Better in Bassetlaw:
Place Plan 2019-2021

BCVS
Bassetlaw Community and Voluntary Service

Bassetlaw
DISTRICT COUNCIL
North Nottinghamshire

healthwatch
Nottingham & Nottinghamshire

NHS
Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

NHS
Nottinghamshire Healthcare
NHS Foundation Trust

Nottinghamshire
County Council

NHS
Bassetlaw
Clinical Commissioning Group

Bassetlaw
Primary Care Homes

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1. Introduction

This Bassetlaw Place Plan sets out how partners will work together to **deliver improvement in experiences, health and wellbeing for Bassetlaw citizens by 2021, through simpler, integrated, responsive and well understood services.** The Plan describes how we will achieve this ambition through a programme of priority work streams to ensure we are better in Bassetlaw:

Integrated support for the wellbeing of Bassetlaw citizens, including community-based, person-centred approaches, encompassing welfare, housing, social activities, employment and health support

Providing the right support at the right time, through integrated health and care pathways in community and acute settings

Joined-up communications and engagement, using shared approaches and putting Bassetlaw people at the heart of service design

Joint Transport strategy, to better understand community needs, make best use of collective resources and improve efficiency and experience.

Sustainable and effective services, enabled by an integrated workforce, digital and estates infrastructure and making the best use of the Bassetlaw £.

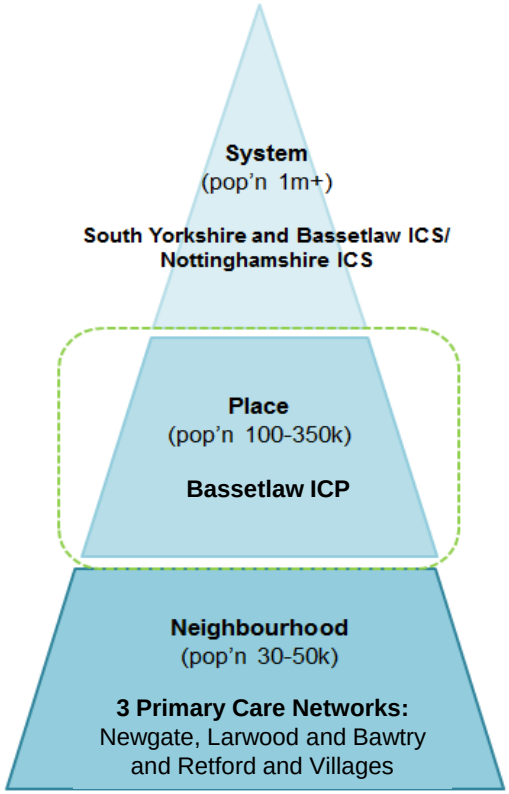
This plan describes the Integrated Care Partnership, how it will use a population management approach, and a collaborative partnership approach to engagement of partners and the public to inform detailed plans. It then describes what the partnership will do, and its measures of success.

Catherine Barn

Director of BCVS, and Chair of Bassetlaw Integrated Care Partnership

2. The Vision for the Bassetlaw Place

This Bassetlaw Place Plan is the document which sets out the vision for the Bassetlaw Integrated Care Partnership (ICP). **The ICP will deliver improvement in experiences, health and wellbeing for Bassetlaw citizens by 2021, through simpler, integrated, responsive and well understood services which ensure people get the right support at the right time.** This will support local people to stay well in their own homes and communities.



Health improvement populations

The ICP in Bassetlaw is a partnership of chief executives and senior leaders from BCVS, Bassetlaw District Council, Bassetlaw NHS CCG, Doncaster and Bassetlaw Hospitals NHS Trust, Healthwatch, Nottinghamshire County Council, Nottinghamshire Healthcare NHS Foundation Trust and three Primary Care Networks.

Underpinned by a memorandum of understanding, through the ICP the Board support the district's three Primary Care Networks, overseeing the performance of the partnership, and enabling developments and strategy best delivered at place level, for all Bassetlaw's 116,000 residents. Primary Care Networks seek to link staff from general practice, community-based services, hospitals, mental health services, social care and voluntary organisations to deliver joined-up care for populations of approximately 30,000-50,000. In Bassetlaw, there are 3 Primary Care Networks:

- Retford and Villages;
- Newgate;
- Larwood and Bawtry.

