line with a challenge map towards healthier choices in life (rewards: discounts, vouchers, awards etc.
- Apply behavioural science to community motivations and behaviours
- Utilise local assets to improve community access to physical activity
- Encourage an approach to health and wellbeing for all ages including gardening , walking and other non-facility based activity.

Our collated 19 recommended breakthrough objectives for 2020/21



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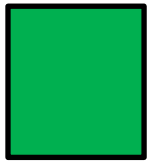
16. Improve social housing and access to greener spaces
17. Use existing campaigns (Feel Good Families, We Are Undefeatables and Your health, Your Way)
18. Increase physical activity in all breakthrough objectives
19. Better understand the barriers to physical activity

Your chance to question and comment



- Do the 5 overarching priorities and 19 breakthrough objectives make sense to you ?
- Are you content with the process followed to identify them?
- Are there any priorities that you think are missing?
- At this stage not all SMART and we deliberately have not said x by y – what are your thoughts on this?
- There are not an equal number of across all five priorities – is this ok?

- Our next steps from now to July Board…