Mid-Nottinghamshire
Place-Based Partnership

PBP Forum Meeting
17th November 2022

Highlight reports for sub-groups of the Mid Notts Place Based Partnership (PBP) for the period January – July 2022:

- The Mid Notts Partnership
- The Mid Notts Health Inequalities Oversight Group

Leanne Monger
Deputy Locality Director – Mid Notts
NHS Nottingham and Nottinghamshire

NHS
Nottingham and Nottinghamshire

PLAN ON A PAGE – DRAFT MID NOTTS PBP GOVERNANCE STRUCTURE

Mid-Nottinghamshire Place-Based Partnership

System Architecture

N&N ICS

N&N ICB

N&N ICP

Notts H&WB

Community Engagement Forums

Citizen Intelligence Advisory Group

Engagement Practitioners Forum

CVS Alliance (e.g. PPE Contract Delivery which includes development of general practice PPGs)

Associate Membership

Scheme of Delegation/MoU

Ongoing Place participation in ICB Workstreams and programmes

ICP Strategy

JSNA/H&WB Strategy

Mid Notts Place Based Partnership Forum

Mid Notts PBP Executive Group

Mid Notts PBP Operational Leadership Team

Sub- groups of the Place Based Partnership focussed on delivery of place priorities

MN Communication and Engagement Group

MN Partnership

MN Health Inequalities Oversight Group

Integrated Delivery Models/Programmes of work

PCN Development

Mid Notts Clinical Directors / PCN Leads

Ashfield – Place Board and H&W Partnership

Mansfield - Place Board and H&W Partnership

Newark and Sherwood – Place Board and H&W Partnership

6 x Primary Care Networks (Ashfield North, Ashfield South, Mansfield North, Rosewood, Newark and Sherwood)

Provider 'Focussed Delivery'

Provider Collaborative(s) at Place

Provider Collaborative(s) at Scale

Enabling Infrastructure

Mid Notts Place Team

Combines designated centralised and mid Notts locality team NNICB staff resources with the PBP programme team – creating a dedicated Mid Notts Place Team, with PMO and transformation skills, capabilities and experience

Mid-Nottinghamshire
Place-Based Partnership

Mid Notts Partnership

Mid Notts Partnership Highlight Report (January – July 2022)

Mid-Nottinghamshire Place-Based Partnership

Chair/ Vice Chair : Leanne Monger. Deputy Locality Director and Diane Carter, Clinical Integrator
Supported by: Olivia Riley, Service Transformation Co-Ordinator

Purpose of group:

An information sharing and operational delivery group made up of partners within the Mid Notts Place Based Partnership (PBP) and wider Nottingham and Nottinghamshire Integrated Care System (ICS), which focuses on supporting partnership working across six Primary Care Networks and three Health and Wellbeing Partnerships in Mid Notts (Ashfield, Mansfield and Newark & Sherwood) seeking to integrate and improve access to services, quality and experience, address wider determinants of health and deliver the PBP vision and objectives through place based working and shared learning.

Membership: Membership Log available.
This continues to be a well attended and a growing partnership and collaborative network of Health, Social Care, Local Authorities, Voluntary Community and Social Enterprise (VCSE) Organisations, Healthwatch and wider partners and patient/public representatives.

Meeting Frequency:
Monthly

Case studies reviewed:

- ICS Patient Story – MSK Together (Jane Ferreira, Head of MSK Together, Mid Notts ICP)
- Bellamy Estate – Helping Residents Register with GP practice (Lesley Watkins, Mansfield CVS)
- End of Life – (Jane Hildreth, N&S CVS)
- Health and Wellbeing – Male citizen access to services (Sharron Reynolds, Chief Executive Officer, Ladybrook Enterprises Ltd)

Guest Speakers:

- **Your Time Is Now project** (Emma Cross, Care4Notts) funded by Prince's Trust to support 75 young people to access employment and apprenticeships in health and social care.
- **Helping Mid-Notts with Employment** (Judith Badger, South Yorkshire Housing Association) Individual placement support model with no exclusion criteria. Support people with multiple barriers to find work, provide counselling sessions and advice.

Sharing of information / service improvement:

- Health and Wellbeing Pop Ups and Roadshows design/delivery/timetable in Mid Notts
- Updates on CVS lead projects and Alliance PPE contract delivery and outcomes
- PPG development, planning and recruitment
- Community services transformation programme – design/themes/action plans/community conversations
- Updates from Healthwatch on GP access and dentistry care
- Launch of Self Help UK projects and promotion in Mid Notts
- Living Well team updates - new strength based/person centred approaches learning and improvement journey
- New connect service referral form and outcomes– Age UK
- Updates from Citizens Advice re outreach and financial inclusion projects (one project reported over 800 PIP forms completed with over £500k reclaimed)
- N&S CVS – Butterfly project (EOL) and how to refer
- NHSEI and Priority places work i.e.. Bellamy estate
- Good Moves project and referral pathways in partnership with Active Notts
- Food clubs / groups – raising awareness / reviewing numbers presenting
- Review of general practice websites re registration access and improvements
- Provide content for the ICS engagement bulletin and PBP Place news
- Contribute to event planning i.e. event held for hate crime awareness
- Social Prescribing Link Worker based in ED – update on pilot/discuss evaluation
- Updates from Care Navigators re MDTs and how to link in
- Men in the Shed project update

Planned Activity

Activity and guest speakers is driven and co-produced by the partnership based on immediate and presenting needs of our population and shared learning across Mid Notts Place.

Emerging themes are partnership approaches to address issues around transport, cost of living crisis (completion of PIP forms), volunteer recruitment and staff wellbeing.