The ICP also locates place-based developments within the South Yorkshire and Bassetlaw shadow Integrated Care System (sICS) which brings together the partners that plan and deliver health and care services from across Bassetlaw, Doncaster, Rotherham, Barnsley and Sheffield, and the Nottinghamshire Sustainability and Transformation Partnership. This Place Plan sets out the strategic direction for the ICP in Bassetlaw, and focuses on priorities most appropriately led at place level.

3. Integrated Care Systems and Bassetlaw

Bassetlaw's unique geography means that it spans two Integrated Care System footprints – South Yorkshire and Bassetlaw, and Nottinghamshire.

South Yorkshire and Bassetlaw ICS

The Bassetlaw Place

Nottinghamshire ICS

As described on page 11, as part of the two integrated care systems, and working with its three primary care networks, the Bassetlaw place has identifies the priorities that will support delivery of the ICP's strategic objectives which are:

- To reduce health and wellbeing inequalities;
- To improve health and wellbeing outcomes;
- Secure sustainable and effective services, and;
- To support independence and people's personal goals.

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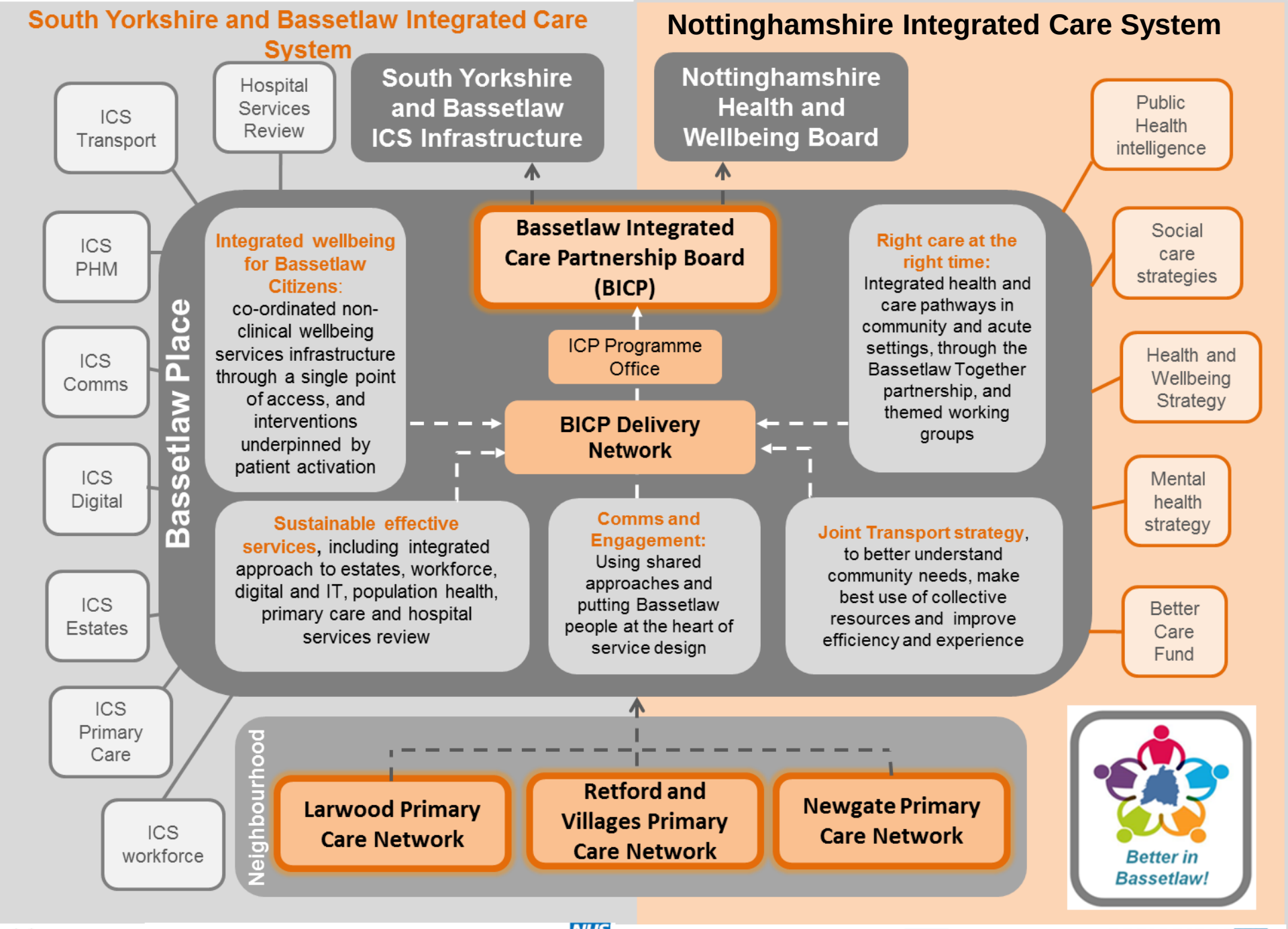
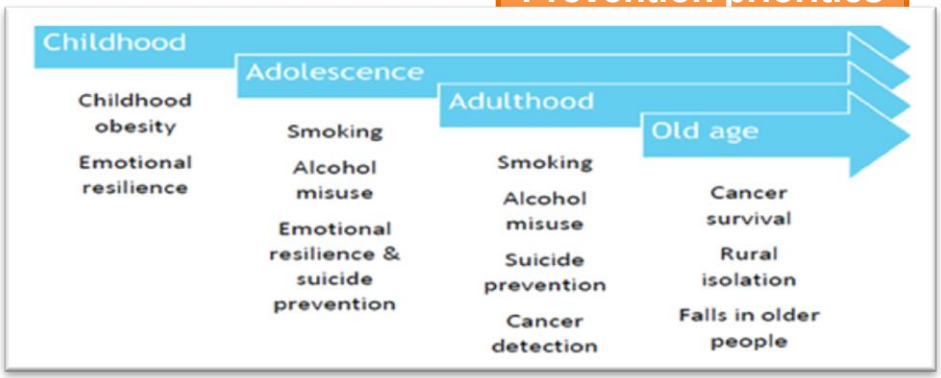

