The Nottingham and Nottinghamshire
Sustainability and Transformation Partnership

Strategic Plan

Prevention, Person and Community Centred Approaches

What Matters to you?

1st August 2018

Contents

1. Introduction

Prevention, person and community centred approaches needs to be at the heart of the Sustainability and Transformation Plan (STP) for Nottingham and Nottinghamshire. This is because we can improve the quality of care and health and wellbeing of local people and create a sustainable future for our local services through scaling up prevention and empowering local people.

It is generally accepted that most people want to live long and healthy lives. Indeed, life expectancy in the UK has doubled in the past 170 years, primarily through reductions in communicable diseases and treatment of long-term conditions. People are now living longer lives but with longer periods in poorer health. Much of this burden of ill health is preventable. As little as 10%[1] of our health is achieved through access to health care services; the rest is influenced by social factors such as good work, good education, healthy environment and strong and supportive communities. This strategy outlines our approach to both prevent ill health and promote good health as well as supporting individuals with existing conditions to live as independently as possible. This requires a rebalance of the relationship between people and public services towards prevention, community resilience and taking shared responsibility for keeping as healthy and well as possible. In addition, by doing so, people will live happier and healthier lives, whilst also reducing demand on services.

We know that supporting people to manage their own health conditions can reduce the need for hospital admission. Offering people rehabilitation and reablement after illness enables them to return to independent living and avoids the need for long-term care. Supportive social networks and resilient communities are good for people's health and wellbeing. Too often, however, the health and care system is better at reacting to crises and relies too much on hospitals and long-term care. This results in overstretched A&E departments, delayed discharges in hospital and people going into long-term care instead of going home. We need a different model. We will only see this improvement in health and wellbeing if we change our approach. This means that we need to focus in people and place rather than organisations. There is now solid evidence that prevention, person and community centred approaches reduce demand on our resource and deliver good outcomes.

2. Our Vision

Our vision is to maximise independence, good health and well-being throughout our lives. We want to empower local people to make healthier choices that support their own health and wellbeing. We want to ensure that people in our communities live long, healthy and independent lives.

This 'healthy' state of being should be experienced fairly by all our communities. We want to ensure that people living with an existing disability or long-term condition can live as well as possible through access to the right advice, treatment, care and support.

By enabling communities to support people to have a healthy lifestyle, with support from local services to do this, we aim to help people to manage their own health and wellbeing, alongside health and social care services if required.

[1] McGovern L, Miller G, Hughes-Cromwick P. Health Policy Brief: The relative contribution of multiple determinants to health outcomes. Health Affairs. 21 August 2014.

Our vision is to develop a system which is focused on delivering improvements in the health, wellbeing and independence of our population, based on the '4 Pillars'[2] identified by the Kings Fund (Appendix One). This means making connections between the following areas:

- Wider determinants of health and well-being
- Our health behaviours and lifestyles
- Communities, health and well-being
- Integrated care and relationships with communities.

3. Our Aims

This strategy focuses on changing behaviours at the levels of the individual, community, workforce and the whole system in order to move away from a reactive, disease-focused and fragmented model of care towards one that is more proactive, holistic, preventative, and focused on improving population health.

This plan aims to support a sustainable future for our public services by reducing demand and costs for health and care services through prevention, community resilience and people taking shared responsibility for keeping healthy and well as possible. Where people require long term support for complex needs, we will offer a personal health budget to maximise choice and control. It recognises that whilst targeted approaches for people with specific long-term conditions can yield short-term results, we know that a greater return on investment will be achieved through primary prevention and addressing the wider determinants of health.

The overarching aim of the prevention, community and person centred approaches workstream is to ensure that prevention is everybody's business. This strategy is not a standalone document as prevention and self-care runs through all of our STP work streams and partner plans.

The intention is to reduce the complexity, inconsistency and duplication of approaches and look for ways to deliver all of the above through a simplified, place-based approach that maximises informal solutions. This will be supported by a commissioning plan that sets out our intentions.

Overall, this strategy is focused on changing behaviours at the level of the individual, community, workforce and whole system, supported by an action plan which will provide a clear, evidence-based and locally modelled system-wide programme to deliver the vision.

3.1 Individuals

- Ensure people's lives are made better because the services or interventions they receive, add benefit and focus on prevention and promoting self-care to enable them to be as independent as possible
- Embed a strength-based approach enabling people to live healthy and fulfilled lives, increasing life expectancy and reducing disease prevalence
- Provide a proactive and universal offer of support to people with long term needs to build knowledge, skills and confidence through supported self-care and community-centred approaches

[2] Kings Fund (2017) The four pillars of a population health system: making the connections

- Embed intensive approaches to empowering people with more complex needs to have greater choice and control over the care they receive
- Ensure anyone who receives a needs assessment under the Care Act 2014 from the local authority can be given a joint health and social care assessment and a joint health and care and support plan where needed

3.2 Communities

- Build community, service providers' and people's support networks so there is a stronger and more resilient community with a focus on prevention
- Work in partnership with local organisations to design and shape services, using people's support networks and working effectively to promote self-care and well-being
- Encourage a vibrant and active community and self-care sector, enabling small, neighbourhood and community groups to develop and grow and support diverse and inclusive groups to evolve to meet local needs and continuing to respond flexibly to changing circumstance and increased demand

3.3 Workforce

- Train and equip staff involved in the delivery of all people's care to identify self-care needs and take a flexible, holistic approach to people's needs with a strong prevention focus, encompassing person-centred approaches.