Coming up on forward plan:

- Citizens Advice – annual Impact report
- Advice on prescription pilot learning
- State of sector survey
- Local area coordinators

Quotes from colleagues about the Mid Notts Partnership

Mid-Nottinghamshire
Place-Based Partnership

"A great meeting to communicate and share with each other, working in a Place based way. We are all busy and stretched and this group helps you to see all the bits of the jigsaw – helping us to make a difference to those we serve through a coordinated approach"
Iris Peel, Social Care

"Really valuable meeting, providing updates and insights of work going on at Place across a breath of different areas covering health and wellbeing"
Richard Mayer, Healthwatch Nottingham and Nottinghamshire

"For Citizens Advice it is seeing where the mutual interest of our clients and organisations sit and how we can contribute together to solve the challenges we face"
Neil Clurow, Citizens Advice Ashfield & Citizens Advice Broxtowe

NHS
Nottingham and Nottinghamshire

Mid Notts Health Inequalities Oversight Group

Mid-Nottinghamshire Place-Based Partnership

Mid Notts Health Inequalities Oversight Group (January – July 2022)

Chair/Vice Chair: Dr Stephen Wormall, GP and Mid Notts Clinical Lead for Health Inequalities and Leanne Monger – Deputy Locality Director
Supported by: Katie Jordan, Steph Haslam and Lauren Shelton

Purpose of group:

To provide strategic and operational oversight, interpret data sources, share best practice and learning, agree priority actions, maximise opportunities for place based interventions, initiatives, plans and projects, adopting asset based, strength based and population health management approaches, monitoring impact, evaluation and making recommendations - influencing, informing and helping to deliver system strategies, such as the ICS Health Inequalities Strategy 2020-2024 and Mid Nott's PBP vision and objectives.

Membership: Membership Log available.

Over 25 system partners, including patient/public members regularly attend to work together to address health inequalities/health equity through integrated working and a culture of service improvement - providing population health management capability and capacity across partner organisations at place level in the delivery of a shared partnership plan.

Meeting Frequency

Once a month

Key Activity / Outcomes:

The following slides provide an update on:

- Agenda items covered. For noting - there has been a recent partnership focus on dentistry.
- A summary overview for each Task and Finish Group
- The MNHIOG developing a **DRAFT** Mid Notts HI Plan framed around the CORE20PLUS5 model (presented and circulated for comments to the group in July 2022 – see ATTACHED)

Planned Activity / Outcomes:

- To finalise the Mid Notts Health Inequalities Oversight group workplan, monitor its implementation and impact / outcomes framework through a new T&F to meet in October 2022, supported by SAIU analysts.
- Delivery of the National Population Health Management Delivery Programme
- Continue to support the Covid Vaccination Programme/Autumn Booster through the ICS Programme Inequalities Steering Group and cohort specific sub groups.
- Reform the ESDS T&F / sub group for 2022/23
- Commence a stakeholder dentistry monthly update – Chair and LDN Chair.

Mid Notts Task and Finish Groups Updates:

(Phase 3/4) Covid Vaccination, Booster and Flu Vaccination Task and Finish Group

It was collectively agreed to stand down this T&F Group in June 2022 and ensure mid notts representation and engagement in the new ICS Vaccination Inequalities Steering Group chaired by Steve Upton, the Mobile Delivery Sub Group and co-hort specific T&F groups for SMI, LD, Eastern European, GRT and Vulnerable Groups. Communication cascades remain in place and the Autumn Booster Toolkit and comms plan has been shared with the group.

Supporting PCNs/Practices with Enhanced Service Delivery Schemes 2021/22

Sub group meeting have taken place to look at Domain 1 – Diabetes, Domain 2 – Frailty and Domain 3 – Mental Health – demonstrating the added value of combined knowledge and expertise applied to

	MNHIOG Agenda Items
Feb 22	• Update from the MN Clinical Lead for Health Inequalities (Dr Stephen Wormall) • Feedback from ICS Health Inequalities, Prevention and Wider Determinants Strategy Committee on 3 February 2022 (Dr Stephen Wormall & Leanne Monger) • CORE20+5 model – an introduction and defining our priorities and measures of success (Dr Stephen Wormall & Leanne Monger) • SAIU Health Inequalities Dashboard Development (Irene Ebyarimpa CCG) • Mid Notts Community Champion – update project to roll out across MN and outcomes (Lesley Watkins MCVS) • Communications and engagement update (Sasha Bipin CCG) • Six monthly highlight report to the Mid-Notts ICP/PBP Transformation Board (Leanne Monger) • Task and Finish Group Updates - Phase 3 Covid Vaccination/Booster/Flu (Leanne Monger, CCG Locality Team) • Task and Finish Group - Enhanced Service Delivery Scheme (ESDS) (Steph Haslam, MN Locality Team)
Mar 22	• Update from the MN Clinical Lead for Health Inequalities (Dr Stephen Wormall) • ICS Update - dates of next ICS Health Inequalities committee 7th April (Dr Stephen Wormall & Leanne Monger) • Update on Dentistry (Evelina Bondareva Healthwatch) • Our Developing PBP and PCN Health Inequalities Plan (Dr Stephen Wormall & Leanne Monger) • Highlight Report (verbal) – district Health and well being Partnership updates on Inequalities work (Andrea Stone, ADC Dominic Ayton, MDC Helen Ellison N&DC) • Communications and engagement update (Sasha Bipin CCG) • Task and Finish Group Updates - Phase 3 Covid Vaccination/Booster/Flu (Leanne Monger, CCG Locality Team) • Task and Finish Group Updates - Enhanced Service Delivery Scheme (ESDS) (Steph Haslam, MN Locality Team)
May 22	• Communications and engagement update (Sasha Bipin CCG) • Dentistry Update - local intervention/comms (Pavni Lakhani – LDN Chair) • Health and Wellbeing Hubs (Roz Howie, Notts City Council) • ICS Health Inequalities Plan (Hazel Buchanan CCG / Leanne Monger, CCG) • Task and Finish Group FINAL- Phase 3 Covid Vaccination/Booster/Flu (Leanne Monger, CCG Locality Team) • Task and Finish Group FINAL- Enhanced Service Delivery Scheme (ESDS) (Steph Haslam, MN Locality Team)
June 22	• Communications and engagement update (Sasha Bipin CCG) • Update on SAIU Health Inequalities dashboard Development (Irene Ebyarimpa CCG) • PHM Refresh Deep Dive into Diabetes (Sergio Pappalettera CCG) • Health Watch to present the findings from their desktop study on GP Surgeries (Evelina Bondareva Healthwatch) • Research Findings on access to NHS Dentists (Evelina Bondareva Healthwatch)
July 22	• Update from the health inequalities clinical lead (Dr Stephen Wormall) • Reflection on the GP access study presented 22.06.22 and proactive action from MN (Evelina Bondareva Healthwatch) • Research findings on access to NHS dentists and proactive action from Mid Notts (Evelina Bondareva Healthwatch) • Communication and Engagement update (Sasha Bipin CCG) • Highlight Report – Delivery of our developing MNHIOG Health Inequalities Plan (Leanne Monger & Katie Jordan, MN Locality Team, ICB) • Highlight Report (verbal) – district Health and well being Partnership updates on Inequalities work (Andrea Stone, ADC Dominic Ayton, MDC Helen Ellison N&DC)