South Yorkshire and Bassetlaw Integrated Care System
Nottinghamshire Integrated Care System
ICS Transport
Hospital Services Review
South Yorkshire and Bassetlaw ICS Infrastructure
Nottinghamshire Health and Wellbeing Board
Public Health intelligence
ICS PHM
Social care strategies
ICS Comms
Health and Wellbeing Strategy
ICS Digital
Mental health strategy
ICS Estates
Better Care Fund
ICS Primary Care
ICS workforce
Bassetlaw Place
Integrated wellbeing for Bassetlaw Citizens: co-ordinated non-clinical wellbeing services infrastructure through a single point of access, and interventions underpinned by patient activation
Bassetlaw Integrated Care Partnership Board (BICP)
ICP Programme Office
BICP Delivery Network
Right care at the right time: Integrated health and care pathways in community and acute settings, through the Bassetlaw Together partnership, and themed working groups
Sustainable effective services, including integrated approach to estates, workforce, digital and IT, population health, primary care and hospital services review
Comms and Engagement: Using shared approaches and putting Bassetlaw people at the heart of service design
Joint Transport strategy, to better understand community needs, make best use of collective resources and improve efficiency and experience
Neighbourhood
Larwood Primary Care Network
Retford and Villages Primary Care Network
Newgate Primary Care Network
Better in Bassetlaw!

4. Population Health Management

Bassetlaw takes a population health improvement approach. **Population Health** refers to improving the health of an entire population, improving the physical and mental health outcomes and wellbeing of people, whilst reducing health inequalities within and across a defined population. It includes action to reduce the occurrence of ill-health, including addressing wider determinants of health. This involves three interdependent pillars:

- **Infrastructure:** the structure of the Bassetlaw Integrated Care Partnership (ICP) (described on page 9), and a collaborative partnership approach (see page 14) ensures that partners are involved, and support and challenge each other, in all elements of population health improvement;
- **Intelligence:** Partners collate their insights and data at place and primary care networks levels, and by population, to form a collective understanding of the needs of Bassetlaw people;
- **Interventions:** Interventions are planned and analysed using a population segmentation approach.