3.4 System

- Embed system wide leadership for prevention and improving population health through a shared understanding of the relationships between the social determinants of health, lifestyles and health behaviours and the role of communities in health behaviours and as partners
- Take a whole population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing and make informed choices and decisions when their needs change
- Use learning from the Integrated Personal Commissioning programme to develop a whole system approach to personalised care and support planning for anyone who receives a needs assessment under the Care Act 2014 from the local authority

4. Our Principles

- Develop a whole system approach to delivering our priorities
- Have a whole population, whole life approach
- Consider both universal and targeted interventions which address primary, secondary and tertiary prevention, based on evidence and cost-effectiveness
- Hold reduction of health inequalities to be a central driver
- Increase the influence of the person in decision making through a co-production approach

- Recognise the value of the workforce in delivering prevention, community and person centred approaches

5. Strategic Drivers for Change

5.1 National Drivers

The **Care Act (2014)** is a comprehensive piece of legislation that governs the provision of social care. It is founded on the new statutory principle of 'promoting wellbeing' and underpinned by the principle of 'personalisation'. Both of these principles apply to all people. The guidance sets out that '*The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life…. Underpinning all of these individual care and support functions ….is the need to ensure that doing so focuses on the needs and goals of the person concerned.'*

The Care Act works in partnership with the **Children and Families Act (2014)** which amends the Children Act 1989. In combination, the two acts enable councils to prepare children and young people for adulthood from the earliest possible stage, including their transition to adult services.

Within the **Health and Social Care Act (2012)** there is a duty to promote the involvement of people and carers in decisions which relate to their care and treatment. The duty requires CCGs to ensure they commission services which promote the involvement of patients, including self-care and self-management support to better manage health and prevent illness. The act aims to focus healthcare on the promotion of personalisation of care with people in control.

The **Equity & Excellence: Liberating the NHS (2010)** this outlines the core principle of 'No decisions about me without me', with the aim of giving everyone more say over their care and treatment with more opportunities to make informed choices to secure better care and outcomes.

The **Health and Social Care Act 2012** also set out local authority Public Health responsibilities, including a duty to take steps to improve public health, health protection and health improvement.

The Five Year Forward View (FYFV)[3] acknowledged that the future sustainability of the NHS hinges on addressing the rising burden of ill health being driven by demographic change, lifestyles, deprivation and other social and economic influences. It set out a central ambition for a radical upgrade in prevention and public health and promotes a shift in power and decision making. The FYFV identified three gaps:

- The health and wellbeing gap:
    - We are living longer lives, but we are not living healthier lives. The overwhelming majority of ill health and premature death in this country is due to diseases that could be prevented.

[3] NHS. Five Year Forward View. October 2014. https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

- The care and quality gap:
    - We need to narrow the gap between the best and the worst whilst raising the quality bar for everyone.
- The finance and efficiency gap:
    - The NHS needs to achieve efficiency to meet the forecast rise in demand, driven by population growth, an increase in chronic conditions, technological change and an aging society.

5.2 Local Drivers

Nottinghamshire Health and Wellbeing Strategy

The Health and Wellbeing Strategy for Nottinghamshire includes four key ambitions:

- To give everyone a good start in life
- To have healthy and sustainable places
- To enable healthier decision making
- To work together to improve health and care services

The healthy and sustainable places ambition aims to tackle the wider issues which affect health and wellbeing like housing, our environment, the food we eat, skills and education, transport and our friends, families and local communities.

Happier, Healthier Lives: The Joint Nottingham Health and Wellbeing Strategy 2016 to 2020

The aim of the Nottingham City Health and Wellbeing Strategy is to increase healthy life expectancy and reduce inequalities between neighbourhoods. A key approach to achieving this is through fostering a culture where citizens are empowered to better look after themselves in order to prevent the onset of ill health for as long as possible or to confidently manage their ill health themselves. The healthy culture element of the plan is about making it easier for citizens to access information about services and information on how to stay healthy. The roll-out of learning from the self-care pilot is also an integral part of the strategy to ensure that citizens can have control over their health.

The Nottinghamshire JSNA[4] provides detail on the impact of local demographics - an aging population with an increasing number of complex long term conditions which has implications for individuals and will lead to increasing costs to wider system.

There is strong evidence from local and national programmes that preventive interventions make cost savings to the health and care systems[5]. The proposed prevention and self-care interventions have been modelled to contribute to the STP financial gap through both demand-related cost savings and future cost avoidance.

The financial benefits will be realised through interventions delivered over short-, medium- and longer-term timescales, and the action plan reflects this.

Our Health and Wellbeing Gap

[4] https://www.nottinghamshireinsight.org.uk/research-areas/jsna/

Some of the key factors that drive demand in health and social care and influence the prevalence of conditions and illnesses and the health and wellbeing outcomes for people in Nottinghamshire are:

- Aging population
- Deprivation
- Healthy life expectancy (see Appendix Two)
- Prevalence of multiple morbidities
- Significantly higher premature mortality (under 75 years) compared with England for all causes, cancer, circulatory disease and coronary heart disease[6]
- Health inequalities
- Lifestyle factors (diet, smoking, weight, alcohol, physical activity)
- Mental Health

A more detailed demographic profile is currently being developed for the STP population and will be published on Nottinghamshire Insight.

Our Care and Quality Gap

Our STP plan highlights areas where Nottinghamshire is a national outlier and where there is wide variation in quality of services or outcomes in organisations and communities within the STP area. The Prevention, Personalised and Community Centred Approaches workstream has identified a range of opportunities to support the delivery of the STP care and quality gaps, such as through Quality Outcomes Framework indicators for prevention and Commissioning for Quality and Innovation (CQUIN) indicators.

