Mid Nottinghamshire Place Based Partnership (PBP)

SFH FT - Governors Meeting 21st June 22

We will work together to create happier, healthier communities
and reduce the gap in healthy life expectancy
across Mansfield, Ashfield, Newark and Sherwood.

PROGRESS TO DATE

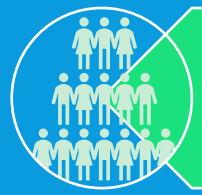
Mid-Nottinghamshire Place-Based Partnership

- The attached presentation is intended to provide an update on the current programmes of work across the PBP including the current priorities for our PCNs
- On the 28th April all of the Place Based Partnerships met with Lucy Dadge to look at how the PBPs will interface with the ICB. The aim of the session was to work through some identified priority areas to identify place based approaches to delivery, areas of opportunity and barriers to success.
- The Integration white paper was published that set out the expectations of the role of place, providing some indicative timelines and expectations.
  - Development of a Place Based Outcomes Framework
  - Publication of a shared Place plan by April 23
  - Significant proportion of delegated responsibility to Places by 2026
  - A focus on pooled resources
  - The balance between national requirements and locally driven population need

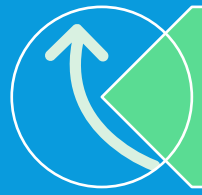
PRINCIPLES FOR HOW WE WORK – ICB/PBP WORKSHOP OUTPUTS

Mid-Nottinghamshire Place-Based Partnership

Everyone thinks place: providers, commissioners, all partner organisations



All learning is good learning: value of seeing learning as progress towards wide system change



Proceed until apprehended: opportunity to try different things

Build on what we have: recognise what currently works well and taking the learning

NEXT STEPS – ICB/PBP WORKSHOP OUTPUTS

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Progress Learning Lab approach

Apply learning lab approach to the key work areas described by each PBP to maximise collective learning and delivery

- Identify and implement solutions for the PBP work programmes
- Ensure right level of engagement with 'communal areas'
- Ensure there is a collective ownership on specific actions to progress PBP priority areas - building on what we have

- **System Development Team**

- Establish System Development team to support delivery of integrated care, identify interdependencies, come together on ambitions and ways of working, bringing together expertise, avoid duplication
- Provider collaborative: understand interface between provider collaborative at scale and provider partnerships
- Ensure access to communal areas and unlock barriers – start conversation with key people to understand role in supporting PBP work areas e.g. contracting, finance, data and key system programmes, Ageing Well, Clinical Design Authority

- **Place development programme**

- Explore new ways of working
- Take learning from work areas to support evolution of PBP governance etc.

- **Review role of Operational Place leads meeting**

- Opportunity to re-orient group as we move from ICS transition into delivery

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Our PCN Priorities

Dr Vibhore Prasad – Newly appointed Clinical Director for Ashfield North PCN

ASHFIELD NORTH AND ASHFIELD SOUTH PCN

Dr Junaid Dar – Clinical Director for Ashfield South PCN, supported by Dr Deepa Balakrishnan, Deputy Clinical Director.

Community service transformation working with social care partners to integrate health and social care teams

Social Prescribing "Creative Space" Hub

Ashfield Health and Wellbeing Village

Towns Fund Projects - £62.6 million has been secured for Ashfield as part of the government's Towns Fund.

Focusing on **priority places** in collaboration with the **Ashfield Health and Wellbeing Partnership**

Sutton in Ashfield
- Leamington Estate

Kirkby in Ashfield
- Coxmoor Estate

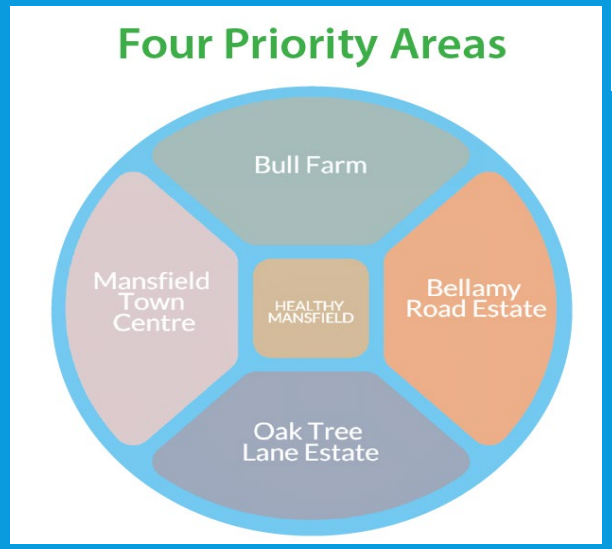
Hucknall
- Broomhill and Butler's Hill

Dr Khalid Butt – Clinical Director for Mansfield North PCN, supported by Dr James Mills, Deputy Clinical Director