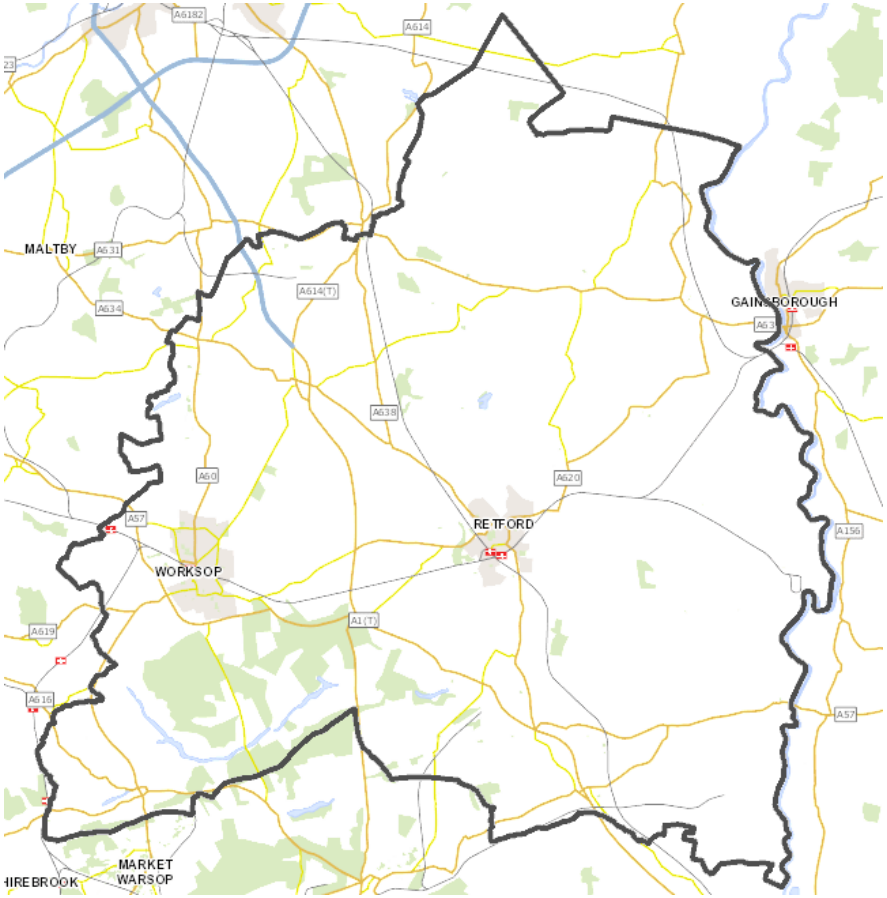
Prevention priorities



Population needs

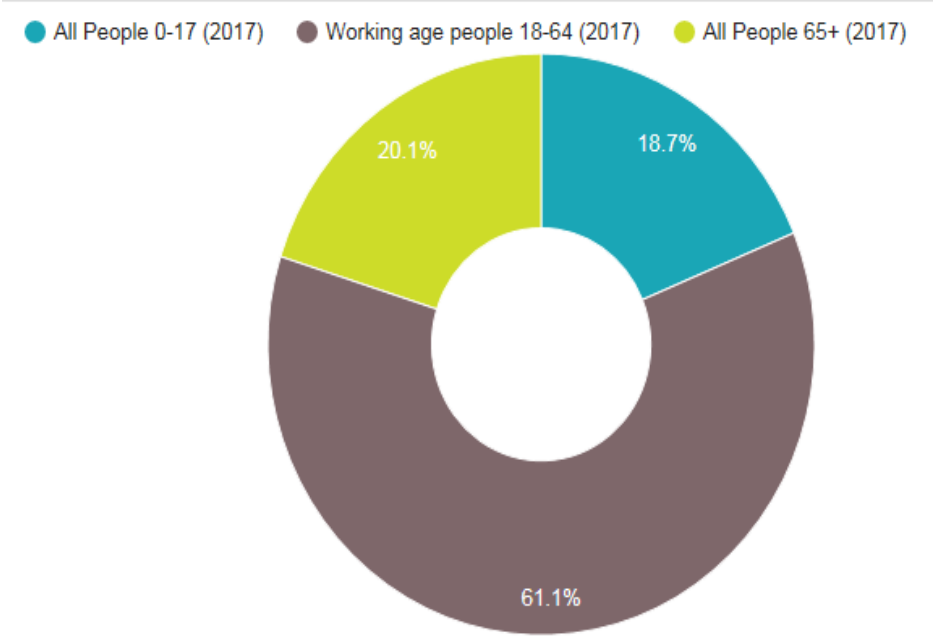
- Alcohol-related hospital admissions are above the national average, particularly for women
- 9% of reception year children (and 20.6% of year 6 children) locally are classified as obese
- No. of patients living with dementia expected to increase by 20% between 2015-21: dementia is the leading cause of death in women nationally
- Bassetlaw has higher incident rates of depression, hypertension, obesity, dementia, CKD compared with regional or national rates
- 33% of Bassetlaw population have at least 1 long term condition – 13% have at least 3
- Smoking prevalence in Bassetlaw above 20% compared to the national average of 18.4%
- In young people mental health problems (e.g. depression, anxiety) and substance misuse now account for 1/3rd all ill health
- Bassetlaw life expectancy is below regional and national average for both men and women
- Nationally, number of people with diabetes expected to increase by 1million to 5million by 2035 – Bassetlaw has a high incidence of recorded diabetes
- The % of people diagnosed with cancer and still alive a year later is lower than national average (breast, lung, colorectal)
- Bassetlaw has higher % of over 80yr olds than footprint average: nationally, people can on average expect to live to about 63yrs in good health