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

Mid Notts (Phase 3/4) Covid Vaccination, Booster and Flu Vaccination Task and Finish Group

- This group met fortnightly from Nov 2021 – May 2022 to support delivery the ICS programme commitments at a place level. Priority activities included:
- Asset mapping
- Utilising data to agree immediate priority areas of focus and cohorts – captured in a strategic action plan.
- Co-ordinated delivery of a MN plan of interventions and communications messages delivered from trusted system partners, using trusted sources and settings, including Community Champions.
- Mobile vaccination planning, scheduling, pre-engagement and system delivery of the Vaccination Vans – *Let's Get Vaccinated* and Vaccination Q&A Clinics – *Let's Talk Vaccinations*
- Community Transport – inequalities funding bid
- Engagement, listening and responding accordingly to address vaccine hesitancy.
- Targeted Health and Wellbeing Pops Ups

Integrated Care System
Nottingham & Nottinghamshire

Nottingham and Nottinghamshire Integrated Vaccination Programme 2021/22

Equalities and Health Inequalities Assessment and Forward Plan

Integrated Care System
Nottingham & Nottinghamshire

6. Phase three commitments

Further to the above principles and activities we will commit to the following actions:

- Produce, use and share data for the programme and its partners, in a variety of population levels, to inform inequalities actions and to measure our progress;
- In addition to continuing to develop community engagement commenced in phase 1 and 2, develop focused work with Eastern European Communities and traveller communities
- Using the bus as a mobile vaccination clinic to target communities and groups where take up is lower
- Work with ICPs, PCNs, district and borough council expertise and the voluntary sector to ensure locally nuanced provision
- Pay particular attention to groups experiencing barriers, to include those on low incomes and those whose voice may not be heard otherwise, including people with LD, severe mental illness, the homeless, refugees and asylum seekers and dementia
- Be attentive to communication needs of our patients, including having appropriate staffing of telephone contact lines, using letters, text messages and social media tailored to the audience, having Braille materials and a process for BSL interpretation and physical accessibility measures
- Upscale messages reinforcing risks of covid to pregnant women using system-wide engagement networks including a whole family approach to engagement
- Maintain a roving team to support vaccination of target communities and groups, care homes and the housebound
- Continue to promote the 'evergreen' offer
- Listen to our patients, and design our offer responsively

Task and Finish Group - Enhanced Service Delivery Schemes 2021/22

Mid-Nottinghamshire Place-Based Partnership

Domain	Specification	Integrated system working at place/neighbourhood level
Domain 1 – Diabetes	The practice will need to confirm that it is following a PHM approach with regard to screening, delivering impactful interventions and working with community partners, and provide evidence, if requested, to demonstrate this.	Involved Diabetes Champions (currently being recruited) in community groups in priority places (e.g. Bellamy Estate and Oak Tree Lane). CVS to identify people with lived experience of diabetes who may be able to talk to community groups. Promotion of structured education sessions at Health & Wellbeing Pop Up sessions. LWTC to attend events and Pop Up sessions to deliver screening and promote self referral to structured education sessions. Link LWTC with Local Authority food banks, cooking clubs, etc.
Domain 2 – Frailty	The practice will adopt a PMH approach to managing frail patients: those at high risk of hospital admission or at the end of life. This will involve a process of prioritisation. Practices are already familiar with the Electronic Frailty Index, which is used to identify patients who would benefit from further assessment. A clinician should verify the frailty diagnosis by direct assessment using a Clinical Frailty Scale (the Rockwood Frailty Score is recommended by the ICS).	Information shared with wider stakeholders re: Making Every Contact Count training Raising the profile of Practice Nurses within the PCN by holding Lunch and Learn sessions and attending local community centre events Shared learning from audits re: Frailty case finding Quality Improvement – using case study approaches Influence/include within scope of the Community Transformation 100 day project in Mansfield Carry out basic community health checks as part of Health and Wellbeing pop ups to help identify frail patients and those who may need support with referrals to memory clinic, continence team, smoking cessation and weight management etc.
Domain 3 – Mental Health	The practice will adopt a PMH approach to managing their patients: identifying those at high risk of mental illness, or those with ongoing mental illness that require regular review and support. There is a strong correlation between deprivation and mental health with factors such as poverty, unemployment and lack of support networks having a significant impact. In turn, poor mental health is a major contributor to the burden of ischaemic heart disease.	Presentation from Insight IAPT to clarify how they can support including the ability to self refer Presence of Insight IAPT at community events, speaking to people and helping with self referral PLT for Recep / Admin – signposting to Mental Health support services. Future development of an up to date directory on line – ONE STOP SHOP. In the meantime, sharing information about mental health support services for all ages available signposting to websites including Notts Alone, Notts Help Yourself and CVS. Review of Insight IAPT referrals – not able to see impact on referral figures just yet. Journey To Wellbeing course publicised.

ATTACHMENT

Working draft for comments

MNHIOG – An overview of our *developing* Mid Notts Health Inequalities Plan Sept 2022