Our Finance and Efficiency Gap

The STP describes a finance and efficiency gap of £628 million across health and care systems in Nottingham and Nottinghamshire by 2020/21.
Properly implemented, there are a wide range of evidence-based interventions which extend healthy life expectancy and deliver financial efficiencies to the health and care systems. The proposed prevention and self-care interventions are being locally modelled in terms of their contribution to the STP financial gap through both demand related cost savings and future cost avoidance. The financial benefits will be realised through interventions delivered over short-, medium- and longer-term timescales and the action plan will reflect this. The planned interventions will also be modelled in terms of their contribution to improvements in health and wellbeing outcomes.

6. Achieving the Vision

We recognise that prevention, person and community centred approaches will need to be scaled up across the STP footprint. There are many examples of prevention, person and community centred approaches that are making an impact and contributing to key outcomes, but these are often on a small scale or geography through pilots or other short term initiatives.
It is now essential that we work together to sustain and build on good practice to roll out across the STP footprint. We have identified several programmes to focus on in the next 18 months that would enable us to make progress at pace and at scale.

[6] PHE. Premature mortality SMR 2011-2015. In Local Health Profiles
http://www.localhealth.org.uk/GC_preport.php?lang=en&s=154&view=map14&id_rep=r04

This approach and related pathways are depicted our local Prevention, Person-based and Community-based Approaches Model (Appendix Three).

Enabling and sustaining this change will need development work on a number of underpinning and enabling factors. There are some key enablers to scaling up prevention, person and community based approaches.

Culture:

Person and community-centred approaches are counter-cultural to a healthcare system which is still too focused on condition-specific diagnosis, treatment and cure. The challenge is for person- and community-centred approaches to be embraced systematically as complementary to, not in competition with, more medical models of care. We know that there is a leadership challenge in engaging system leaders at every level to support and endorse this approach. This engagement needs to go beyond giving permission to adopt the approach and instead create an expectation of a new way of working.

Work to progress: Organisational development and workforce will build into senior leaders' development programmes on prevention, person and community based approaches.

Capacity:

Generating the capacity to adopt a changed way of working is difficult as this involves implementing new systems, developing new working protocols and releasing staff for training whilst current services are short-staffed, under pressure and facing increased demand.

Work to progress: Organisational development and workforce will consider how long-term capacity can be developed. Appropriate training and support along with new protocols will be developed collaboratively with staff and people using services. We will address barriers to integration of VCSE partners so volunteers can be viewed as recognised assets who will support outcomes in health and social care and add to workforce capacity.

Capability:

Developing the right kind of capability involves widespread organisational and staff development, in general terms around the values and principles of community and asset-based approaches but also specifically around training in new models of working such as person-centred care and support planning, working with social prescribing models and personal budgets.

Work to progress: We will use 'Person-Centred Approaches: Empowering people in their lives and communities to enable an upgrade in prevention, wellbeing, health, care and support - a core skills education and training framework'[7] as a basis for training across the system. We will explore the role of the VCSE sector in bridging the gap between statutory organisations and communities/people, helping people access the information and support they need

Enablers:

[7] http://www.skillsforhealth.org.uk/news/latest-news/item/576-new-framework-to-promote-person-centred-approaches-in-healthcare

There are a whole range of system enablers which, if not addressed, have the potential to become blockers in practice to adopting person- and community-centred approaches.

These include information systems and governance; financial flows and contracts; and metrics and monitoring amongst others. We also know that success is dependent on having thriving private, public and third sectors, each independently successful but also working together in partnership and the need to support the development of a sustainable, responsive, diverse and resilient third sector economy.

Work to progress: We will ensure that there is a common understanding about what we mean by prevention, person and community centred approaches (see Appendix Four) across the system. We will work to ensure that integrated information and commissioning systems to developed as part of wider STP progress have are linked into the deliverables and metrics of this programme. We will encourage a vibrant and active community and self-care sector, which enables small neighbourhood and community groups to develop and grow and support diverse and inclusive groups to evolve to meet local needs and continue to respond flexibly to changing circumstance and increased demand.

Sustaining the Investment:

Much of this work is using resource from non-recurrent funds to progress person- and community-centred approaches; this will need to come from mainstream commissioning budgets on a long-term basis. Commissioners must be planning for this now with active involvement of providers. We will have a specific focus on commissioning for the future to develop new ways of releasing resource by having a more integrated and targeted approach.

Work to Progress: Develop an STP commissioning plan for prevention, community and person based approaches to deliver a simplified, place-based approach maximising on informal solutions.

7. Delivering the Vision

In looking to overcome these challenges and deliver our vision, we will:

- Promote prevention and person- and community-based approaches as a golden thread which should run through all STP work streams
- Ensure that senior leaders and staff from across the STP are engaged in all areas of work, developing champions to share the messages
- Develop a strong and consistent communication strategy which raises the profile of the prevention, person- and community-based approaches work
- In collaboration with the STP workforce leads, train and support the workforce to enable a shift in relationships with a focus on prevention, co-production and promoting self-care for all people
- Work to understand and rationalise commissioning and service delivery across the footprint where this supports achievement of these aims, looking at new models of commissioning to support this
- Ensure best use of resources across the system to ensure that in times of financial challenge duplication of effort and resource is minimised

- Ensure clear partnership arrangements between statutory and non-statutory services toward the common objectives recognising the pivotal role the VCSE organisations have at the heart of local communities and the ability that they have to organically grow through those communities
- Ensure all decisions made regarding commissioning or delivery across the system are influenced and informed by people with lived experience who have the knowledge, skills and confidence to engage with the system
- Build appropriate prevention into individual contact work

There are five key programmes of work for the prevention, person- and community-based approaches. The focus is for place-based, person-centred services delivered in local communities in partnership with the public, community and voluntary and private sectors. We will work with Greater Nottingham and Mid-Nottinghamshire in the delivery of the programme plan that has been developed (Appendix Five).