MANSFIELD NORTH AND ROSEWOOD PCN

Dr Milind Tadpatrikar – Clinical Director for Rosewood PCN

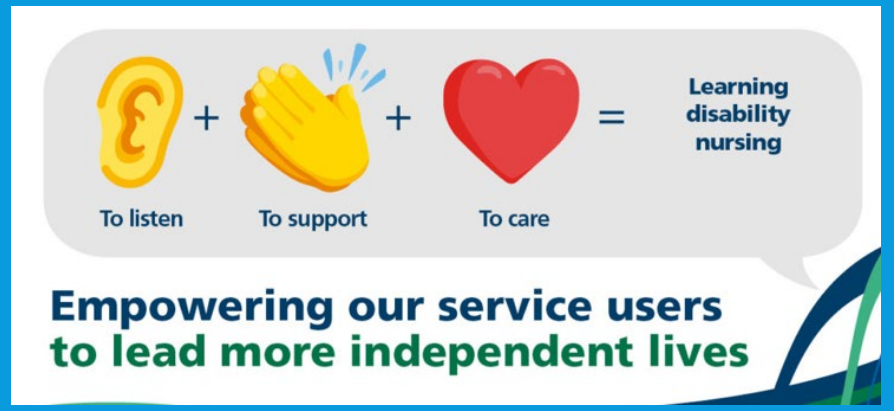
Healthy Mansfield Board chaired by Dr James Mills, Deputy Clinical approved the priority places:



Fuel Poverty pilot – in collaboration with the Healthy Housing Service

Community Services Redesign: Integrated Nursing Pilot

Learning Disabilities Nurse Practitioner employed by Rosewood and Mansfield North PCN



Dr James Cusack – Clinical Director for Newark PCN, supported by Dr Karen Fearn, Deputy Clinic Director

NEWARK & SHERWOOD PCN

Dr Kevin Corfe – Clinical Director for Sherwood PCN

Utilising **The Better Care Fund:** Dr Karen Fearn, clinical lead, in collaboration with Notts County Council, social and home care providers.

Community services redesign – Home care and early escalation of deteriorating health

New MSK Pathways - Dr Subash Das, Mid-Notts MSK Clinical lead, supported by the PPG and in collaboration with Notts Health Care, SHF and other providers to develop a risk stratification tool.

PCN POPULATION HEALTH MANAGEMENT PROJECTS:

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Our Place-based programmes of work

Current Work with our Communities

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- Community Services Transformation – 3 early adopter sites testing models for the future
- Health and Wellbeing pop up clinics
- Phase 3 Covid and Flu Vaccination Programme
- National Population Health Management Programme – Focusing on Younger People with specific insights into Mental Health conditions and also young pregnant women who smoke
- NHSEI Prevention Programme – Bellamy and Coxmoor Estates – working with the community to identify approaches that will tackle health inequalities and wider determinants of health
- Community Champions
- Ageing Well

Developments and Priorities

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MN EOL Together Service

- Review current delivery model
- Programme Budget Approach
- Inclusion of Fast Track into one single pathway

MSK for the Future

- MSK Together through Provider Collaborative
- MSK – Low Impact – Primary Care working with the MSK Hub and building in the role of practice based physio
- MSK Prevent – Community/Workplace interventions focusing on prevention

Integrated Model for Care Homes

- Single integrated model that brings together existing services into a collaborative and shared pathway
- Services currently commissioned from a number of providers, exploring the opportunity of building on the principle of making every contact count

Working with the Health and Wellbeing Board to understand the role the PBP will play in delivering the Health and Wellbeing Strategy

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Aligning our programme of work to support delivery

Next Steps for our Partnership

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- In response to the Integrated White Paper we will during 22/23 start to develop a PBP Outcomes Framework and shared plan, working with our partners and communities to ensure it has the balance between national requirements and those locally determined priorities
- A series of learning labs are to be scheduled to support the delivery of some of the PBP priorities which will bring CCG and Local Authority Commissioners, Providers and partnership members to learn by doing and working collaboratively to move forward
- The national Population Health Management Programme commences on 26th May 22
- Work will continue on the delivery of our PBP priorities with a number of key projects already commenced – Transformation of Community Services and NHSEI Prevention Programme as 2 examples and ongoing evaluation of progress will commence during May.
- PBPs were awarded some funding to support a shared OD programme in response to the white paper. The plan is being developed across the PBPs with a view to the focus being the development of the outcomes framework and PBP readiness

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An example of our Prevention Work

A focus on Bellamy

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NHS Prevention Programme Targeted Funding Project.

Our Aim

To promote healthy and happier communities in areas of Nottingham and Nottinghamshire by identifying purposeful and sustained approaches to tackle health inequalities through co- production with these communities.