NHS Nottingham and Nottinghamshire

Mid-Nottinghamshire Place-Based Partnership

Integrated Care System Nottingham & Nottinghamshire

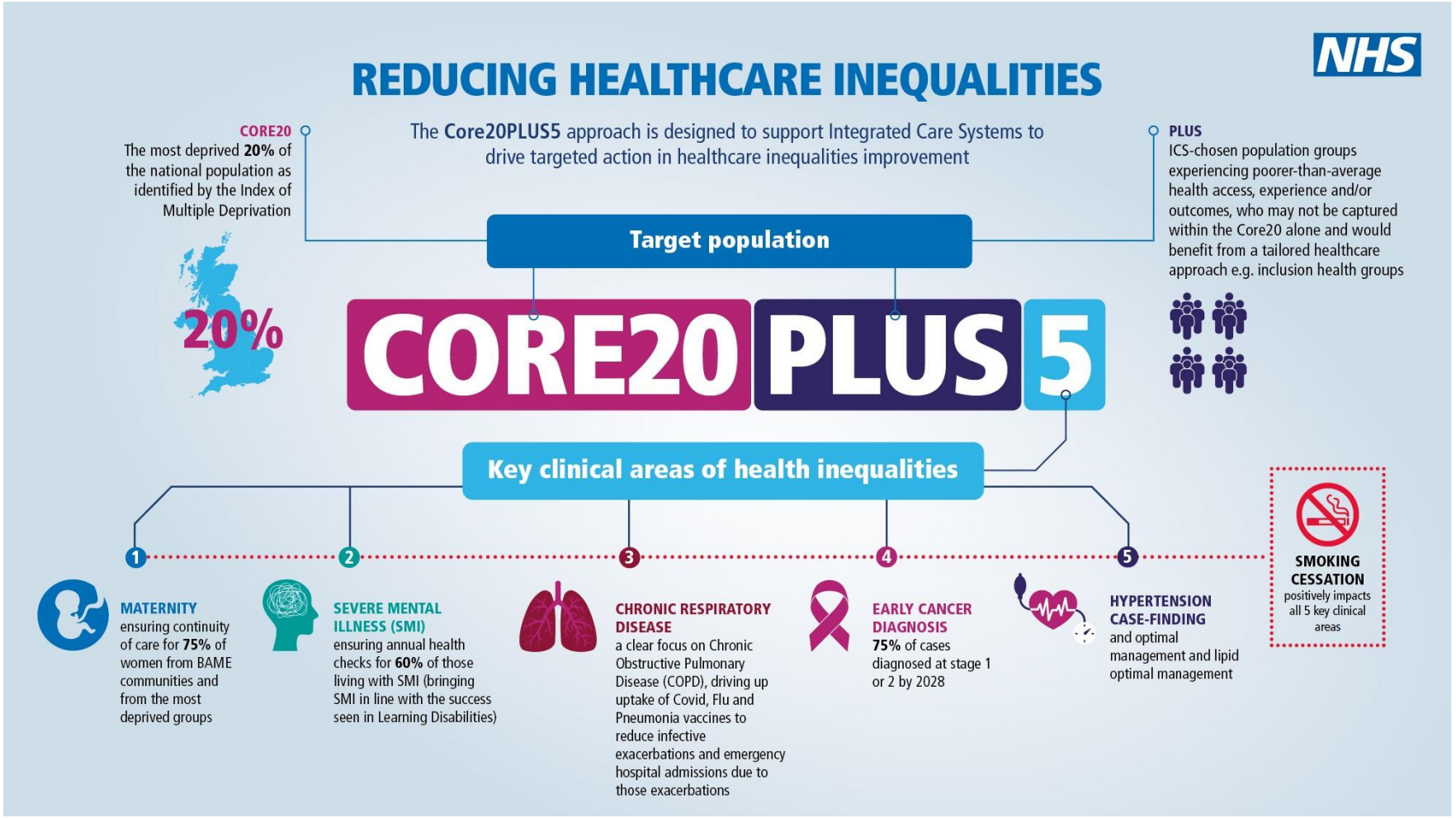
DRAFT FOR COMMENTS

MNHIOG – An overview of our *developing* Mid Notts Health Inequalities Plan Sept 2022

Katie Jordan, Leanne Monger, Dr Stephen Wormall

Reducing Healthcare Inequalities using CORE20PLUS5

Mid-Nottinghamshire Place-Based Partnership



Our Place Based Partnership (PBP objectives)

Mid-Nottinghamshire Place-Based Partnership

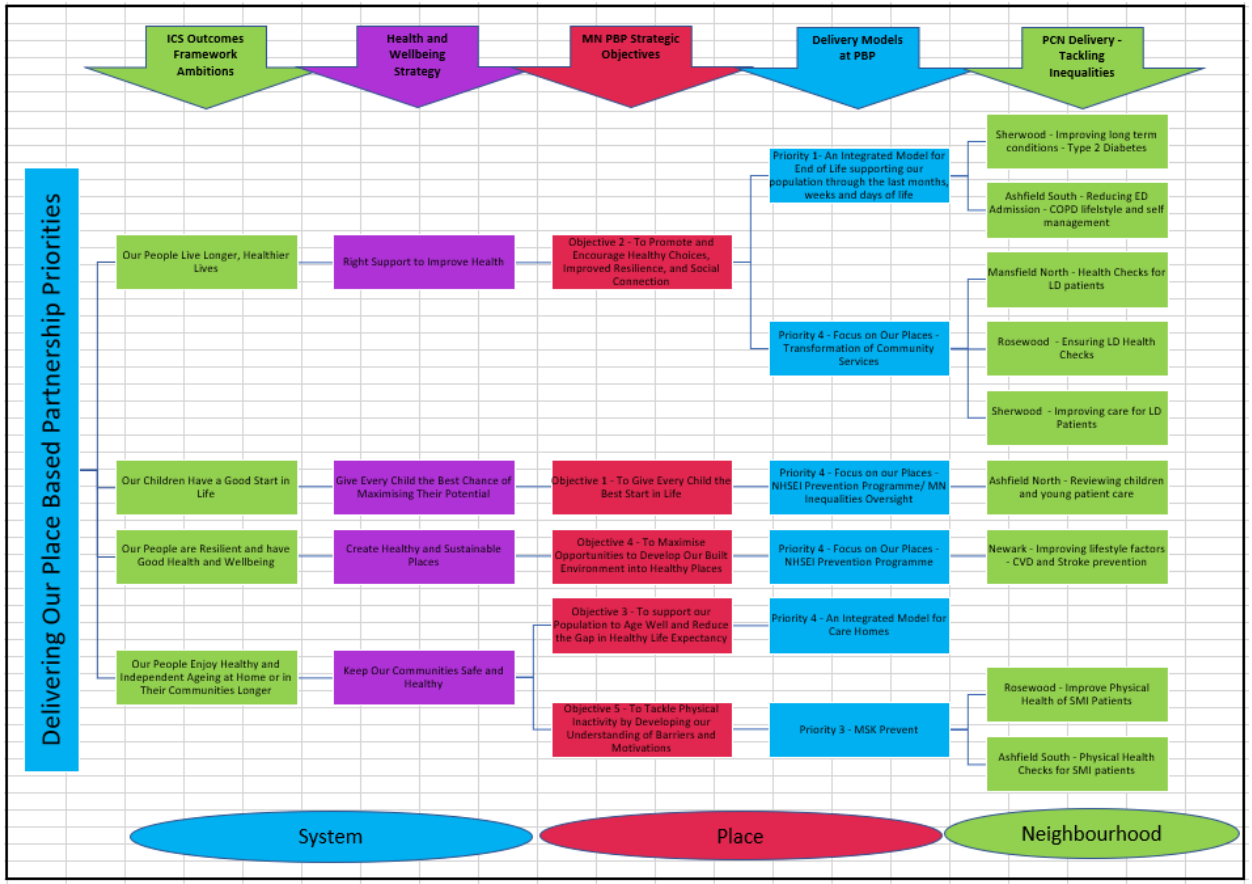
1) To give every child the best start in life

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

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.