7.1 Programme 1: Primary Prevention

- A range of behaviour change approaches and interventions will be modelled in order to provide a quantified evidence base of outputs required to achieve the targets for improved healthy life expectancy.
- Approaches and interventions will be evidence-based and include primary and secondary prevention approaches which have an initial focus on delivering outcomes over a short-term timescale.
- We will consider prevention initiatives which will impact on outcomes in the medium to long term. Such approaches will have a greater emphasis on primary prevention and social determinants of health.
- We will model behavioural change and assumptions required to deliver healthy life expectancy targets. This modelling will consider options for universal and stratified targeted work relative to maximising cost-effective interventions linked between primary and secondary prevention at individual and community level.
- We will explore options for universal and stratified targeted work relative to maximising cost-effective interventions linked between primary and secondary prevention at both individual and community levels.
- We will identify, quantify and model benefits of specific prevention work in cancer, urgent care and planned care using MECC and supporting evidence-based aspects of care pathways.
- We recognise the need to develop other preventative work in strategies for overall wellbeing, children and young people, frailty, and mental health, and we will work with the relevant workstreams to identify next steps.
- We will ensure that the role of the Health and Wellbeing Boards is central to system-wide efforts on primary prevention, and this area of work should take its strategic advice from these established leadership processes.

7.2 Programme 2: Secondary Prevention

- We will make every contact we have with people count (MECC) in ensuring opportunities for prevention are maximised.

- We will support staff in all interactions with people to have brief conversations on how they might make positive improvements to their health or wellbeing in order to have a significant impact on the health of our population through supporting people and their families to live healthier lifestyles[8][9].

- We will focus initially on action on **smoking and alcohol i**n order to make a difference to NHS and social care demand and utilisation:
    - Smoking: Maintaining current improvements in smoking prevalence with a particular focus on groups and areas where prevalence remains high and demonstrates great inequality with population norms by using brief and targeted intervention approaches
    - Alcohol: Developing systematic work in healthcare settings across the STP footprint with a particular emphasis on individuals or communities with high NHS or social care utilisation using brief and targeted intervention approaches

- We will work systematically in healthcare settings across the STP footprint with a particular emphasis on individuals or communities with high NHS or social care utilisation using brief and targeted intervention approaches to promote improved outcomes.
- We will continue to support existing programmes around cardiovascular disease and stroke prevention. These (health checks and RightCare stroke prevention) are firmly embedded in healthcare work and must continue to be strongly supported by the STP.
- We will ensure future choices about focus in a strong evidence base and speed of effect of changes in behavioural factors (e.g. stronger evidence base developing for secondary prevention in obesity management with a longer term need to see a step change in exercise levels).
- We will regularly consider NICE and Public Health England guidance to assess if new or revised prevention work should be prioritised.
- We will ensure that other preventative work is developed in strategies for overall wellbeing, children and young people, frailty, and mental illness, and we will work with the relevant workstreams to identify next steps.

7.3 Programme 3: Person-Centred Approaches

- We will ensure a focus on promoting self-care without unnecessary services and intervention, developing access to a range of appropriate choices to support this.
- For those who need more assistance, we will provide personal budgets, personal health budgets or integrated budgets in order to ensure meaningful choice and control, resulting in social care appropriate to their needs.

- We will give people access to a range of services that enable them to make choices that will focus on self-care without unnecessary intervention. For those eligible for personal budgets, we will ensure that there is meaningful choice and control resulting in both health and social care that meets the person's needs.

[8] NICE. Behaviour change: individual approaches. 2014. https://www.nice.org.uk/guidance/ph49 [accessed June 2018]

[9] PHE, NHSE, HEE. Making Every Contact Count (MECC): a consensus statement. 2016. http://mecc.yas.nhs.uk/media/1014/making_every_contact_count_consensus_statement.pdf [accessed June 2018]

- We will develop a genuinely personalised approach to empower a real, sustainable outcome, using all of people's available resources. A different conversation should take place involving people and their support network; this should include a holistic, joined-up process to facilitate assessment and planning.

- We will ensure a person centred approach is used to empower all people using health and social care services in order for them to build their own knowledge, skills and confidence to self-care.

- We will support a culture where a different, person-centred conversation is the norm and people are recognised as equal partners. To do this, we will ensure our co-production group My Life Choices are involved at all stages of project planning, delivery and service development.

7.4 Programme 4: Community-Centred Approaches

- We will develop and share clear health and wellbeing goals and approaches across communities and community organisation assets.
- We will work with partners to develop simplified and consistent availability of community-based wellbeing support, targeted at supporting people who lack the skills and confidence to meet their own wellbeing needs and focused on promoting independence and self-care skills.
- We will map and fully assess the range of community-based support already available across Nottinghamshire so we can build on good practice already being delivered, engaging closely with the third sector.
- We will roll out the use of Patient Activation Measures, community signposting, including social prescribing, and health coaching and structured education, identifying existing best practice and scaling up across the STP.
- We will collaborate on a system-wide basis across agencies and workstreams, including prevention, housing, and social, primary and acute care to build on Community Connectivity models in operation across the county. Implementation will recognise the importance of ongoing engagement with the Voluntary, Community and Social Enterprise sector (VCSE).
- We will work together to develop more effective ways to recognise and direct people towards community-based skills and resources that support people from those communities to achieve wellbeing goals.