5. About Bassetlaw



With a population of approximately 116,300, Bassetlaw has a higher birth rate than the average for the county (63.9 per 1000 women, compared to 51.6).

Crime rates and educational achievement are comparable to the wider county, however there are a higher proportion of people living with a long term limiting condition (21.8% compared to 20.32%), and in social rented accommodation (12.9% compared to 9.3%) than in the rest of Nottinghamshire.



Bassetlaw is located as the northernmost district in the county of Nottinghamshire. Median earnings for Bassetlaw people are lower than for the wider county, at £458.70 a week, compared to £494.90 for Nottinghamshire.

Bassetlaw citizens benefit from excellent primary care services, a vibrant voluntary and community sector, 'good' children's services and schools and an established social prescribing offer. Local people have on average a higher happiness score, and for feeling satisfied with life than either the East Midlands or national average (ONS 2012-2015).

However, Bassetlaw people experience lower life expectancy than for people in the wider East Midlands (78.8 compared to 79.3 for males, and 81.8 compared to 82.9 for females). The numbers of people who view their own health as 'very bad' is high. Incidence of excess weight in Bassetlaw children is too high, with almost 9% of reception year children (and 20.6% of year 6 children) locally are classified as obese.

Compared to other areas, emergency admissions are high. National data identified that 2-16% of all older people experience regular loneliness which increases to approximately 50% in the over 80s, although loneliness can be experienced at any age – with a large elderly population and many rural communities, social isolation where this results in loneliness is a concern in Bassetlaw.

Smoking prevalence in Bassetlaw is 19.6% (2017) compared to the national average of 14.9%. Alcohol-related hospital admissions in Bassetlaw are above the national average. The percentage of people diagnosed with any form of cancer who are still alive a year later is also low (67.9% compared to 69.6% nationally).

There are also significant inequalities within the district. For example, life expectancy for a female born in Worksop South East ward (77.4 years) is almost 9 years less than for a female born in East Markham ward (86.3 years). Over 48% of households Sutton are economically inactive, compared to 24% in Worksop North ward, and 12.7% of people in Sutton have their day to day activities limited by long term health conditions, compared to only 8.6% in East Retford West ward.

The local population is increasing, nationally demand and expectations of health and care services are rising whilst there are reduced financial resources for public services. Much has been achieved in Bassetlaw but there is more to do.

6. Journey and Challenge

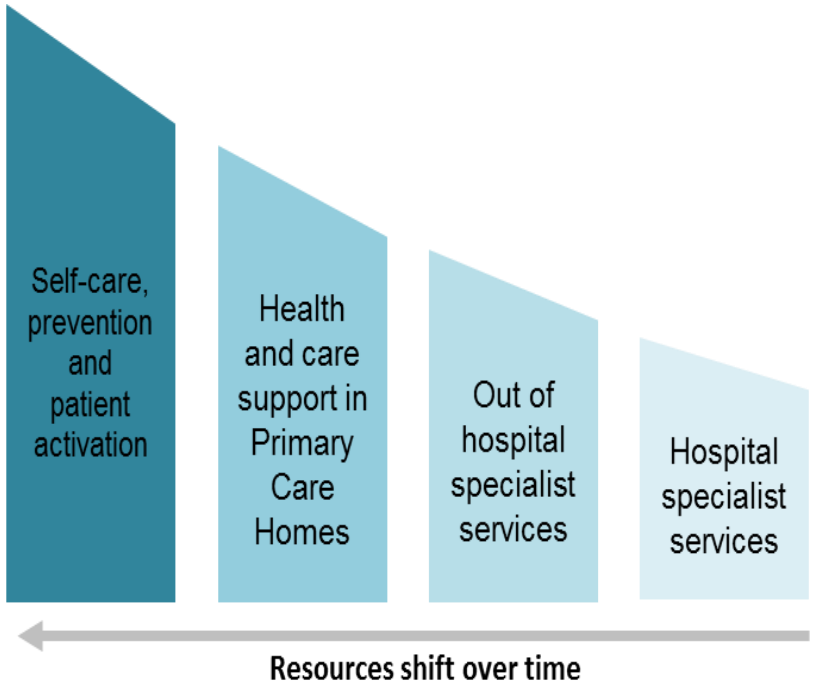
Bassetlaw integration journey began in 2013 when partners began working together, sharing strategic plans, service priorities and cross-sector programs through the Bassetlaw Integrated Care Board. In 2015, the NHS Five Year Forward View in 2015 then set a clear vision for the NHS, underpinned by strong collaboration across health and care systems and the necessity to develop new models of care. Bassetlaw responded to this through the establishment of social prescribing, three primary care networks and a range of integration initiatives, followed by the creation of the Accountable Care Partnership Board in 2016. The joint commitment, aligned plans and clear vision has successfully driven forward a number of service improvements that have improved outcomes and experience for local. These include:

- Innovation through primary care networks, including pharmacy in care networks, teenage counselling and engagement with schools;
- Integrated community health and social care teams aligned to primary care networks;
- Further integration of hospital discharge teams to include community services, and covering weekends;
- Development of interoperable information sharing systems between Bassetlaw Hospital and social care.

However, there remains more to do, and new challenges are emerging. The Bassetlaw population is projected to increase by just over 2% to 2021. Population growth in the over 65's is an estimated 10.6% between 2016 and 2021. The number of people over 65 with living with dementia is anticipated to increase by 20% between 2015 and 2021. The number of patients with a long term limiting illness is projected to increase by 20.8% between 2015 and 2025.

All statutory partners within Bassetlaw, including the CCG, County and District Councils, and the community acute NHS providers are subject to finite financial envelopes with which to respond to increase in expected demand for health and care services

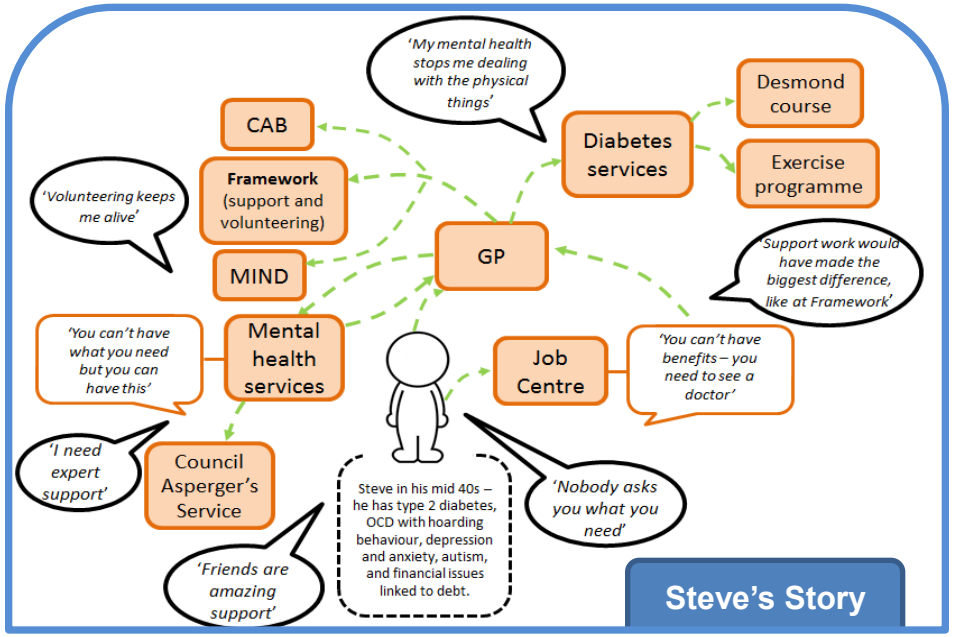
Our collective challenge is to identify how we work differently and better together so that Bassetlaw people get the right support at the right time, so that we improve health and wellbeing, and make best possible use of the Bassetlaw £.