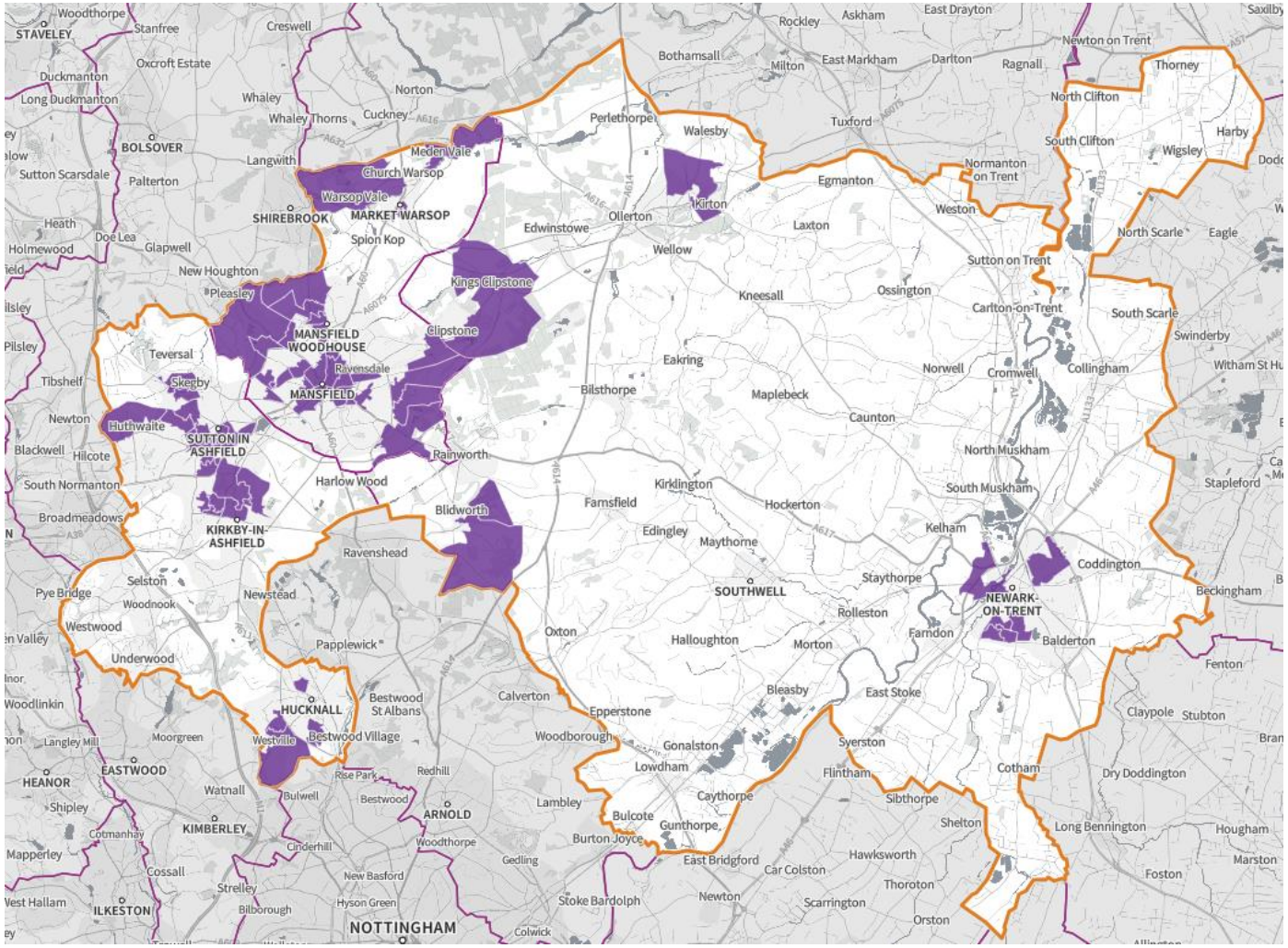
5) To tackle physical inactivity by developing our understanding of barriers and motivations



Our CORE20 Target Population

Mid-Nottinghamshire Place-Based Partnership

The most deprived 20% of the national population as identified by the Index of Multiple Deprivation.



There is a total of 211 Lower Super Output Areas (LSOA) areas in Mid Notts:

- approximately 58 LSOA areas are in the 20% most deprived nationally.
- approximately **27% of the Mid Notts population live in an area of high deprivation.**