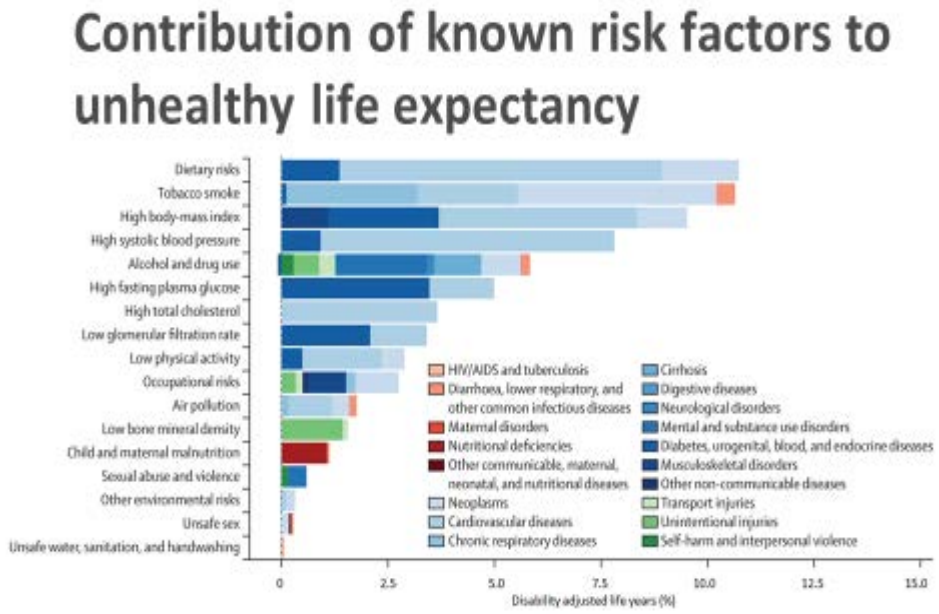
7.5 Programme 5: Integrated Health and Social Care Pilot

- We will ensure people will experience a simpler, more streamlined process for needs assessment and review, with health and wellbeing needs included in the process.
- We will work together as a system so that people will have a joined-up personalised care and support plan which covers health and wellbeing needs.
- We will develop systems so that, when needed, people can get an integrated personal budget (including health as well as social care funding).

8. How will we know we have been successful?

Evaluation of the prevention, person- and community-centred approaches will form part of the overall evaluation of STP activity and programmes. This will need to look at, amongst other things, the extent to which the growth of demand for statutory services is reducing, including unplanned acute care, A&E attendance, GP appointments and social care packages. In the longer term, we will also use population health measures to understand the extent to which this work is improving life expectancy and narrowing the health gap.

8.1 Prevention



England 2013
Newton et al. (2015) The Lancet
DOI: 10.1016/S0140-6736(15)00195-6

Evidence from the Global Burden of Disease study[3] identifies the degree to which key risk factors contribute to ill health (or the gap between life expectancy and healthy life expectancy). The five greatest contributors by some margin are dietary risks, smoking, obesity, high blood pressure, and drug use including alcohol. This is mirrored within the Nottingham and Nottinghamshire ICS and provides the rationale for concentrating on the following areas:

Risk factor	Primary prevention	Secondary prevention
Tobacco	✓	
Diet	✓	
Physical activity	✓	
Weight	✓	
Alcohol	✓	✓
Hypertension		✓
Atrial fibrillation		✓
Diabetes		✓

Table 1: key risk factors for preventable ill health

8.1.1 Metrics

Outcome measure	City				County **			
	Latest period	Latest value	2020/21 ambition	Trajectory to reach ambition	Latest period	Latest value	2020/21 ambition	Trajectory to reach ambition
Healthy life expectancy at birth -male (years)	**2014/16**	57.4	58.1	59.4	**2014-16**	61.7	65.4	64.2
Healthy life expectancy at birth - female (years)	**2014/16**	55.1	59.5	60.8	**2014-16**	62.4	65.7	64.6
Adult smoking prevalence	**2017**	19.4%	22.3%	21.5%	**2017**	15.1	15.2	-
Smoking at the Time of Delivery	**2017/18**	17.2%	13.8%	12.2%	**2016/17**	14.8	12.1	13.5
Admission Episodes for Alcohol Related Conditions (per 100,000 pop)	**2015/16**	999.7	888.9	773.2	**2015/16**	693.3	585.9	628.8
Alcohol consumption ***	-				-			
Percentage of adults (aged 18+) classified as overweight or obese *	**2016/17**	61.6%	Targets to be reviewed following changes in indicator methodology		**2016/17**	64.4	Ambitions to be reviewed following changes in indicator methodology	
Childhood obesity†	†	†			†	†		
Percentage of physically active adults *	**2016/17**	65.3%			**2016/17**	66.4		
Percentage of physically inactive adults *	**2016/17**	23.3%			**2016/17**	23.2		
Proportion of the population meeting the recommended '5 a day' *	**2016/17**	52.6%			**2016/17**	58.7		
Low birth weight at full term	†	†			†	†		

Source: Public Health England (PHE) PHOF, LAPE fingertips profiles, URL: https://fingertips.phe.org.uk/

Key
Better than target
Worse than target

* Change in indicator methodology: ambitions to be reviewed

** County ambitions are set to indicate direction of travel for reasonable improvement rather than hard committed targets and may be subject to review

*** alcohol consumption: No directly related outcome measure has been agreed, however to consider future inclusion

† childhood obesity: No directly related outcome measure has been agreed, but again to consider for future inclusion

8.2 Person and Community

Personal outcomes will need to be developed and feature in future STP population level outcomes frameworks as person- and community-centred approaches are central in preventing ill health, delaying deterioration of health and improving population health and wellbeing outcomes. Personal outcomes, based on "I" statements and building on work to date locally and nationally, should be developed to cover things like health and wellbeing, social connectedness, independence and resilience, dignity and respect, full involvement in decisions, and good quality and accessible information. A set of draft personal outcomes metrics should be developed and used to provide both a baseline and a measure of success.