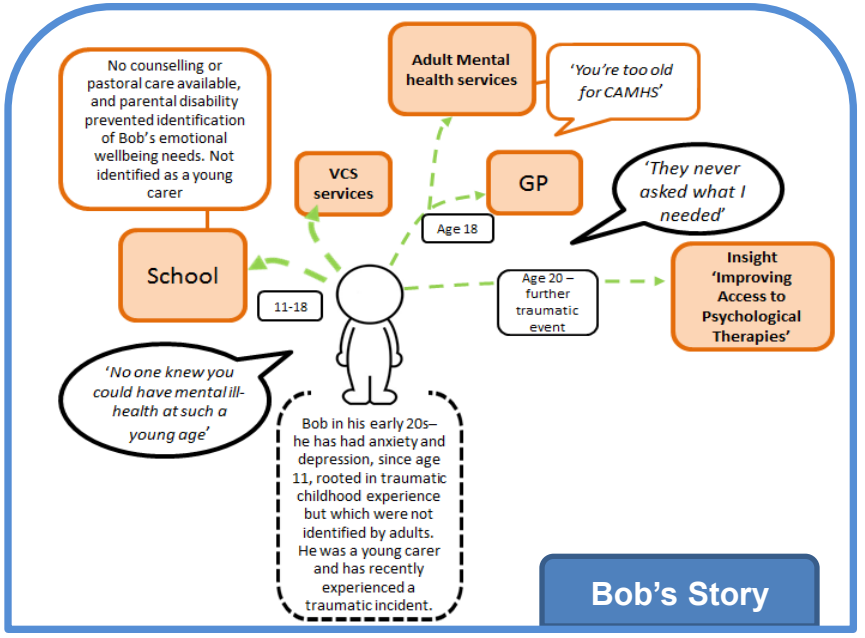


7. Bassetlaw ICP Priorities

The ICP priorities are those identified by Bassetlaw partners as those where by working across NHS, local government and voluntary sectors and beyond, the greatest impact on the ambitions for healthy individuals families and communities can be achieved, that would not be possible without such collaboration. This will realise the vision for the Bassetlaw place, to **deliver improvement in experiences, health and wellbeing for Bassetlaw citizens by 2021, through simpler, integrated, responsive and well understood services which ensure people get the right support at the right time.** Using the lived experience of Bassetlaw people, partners are working together on shared projects and initiatives on the following priorities:

- **Integrated support for the wellbeing of Bassetlaw citizens**, including community-based, person-centred approaches, encompassing welfare, housing, social activities, employment and health support
- **Providing the right support at the right time**, through integrated health and care pathways
- **Joined-up communications and engagement**, using shared approaches and putting Bassetlaw people at the heart of service design
- **Joint Transport strategy**, to better understand community needs, make best use of collective resources and improve efficiency and experience
- **Sustainable and effective services** enabled by an integrated workforce, digital and estates infrastructure and making the best use of the Bassetlaw £.





8. Reducing health and wellbeing inequalities

To reduce health and wellbeing inequalities Bassetlaw's primary care networks and all ICP partners will seek to:

- Enable integrated service delivery, targeted in areas of highest need, ensuring all partners are trained and skilled in supporting those hardest to engage, and with the poorest outcomes;
- Reduce difference in healthy life expectancy by targeting support with self-care/ patient activation with segments of the population with the poorest health and wellbeing, including diabetes;
- Reduce disadvantages faced by rural communities, particularly those experiencing economic deprivation, housing issues and poor transport links, to improve equality of access to services through transport initiatives;
- Identify communities and individuals where loneliness and isolation is a particular factor, and targeting of schemes and interventions;
- Support and enable engagement and communications with target populations and communities;
- Work together to explore and address local inequality issues, such as rurality, social isolation and transport;
- Identify and implement opportunities to use digital solutions to improve access and engagement with prevention, early intervention and cancer detection, and other health and care services, in particular for communities most likely to experience poor health, including with children.
- Enable employment initiatives which support people into work to tackle disadvantages caused by worklessness to individuals and communities;
- Design public spaces and buildings which meet the needs of different communities, and which encourage healthy behaviours.

Indicators of success

The gap in under 75 standardised mortality ratios for deaths from circulatory, respiratory and coronary heart disease between the best and worst performing wards closes

The percentage of children living in out of work families, and childhood obesity, reduces

More people with long term conditions are supported back in to work

The number of 'healthy options takeaways' in target communities increases;

9. Improving health and wellbeing

Indicators of success

The number of people participating in sport and physical activity increases

More people benefitting from person-centred care and identifying improvements in their health, using patient activation measures

Improved cancer prevention, waits and survival

Fewer suicides, and better mental ill-health prevention

To improve the health and wellbeing Bassetlaw's primary care networks and all ICP partners will seek to :