Projects targeting our CORE20 population

Mid-Nottinghamshire Place-Based Partnership

PBP Priority 2

PBP Priority 4

PBP Priority 5

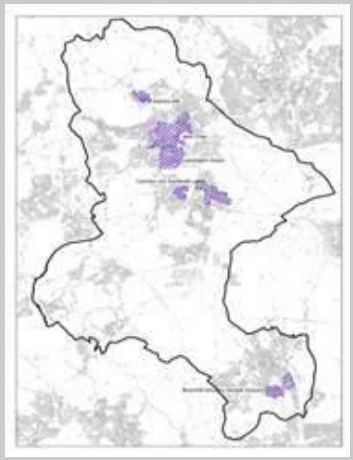
★ PCN DES Requirement

OUTCOMES							
To reduce the number of hospital admissions due to cold related harm/ excess winter deaths and improve wellbeing/HLE.	Early diagnosis of diabetes to improve prognosis through early intervention.		To improve management of diabetes and understand any barriers for accessing healthcare reducing HI	Supporting patients on long term sick back into work (supporting economic growth)	Increase in exercise/physical activity to improve health and HLE.	Reducing alcohol intake - improving access to prevention services.	Reduce the number of smokers and improve access to prevention services
KEY INITIATIVES							
Fuel Poverty Intervention Scheme: • Patients living in fuel poverty who are at risk of cold related harm are identified. • Patients are then contacted and offered a referral to the Healthy Housing Service who can offer free or subsidised home heating upgrades such as insulation and fuel vouchers and a range of other interventions.	**Diabetes Case Finding:** • Patients living in socioeconomic decile 1 who are at risk of having diabetes are identified. • Patients are invited to the GP practice for a HbA1C blood test. • Patients with pre-diabetes to be referred to the National Diabetes Prevention Programme. • Patients with diabetes to consider a referral onto the low calorie diet programme (a 12 week meal replacement drink to encourage rapid weight loss)		**Sherwood PCN:** • Patients living in socioeconomic decline 1 with poorly controlled diabetes. • A clinician to discuss management of diabetes and understand any barriers to accessing Heath Care. • Findings to be feedback to local services to highlight any changes required to meet the need of our most deprived population. ★	**DWP Access to Work Referral Scheme:** • Access to work can offer discretionary grant based awards to pay for work related support to try and get people who are on long term sick back into work. This includes mental health support, specialist equipment, travel, support workers etc. • Patients are identified and contacted by a SPLW to discuss a referral to the service.	**Gym Prescription Scheme**: • Patients with a new diagnosis of depression or anxiety are offered a gym membership to try and improve their mental health. Patients are also signposted to IAPT. • Patients with diabetes or obesity are also offered a gym membership to try and help them to loose weight.	**Case Finding Patients who have a high alcohol intake**: • Patients who are drinking harmfully are identified and contacted to discuss a referral to change grow live.	**Smoking Cessation**: • See slide 15
MONITORING METRICS							
Outcome data from the referrals to the Healthy Housing Service. To date 31 patients have been referred. Awaiting outcome evaluation.	Remission of diabetes through the NHS Low Calorie Diet Programme.	Increased number of referrals to the National Diabetes Prevention Programme.	Increased management of diabetes. Increased contacts with health care services.	Outcome data from DWP Case studies.	Numbers of patients referred onto the GP Exercise Referral Scheme. Case studies.	Outcome data from Change Grow Live.	Data from Your Health Your Way

PLUS – Our Priority Places

Mid-Nottinghamshire Place-Based Partnership

ICS-chosen population groups experiencing poorer than average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach eg inclusion health groups.

Ashfield	Mansfield	Newark and Sherwood
Broomhill, Coxmoor, Leamington Estate, New Cross, Stanton Hill  health-and-wellbeing-strategy-2021-2025-v4-min.pdf (ashfield.gov.uk)	Bellamy estate, Bull Farm, Oaktree, Portland (town centre)  Towards 2030: A plan for Wellbeing (mansfield.gov.uk)	Currently under review, previous areas of focus were: Newark: Bridge, Castle, Devon Sherwood: Bilsthorpe, Boughton, Edwinstowe, Clipstone, Ollerton  Strategy/plan being refreshed

Projects targeting our PLUS Priority Places

Mid-Nottinghamshire Place-Based Partnership

PBP Priority 2

PBP Priority 4

PBP Priority 5

OUTCOMES						
Improving access to healthcare for health and inequalities and meeting the needs of the local population.	Tackling unwanted variation, increase mental wellbeing and reduce health inequalities.	Meeting the future needs of local populations and reducing future risks to ill-health, utilisation and financial risk	To identify at risk groups and develop & deliver new holistic model of care and support	Reduced inequality in vaccine uptake rates leading to reduced inequalities in outcomes	To encourage people to improve their own health and wellbeing – self care and prevention.	Making Healthcare more accessible.
KEY INITIATIVES						
Place Based Priority Area – Bellamy Estate, Mansfield, Coxmoor Estate, Kirkby in Ashfield: • A whole system approach to be developed to support these priority areas to look at opportunities to do things differently led by the needs of the community.	**National Population Health Management Programme – PLACE:** • A 20-week supported action learning set programme by Optum to design and deliver new models of care for impactable patients. • The focus cohort of patients is Younger People with Mental Health Conditions and planning interventions and assessing impact on the system as a result.	**National Population Health Management Programme – PCN GP Coaching Session:** • PCNs to agree a cohort of patients to design an intervention. • Ashfield North PCN are case finding patients aged 20-39 who are obese and have asthma. Patients with mental health problems are excluded. Identified patients are signposted into existing community assets and services.		**Vaccination Health Inequalities:** • To promote and encourage vaccination in areas and cohorts of low uptake. • There are 2 vaccination vans that offer a door-to-door vaccination service and pop-up clinics in communities. • Vaccination sanctuaries are also being held to address any vaccine hesitancy or concerns. • Data is used to agree priority areas to target.	**Health and wellbeing Pop ups:** • Health and wellbeing pop up clinics held in communities. They include covid testing, GP registration and care navigation into the correct healthcare services. **GP Registration:** • To encourage people who aren't registered with a GP practice to register and provide support doing this.	
MONITORING METRICS						
Outcomes from the work being delivered. Including courses, events, drop-in sessions for local residents.	Shorter waiting lists for mental health services.	Number of referrals into community services.		Increase in vaccination uptake.	Decrease in inappropriate A&E Attendances.	Increased patient population registered to GP practices.