The process and output measures suggested below would act as proxies for progress against longer-term outcomes in the short to medium term. These output measures are generic in that they highlight common characteristics and features shared by prevention, person and community centred approaches. They would not be specific to a particular model of delivery, nor would they set any targets for local delivery, but they will be an important tool to monitor and account for progress and are linked to the NHSE Nottinghamshire MOU (Appendix Six).

These will include:

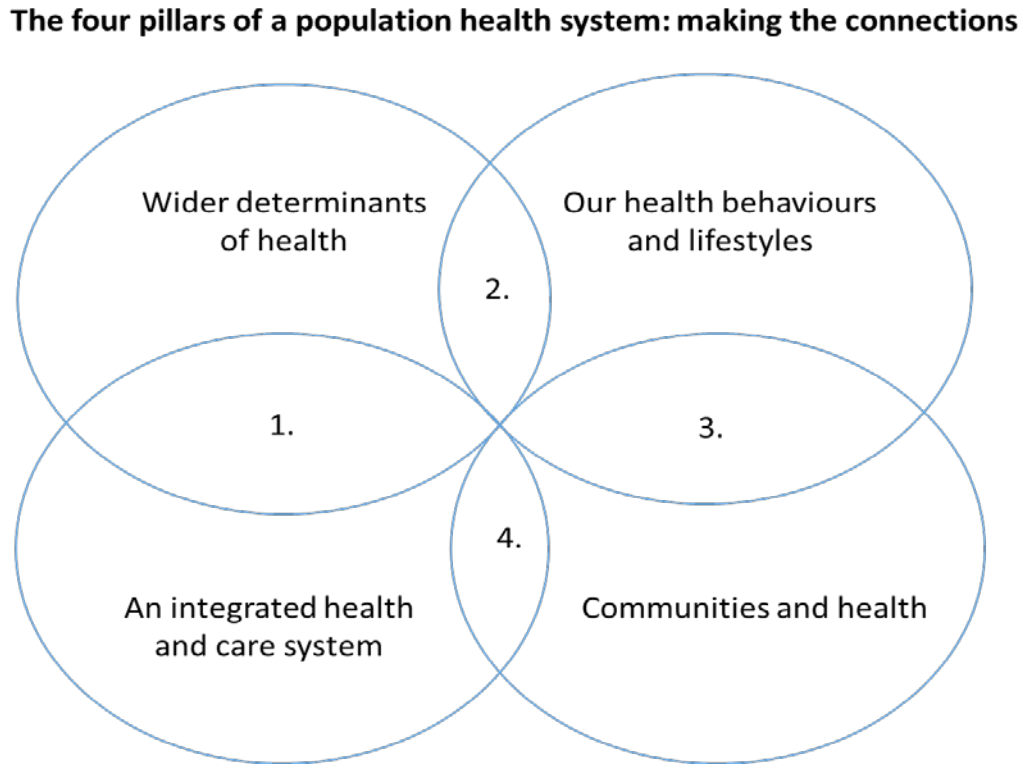
- Increased number of personal health budgets or integrated budgets (PHBs/health and social care funded) to 2,060 by March 2019.
- At least 50 looked-after children and young people with identified mental health needs receiving a PHB/integrated personal budget
- Increased number of person-centred care and support plans to 10,840 across the STP by March 2019.
- Increased number of community signposting referrals or equivalent, e.g. self-referrals/people participating in asset-based approaches to10,840 across the STP by March 2019.

- Increased number of people on the Patient Activation Measure (PAM) or equivalent.
- Improving PAM scores.
- Proportion of community practitioners (all sectors) trained for and confident in person-centred conversations.
- Proportion of MDTs including VCSE and/or “care navigator” link workers.

Appendices

Appendix One: The Four Pillars of a Population Health System: Making the Connections (King's Fund, 2017)

The 'system' = connections between the pillars:



Our vision = making those connections

Connection 1 – wider determinants and integrated care

- The NHS narrows income inequalities and adds more net-VA in poorer communities
- Providers as anchor institutions

Connection 2 – wider determinants and health behaviours

- Behaviour is socially determined, including poverty and decision-making
- Clusters of health behaviours, population groups and future inequalities

Connection 3 – health behaviours and communities

- Social norms, social networks and roles in setting behaviours
- Communities as assets, seen as partners as well as (not instead of) needs

Connection 4 – integrated care and communities

- Community and social models of health and the relationship with integrated services
- Community as part of pathways of integrated care (including VCSE)

Appendix Two: Healthy Life Expectancy

Healthy life expectancy describes how long a person might be expected to live in 'good health' based on data from the Annual Population Survey. It is measured separately for both men and women. Both life expectancy and healthy life expectancy have increased nationally and locally over recent years; however, life expectancy continues to increase at a faster rate, meaning that the population is spending a greater proportion of its total life in poor health. This has implications for both individuals, due an increased proportion of life spent with illness and disability, and society, due to associated health and social care costs.

Women in Nottingham City can expect to spend 26 years (or 32% of their life) in poor health. In Nottinghamshire County, the equivalent is 20.3 years of poor health (25% of their life). Men in Nottingham City can expect to spend 19.6 years (25% of their life) in poor health; in Nottinghamshire County men can expect 17.8 years in poor health, or 22% of their average lifespan.