Our focus;

The three Integrated Care Partnerships identified communities/ neighbourhoods within them where there are higher levels of: Income, Health & Disability Deprivation and higher percentages of people who are: Diagnosed with Type 2 Diabetes; have a Family History of Diabetes; Recorded overweight or obese; currently smoke or misuse alcohol

Desired Outcomes and Outputs

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Demonstrate engagement with and listening to our communities

New partnerships between organisations

Increased Flu, COVID and other Vaccination rates

Actions by partner organisations in response to the information from the communities

Increased uptake of prediabetes programme/ IAPT/ Your Health Your Way

A network of community health ambassadors are embedded into community organisations.

Forums to share practice and learning in place

Where are we

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Steering Groups

Regular meetings with the Steering Groups and a quarterly meeting for all groups to share learning and listen to the progress of the other areas

Monthly meetings with NHSEI

Monthly reporting to team on the KPIs and case Studies

Stages of development are different for each area

Finances
Allocation of Funds and
Monthly reporting on spend

Evaluation

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KPIs	Measure
Community consultation – have we delivered what communities have asked for	Key themes from Community feedback this month. Number and type of events delivered, include number of attendees What has been delivered this month the community have asked for?
Increased uptake	Coordinate and facilitate the delivery of specialist services on an outreach basis within the Estate Referrals to prediabetes programmes Referrals into Smoking cessation programmes. Referrals into YHYW IAPT Referrals Weight Management program referrals Any other referrals
Increased flu, COVID and other Increased Flu, COVID and other Vaccination rates	How many Health & Wellbeing pop-ups have been delivered this month? How many Health & Wellbeing pop-up opportunities number planned for next Minth? Any new outreach services? Number of Flu Vaccinations given? Number of Covid Vaccinations given? Number of other vaccinations given, what vaccine and how many?

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Case Study

New Resident to the estate arrived with no money, food or essentials

Has life threatening health issues

Including Epilepsy, Mental Health issues including anxiety and depression

Support was given to help with food to keep him going until his next benefit payment and this was enabled with help from Family Action Nottinghamshire Food Club.

Attends the 'learn as you grow' health and wellbeing and horticulture course set up as part of the prevention bid and is currently running two mornings a week at Trowell court community centre. He is really enjoying this and engages fully with both the tutor and group.

Bellamy Health

Prevention Project

Mansfield Community & Voluntary Service

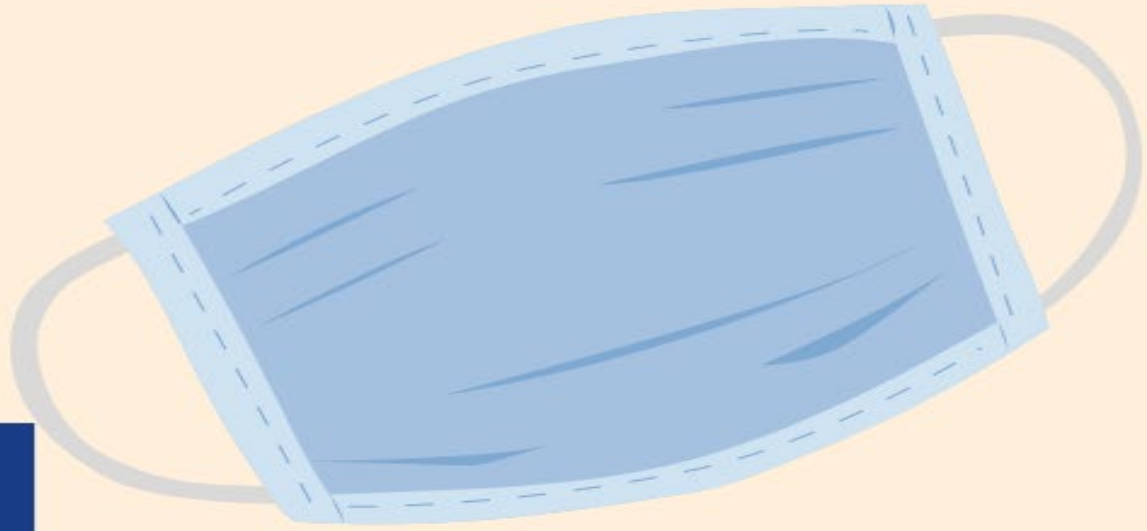
Supported by:

Mid-Nottinghamshire Place-Based Partnership

Progress Highlights April/May

- Bellamy Community Officer recruited
- Learn as You Grow – Adult Learning Course
- Health & Wellbeing Pop-Up event delivered
- Contact with ABL to commence weight Management

BELLAMY HEALTH & WELLBEING EVENT 6 APRIL 2022



- 13 vaccinations
- 2 GP sign ups
- 16 blood pressure checks
- 11 IAPT signposts
- 4 AGE UK Connect referrals
- 4 potential BBO participants

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How could you get involved?

Any Questions?