Projects targeting our PLUS Priority Places continued

Mid-Nottinghamshire Place-Based Partnership

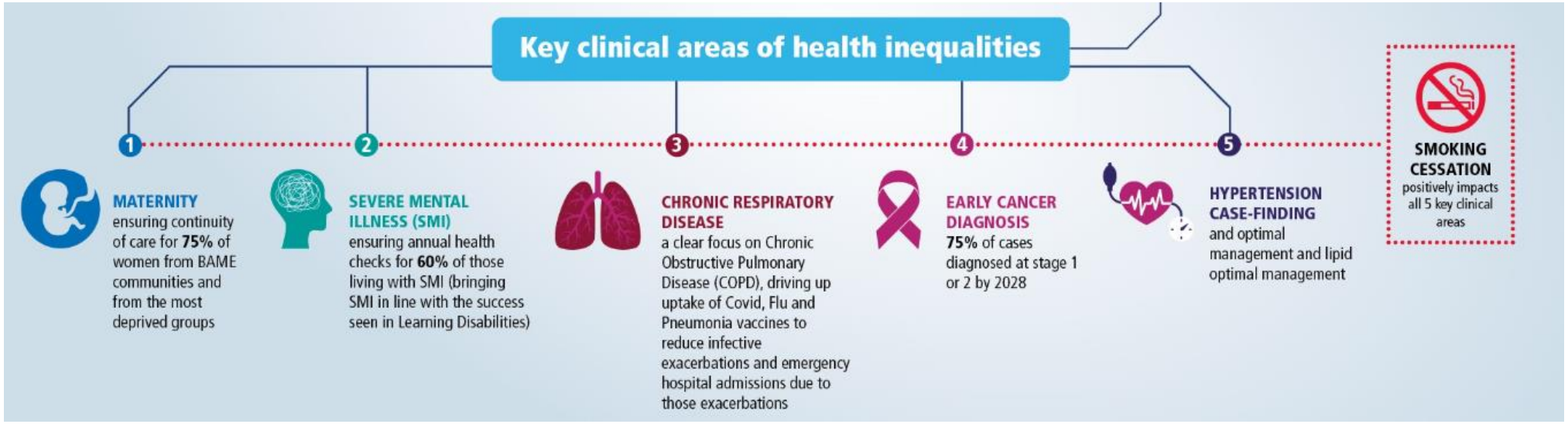
PBP Priority 2

PCN DES Requirement

OUTCOMES						
Health care organisations working in partnership to improve health and wellbeing and HLE	Improving quality of life.	Improving physical activity and education around the importance of diet and wellbeing	Reduce inappropriate attendances in ED and promote preventative pathways across our system	Support people to enjoy meaningful lives where they can make positive contributions to their families, networks and communities.	Supporting people to live independently.	To remove barriers to health care and promote services available.
KEY INITIATIVES						
Enhanced Service Delivery Scheme Task and Finish Groups: • Partners bought together in task and finish groups to adapt a population health management approach for the following domains: diabetes, mental health, frailty, health promotion.	**Additional Role Reimbursement Scheme (ARRS):** • Social prescribing link workers and health and wellbeing coaches supporting people with complex issues that are affecting their wellbeing. • Referring patients into community services for support and also holding group activity in local community venues.		**Social Prescribing Link Workers (SPLW) in ED:** • Patients arriving at ED with complex socio-economic issues rather than requiring medical intervention will be seen by a SPLW. • Patients will receive holistic care tailored to their needs through onward referrals to established services within their community and advised how to correcting access health care services.	**Strength Based Approaches:** Providing additional project management capacity to support the integration of the delivery of the Strength Based approach innovation site programme funded by Nottinghamshire County Council to include the Living Well Social care teams, health, relevant PCN ARRS roles and community and voluntary sector within the innovation sites.		**Ashfield North PCN – Pathways of Care for children and young adults with mental health or behavioural symptoms**: To increase awareness of health services amongst children and young people.
MONITORING METRICS						
Achievement of the Enhanced Service Delivery Scheme PCN requirement.	Reduced contact with GPs. Increased number of patients seen ARRS staff.		Decrease in inappropriate attendances in ED.			Engagement with schools, local media and consultation with third sector organisations

5 Key Clinical Areas of Health Inequalities – Lead by PCNS

Mid-Nottinghamshire
Place-Based Partnership



Clinical Area 1 Maternity

Integrated Care System
Nottingham & Nottinghamshire

Ensuring continuity of care for 75% of women from BAME communities and from the most deprived groups.

PBP Priority 1

PBP Priority 2

OUTCOMES	
To encourage pregnant women to stop smoking.	To reduce any harm caused by smoking and give every child the best start in life.
KEY INITIATIVES	
Financial Incentives for pregnant: • Pregnant women are offered financial incentives to quit smoking.	
MONITORING METRICS	
Data collected on the number of pregnant women who have quit smoking through the financial incentives for pregnant women scheme.	

Mid-Nottinghamshire Place-Based Partnership

Clinical Area 2 Severe Mental Illness (SMI)

Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success seen in Learning Disabilities.

★ PCN DES Requirement

OUTCOMES		
To improve physical health in patients with Severe Mental Illness.	To ensure all physical health checks have been completed.	To improve mental wellbeing in patients with Severe Mental Illness.
KEY INITIATIVES		
SMI PCN Clinic: • Ashfield South are running a PCN SMI clinic to complete physical health checks. ★	**Supporting patients with SMI:** • A care coordinator, SPLW, Mental Health OT, Mental Health Nurse and Health and Wellbeing Coach are supporting patients experiencing Severe Mental Illness in Rosewood PCN. • The team are supporting patients to explore opportunities available to them to improve their mental wellbeing, look at their lifestyle and offer support for areas which could be/are contributing to the level of the SMI as well as offering support with 1-2-1 Mental Health and Health & Wellbeing sessions to encourage a more positive outlook, fight to improve own health.	
MONITORING METRICS		
Data collected by the PCN on how many health checks have been completed.	Outcomes from Rosewood PCN.	Developing case studies.

Mid-Nottinghamshire Place-Based Partnership

Clinical Area 3 Chronic Respiratory Disease

A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving up uptake of Covid, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations. .