While increasing healthy life expectancy is the primary aim for the STP health and wellbeing gap, this should not be to the detriment of life expectancy in any population group: Increasing 'life to years' should not adversely affect added 'years to life'.

The rationale for the STP approach to improve HLE can be summarised by results from the World Health Organisation's work on the global burden of disease. The figure below illustrates how multiple risk factors interact with multiple disease outcomes for the STP population. It is clear that to achieve the largest possible gain in healthy life expectancy, consistent and concerted effort will be required to support healthy lifestyles, including smoking, alcohol consumption, diet, physical activity and healthy weight; halt the harmful effects of issues such as high blood pressure or cholesterol; and also modify the environment to prevent ill health (for example, by tackling air pollution or risks at work). This requires a comprehensive, systematic approach which incorporates addressing wider social factors that have a greater influence on health and wellbeing than good access to health and care services. Schemes to tackle risk factors in isolation, or focussing on diseases of one part of the body, will not maximise the potential increase in healthy life expectancy.

Inequalities in healthy life expectancy:

Within the STP footprint, HLE differs substantially. Within Nottinghamshire there is a 12 year difference in HLE for men and 9 years for women. Within Nottingham City these differences are 12.8 years for women and 11.9 years for men. The difference is likely to be even greater if it was calculated across the STP footprint. In order to tackle these inequalities, populations with the lowest healthy life expectancy will be targeted across the STP area, and progress to change inequalities will be measured.

Risk factors and conditions amenable to change in the STP population

Risk factors related to conditions

Risk factors	The impact that changing these risk factors ... will have on the disease burden caused by these conditions	Conditions: Circulatory diseases	Diabetes, reproductive, urinary	Cancers	Chronic chest diseases	Mental and substance use disorders	Unintentional injuries	Musculoskeletal disorders	Cirrhosis	Nutritional deficiencies
higher contribution to total DALYs ->>	Dietary risks	✓✓✓	✓✓	✓✓	-	-	-	-	-	-
	Tobacco smoke	✓✓	✓	✓✓✓	✓✓	-	-	-	-	-
	High body-mass index	✓✓✓	✓✓	✓	-	-	-	✓	-	-
	High systolic blood pressure	✓✓✓	✓	-	-	-	-	-	-	-
	Alcohol and drug use	-	-	✓	-	✓✓	✓	-	✓	-
	High fasting plasma glucose	✓✓	✓✓✓	-	-	-	-	-	-	-
	High total cholesterol	✓✓✓	-	-	-	-	-	-	-	-
	Low glomerular filtration rate (kidney function)	✓	✓✓	-	-	-	-	-	-	-
	Low physical activity	✓✓	✓	✓	-	-	-	-	-	-
<<- lower contribution to total DALYs	Occupational risks	-	-	✓	✓	-	✓	✓	-	-
	Air pollution	✓	-	✓	✓	-	-	-	-	-
	Low bone mineral density	-	-	-	-	-	✓✓	-	-	-
	Child and maternal malnutrition	-	-	-	-	-	-	-	-	✓

<<- higher contribution to total DALYs — *lower contribution to total DALYs ->>*

Notes

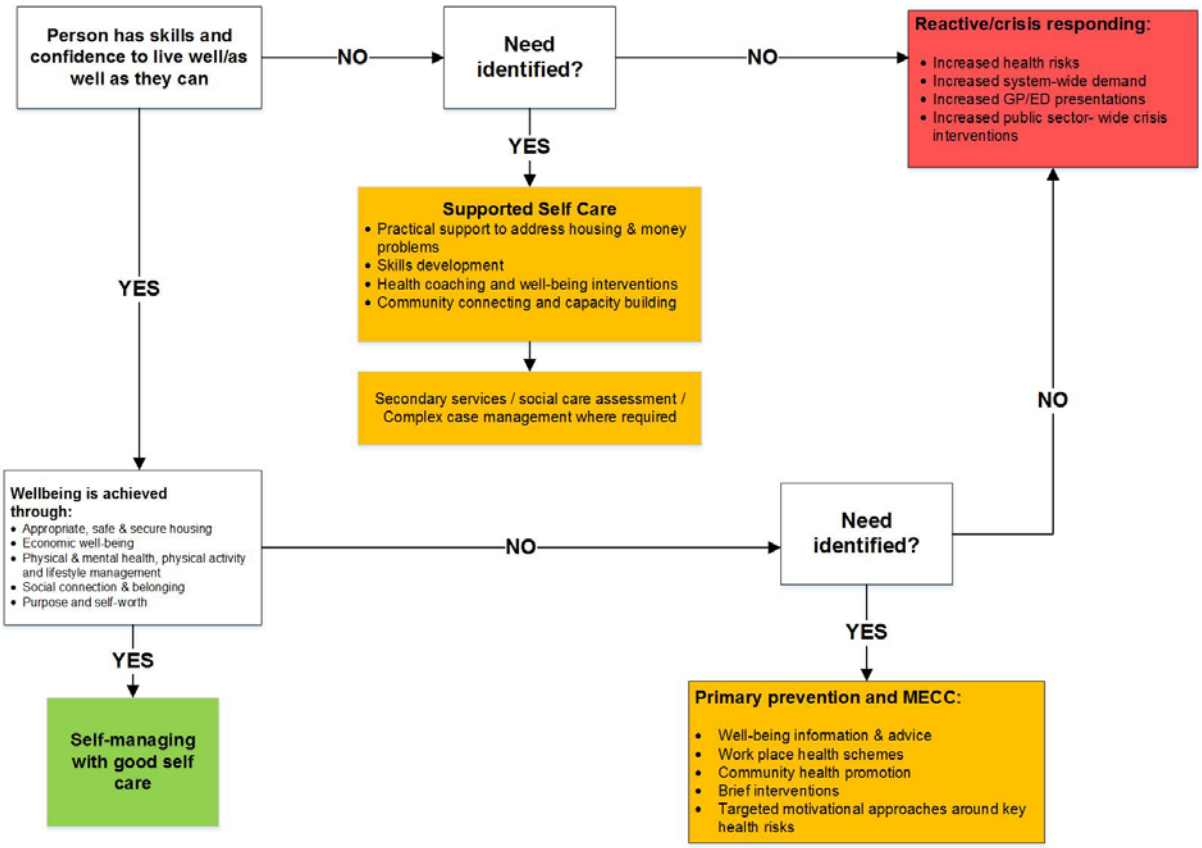
- Estimates for the STP population are derived from data for East Midlands deprivation quintiles, from the WHO Global Burden of Disease initiative
- This chart incoporates 95% of all disability adjusted life years (DALYs) amenable to intervention
- DALYS are a summary measure of years lived with disability and years of potential life lost. A reduction in DALYs is closely related to increases in healthy life expectancy (adding 'life to years' as well as 'years to life').