- Enable local, accessible integrated health and care services which provide the right support at the right time;
- Create a shared workforce strategy approach and practice model, underpinned by person-centred care and patient activation;
- Support better self-care and emotional resilience so that risky health behaviours are reduced across the life course;
- Improve access to services through transport initiatives, targeted at communities with poor health outcomes and transport links
- Reduce the impact of loneliness on poor mental and physical health through increasing social capital and contact for the most isolated, including through social prescribing;
- Communicate the shared service offer and developments across partners so all services and practitioners are aware of the spectrum of services available, and people use the most appropriate service for their needs, including social prescribing and non-clinical sources of support.
- Enable engagement with the public that shapes commissioning and design of health and care services;
- Commission creatively to manage demand, including for crisis, emergency and intermediate care.
- Developing interoperable recording systems to support all agencies to give the right support at the right time with the right information to inform effective decision making.
- Enabling Bassetlaw people to have access to information and support where they are, such as via online services.

10. Sustainable, Effective Services

To enable sustainable and effective services the ICP will seek to :

- Understand how the Bassetlaw £ is spent, and plan for future services better together;
- Build health improvement into all policies;
- Link effectively to the ICS, and influence transformation approaches in the best interests of Bassetlaw;
- Enable integrated delivery, provision and commissioning of services which reduce duplication and increase efficiency, by optimising the sharing of functions, people and resources, including sharing care records with permission;
- Reduce preventable demand for health services in the medium to longer term through early intervention and patient activation;
- Support more cost effective, sustainable and fair transport availability in communities;
- Secure a sufficient workforce, with a diverse skill mix that offers best value for the Bassetlaw £, and high quality services.
- Enable engagement with the public that shapes commissioning and design of health and care services that are responsive to local needs.
- Reduce administrative burden, inefficiency and preventable hospital stays caused by insufficient interoperability and lack of shared care records
- Make best use of public buildings, reducing duplication, and sharing resources
- Improved wellbeing at work offer across partners and through local employers
- Increased joint commissioning across local government and health sectors.

Indicators of success

More efficient workforce, with improved staff experience and better recruitment and retention

The rise in Accident and Emergency attendances is reduced

Improved information sharing and value for money

Reduced smoking prevalence

11. Supporting people to stay independent for longer, and supporting their personal goals

Indicators of success

Reduction in falls and hip fractures

Low levels of delayed transfer of care from hospital, with people receiving personalised support to remain independent

Increased self-care and prevention with a reduction in demand for long term social care services

Reduced delayed transfers of care from hospital

To people to stay well and independent for longer, Bassetlaw's primary care networks and all ICP partners will seek to:

- Enable local, accessible integrated health and care services which provide the right support at the right time, to prevent escalation of needs and early intervention where support is required
- Supporting better self-care and emotional resilience so that more challenging health and care issues are delayed or prevented, enabling people to live well for longer.
- Reduce delayed transfers of care, and ensure appropriate support packages are in place to prevent re-admission;
- Reduce the demand burden on health and care services from loneliness and isolation through increasing social capital and contact for the most isolated
- Ensuring the workforce is trained and skilled in prevention and early intervention, including patient activation, to support people to stay well at home for longer
- Identifying and implementing opportunities to use digital solutions to improve access and engagement with prevention, early intervention and other health and care services, in particular for communities most likely to experience poor health.
- Work together to address housing issues, and prevent falls
- Increase the use of personal budgets;
- Embed person-centred care as an approach across partners
- Develop effective intermediate care provision
- Working jointly to optimise the potential of investments via the Better Care Fund.

12. Collaborative Partnership Model

The ICP has endorsed the use of a collaborative partnership model, developed by one of its partners, Nottinghamshire Healthcare NHS Foundation Trust, working with the King's Fund. The model sets out our ambition to work collaboratively with our communities, our staff and our partners to develop and change services. It outlines the principles and processes so we can work successfully together. We will use all our skills, knowledge, experience and learning to develop the best services possible within the finances available. The model sets out the principles for partnership working in Bassetlaw.

The partnership will:

- Listen to and understand others' views and agendas
- Build mutual trust and respect
- Work in a way that emphasises dialogue rather than debate
- Think, talk, plan and reflect together
- Be open, honest and clear on the scope and purpose of the service change and what people can influence and how and by whom and by when decisions will be made.
- Make communications simple, accessible and inclusive
- Ensure the partnership will actively listen to the views of the communities we serve and represent those voices in its decision making

Better in Bassetlaw: Place Plan 2019-2021

Approved by Bassetlaw Integrated Care Partnership, February 2019

For more information, visit: **www.betterinbassetlaw.co.uk**

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