PBP Priority 2

PCN DES Requirement

OUTCOMES									
To improve quality of life for patients with COPD.	To increase activity and exercise levels in patients with COPD.	To reduce hospital admissions due to exacerbations.	To educate patients on self management and lifestyle advice.	To support better self-management to reduce the number of exacerbations.	To reduce the risk of long term side effects from systemic corticosteroids (inhalers)	Reducing length of stay in hospital.	Ensuring patients with COPD or Asthma have had an annual review.	To ensure all patients have been fully vaccinated for Covid and Flu.	To encourage any smokers to stop smoking.
KEY INITIATIVES									
Pulmonary Rehab Case Finding: • Patients with COPD who haven't had pulmonary rehab within the last 24 months are identified using e-Healthscope. • Identified patients are then contacted by a care navigator to discuss a referral to pulmonary rehab.	**Ashfield South PCN COPD Clinic:** • Patients with mild to moderate COPD are invited for an appointment for advice on self management and when to seek help. • Group sessions will also be held to to encourage and offer advice on exercises, health living, educate to increase vaccination. ★	**Asthma Biological Therapy:** • Patients with severe asthma are referred to a virtual MDT held by the Respiratory Consultant at SFH for a specialist review. • Eligible patients will be given monoclonal antibodies by subcutaneous injections every 2-8 weeks.	**Virtual Ward:** • Supporting early discharge from hospital using pulse oximeters and digital remote monitoring.	**Improving management of COPD Registers:** • Respiratory Nurses from Notts Health Care are helping GP practices COPD registers.	**Vaccination Health Inequalities:** • See slide 7	**Smoking Cessation:** • See slide 15			
MONITORING METRICS									
Increase in number of patients attending pulmonary rehab.	Reduction in emergency admissions.	Review of outcomes from the virtual Respiratory MDT. Case studies.	Reduction in hospital length of stay.	100% of annual reviews completed.	Flu and Covid Vaccination Data.	Your Health your way data.			

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Clinical Area 4 Early Cancer Diagnosis

75% of cases diagnosed at stage 1 or 2 by 2028

OUTCOMES				
Earlier diagnosis of lung cancer	To encourage patients with any cancer symptoms to book an appointment with their GP as soon as possible.	Increased uptake for cancer screening.	To improve 2ww referral practice.	Understanding of 2ww referral data and identifying PCNs that are significantly lower than the national average for 2ww referrals.
KEY INITIATIVES				
Targeted Lung Health Check Programme: Lung health checks to participants aged 55 to 74 who are current or former smokers. The programme aims to improve earlier diagnosis of lung cancer, at a stage when it is much more treatable.	**Early Cancer Diagnosis PCN DES:** PCNs are required to review referral practice for suspected cancers and recurrent cancers, and work with their community of practice to identify and implement specific actions to improve referral practice, particularly among people from disadvantaged areas where early diagnosis rates are lower.	**Comms campaigns on the following:** • Cancer screening • To encourage any patients with cancer symptoms to contact their GP asap.	**Clinical Support Tools:** To share 2ww guidelines and clinical support aids to help stratify is a 2ww referral is required.	**PCN with low cancer referrals:** To consider piloting a hot line for patients to call if they are concerned about cancer. This bypasses the GP. Patients who phone are risk stratified and if they meet certain criteria can be referred directly for tests.
MONITORING METRICS				
Increase in patients attending the Lung Health Check programme.	More cancers being diagnosed at an earlier stage.	Cancer screening data.	2WW referral data.	

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Clinical Area 5 Hypertension

And optimal management and lipid optimal management

PCN DES Requirement

OUTCOMES						
Improving hypertension case finding and diagnosis, where the largest undiagnosed prevalence gap remains and where the greatest reductions in premature mortality can be made.	**Supporting clinically extremely vulnerable patients with uncontrolled hypertension**	**Interventions to optimise BP and minimise the risk of heart attack and stroke.**	**To improve blood pressure control for at risk patients.**	**To reduce pressures on general practice.**	**To prevent avoidable heart attacks and strokes.**	**To improve lifestyle factors to reduce the risk of CVD and stroke.**
KEY INITIATIVES						
Hypertension Case Finding : • Patients with a last high blood pressure reading without a diagnosis of hypertension are identified using e-Healthscope. • Patients are contacted by the PCN Health and Wellbeing Coach and asked to record a home blood pressure diary for 5-7 days. • If the average reading is raised the patient is referred to the GP for further management.		**Blood Pressure at Home Scheme:** Blood pressure monitors have been provided to GP practices by NHS England. Clinically extremely vulnerable patients with poorly controlled hypertension are given a blood pressure monitor and asked to record a blood pressure diary.		**Community Pharmacy Hypertension Service:** Community Pharmacies to offer blood pressure readings.	**Health and Wellbeing Pop Ups –** Blood pressure readings offered at Health and Wellbeing pop up clinics in the community.	Newark PCN: • To implement targeted support and interventions including obesity, smoking and alcohol excess to reduce the risk CVD and stroke. • Collaborating with local partners for promotion within the community.
MONITORING METRICS						
Reduction in hospital admissions relating to hypertension, CVD and Stroke		Reduction in the number of heart attacks and strokes.		Reduction in appointment in general practice in relation to hypertension.		Increased referrals into community services. Case studies.

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Clinical Area Smoking Cessation

PBP Priority 1

PBP Priority 2

OUTCOMES						
To decrease the number of smokers.	Reduce the number of diseases caused by smoking.	Reducing patient's needs for healthcare contacts in the future.	Reduction in preventable deaths / reduce the risk of premature deaths.	To improve surgery outcomes and lower risk of complications.	To encourage pregnant women to stop smoking.	To improve health and enhance quality of life.
KEY INITIATIVES						
Opt Out Smoking Cessation Text Messages – Primary Care: • An opt out text message is sent to patients who smoke. • If the patient doesn't reply NO to the text message within 14 days the patient is referred to the smoking cessation service. • Patients referred will then be contacted by Your Health Your way and offered enrolment onto a smoking cessation programme.		**Opt Out Smoking Cessation Text Messages – Secondary Care:** • Patients who smoke that are on an elective waiting list in secondary care are sent an opt out text message from Sherwood Forest Hospitals. • If they don't reply NO within 14 days, they are referred to the smoking cessation service. • Patients referred will then be contacted by Your Health Your Way and offered enrollment onto a smoking cessation programme.			**Financial Incentives for Pregnant Women who Smoke:** • Pregnant women are offered financial incentives to quit smoking.	**Smoking Cessation Comms Campaign:** • Encouraging people who smoke to switch to e-cigarettes. • (people who do not smoke should not be using e-cigarettes)
MONITORING METRICS						
Outcome metrics from the smoking cessation pilot, to be upscaled: • From the opt out text message in primary care, to date (July22) 643 patients were referred to Your Health Your Way. • 59% of patients referred were contactable. • Out of the contactable patients 22% enrolled onto a smoking cessation programme. • 9% of contactable patients quit smoking.					Data collected on the number of pregnant women who have quit smoking through the financial incentives for pregnant women scheme.	Reduction in smoking related cancer / diseases.