Key

✓✓✓	Largest impact - 5% or more of all DALYs
✓✓	Medium impact - 2 to 5% of all DALYs
✓	Lower impact - up to 2% of all DALYs
-	No contribution

Common factors driving preventable illness (GBD).

Appendix Three: Nottingham and Nottinghamshire Model for Prevention, Person-based and Community-based Approaches



Appendix Four: What do we mean by prevention, person and community centred approaches

Prevention

The term "prevention" or "preventative measures" can cover many different types of support, services, facilities or other resources. There is no one definition for what preventative activity is, and this can range from whole-population measures aimed at promoting health to more targeted, individual interventions aimed at improving behaviour, knowledge or skills for one person or a particular group. Prevention is often broken down into three general approaches, primary, secondary and tertiary prevention, with these three levels informing our approach:

1. **Primary prevention:**

   Primary prevention is aimed at people with no particular health or care needs. These are services aimed at keeping people well and independent by avoiding needs developing for health and social care.

   Primary prevention also extends to population-wide measures and social determinants of health, such as improving air and water quality, mass immunisation, and strengthening family and community ties to promote good mental health and reduce loneliness.

2. **Secondary prevention:**

   These are more targeted interventions aimed at individuals who have an increased risk of developing needs. Secondary intervention consists of screening for illnesses, particularly when risk factors are present, and early intervention measures to slow the progress of the disease while it is still in its early stages, i.e. pre-diabetes. It also includes provision of support to slow down or reduce any further deterioration. Some early support could stop a person's life tipping into crisis, such as a few hours of support to a family carer who is caring for their son with learning disabilities.

3. **Tertiary prevention:**

   These interventions are aimed at minimising the effect of disability or deterioration of people with established health conditions. It is particularly relevant for patients with complex needs and focuses on their recovery, rehabilitation and reablement after acute exacerbation of their chronic illness, i.e. self-management programmes or enablement for a person with mental health issues to regain skills and confidence to live independently.

Community-Based Approaches

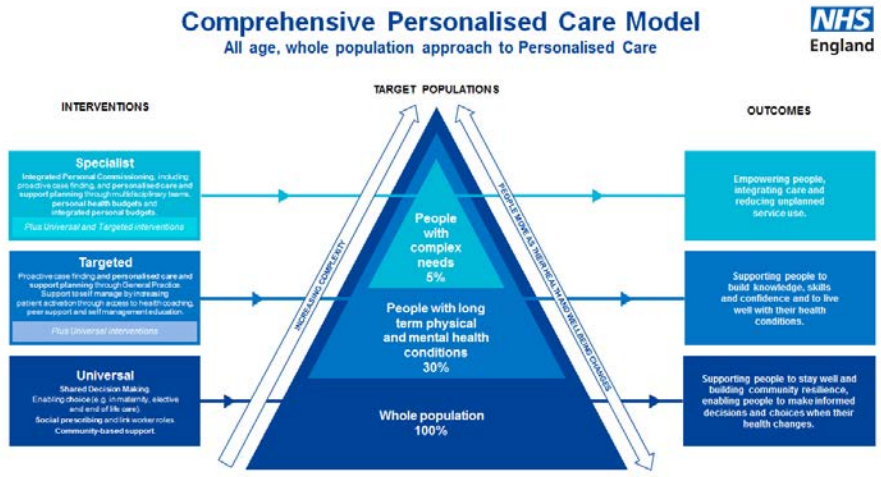
This is based on a whole population approach to supporting people of all ages and their carers to manage their physical and mental health and wellbeing and make informed choices and decisions when their health and social care changes. A community-based approach provides a proactive and universal offer of support to people with long term physical and

mental health conditions to build knowledge, skills and confidence through supported self-care and promoting needs. This is achieved by ensuring that people's preferences, needs and values guide health and social independence.

Self-care is the actions that we all take to look after individual health and wellbeing, in order to stay well and to manage long-term conditions. People who have the skills and confidence to self-care or who are more 'activated' have healthier lives, better outcomes, better experience of care and a lower impact on services. Linked to this, the assets or resources within our communities, such as the skills and knowledge, social networks and community organisations, are key building blocks for good health and wellbeing. It therefore follows that people and communities should be supported to self-care, and to do so it is necessary to build community resilience. One of the best ways to build community resilience is to start with a very practical understanding of what resources already exist and are strong within local communities, with a view to helping people to connect with them (referred to as 'social prescribing'). Other approaches such as shared decision making, health coaching and self-management education also help people with long term conditions to build self-management skills.

Person-Centred Approaches

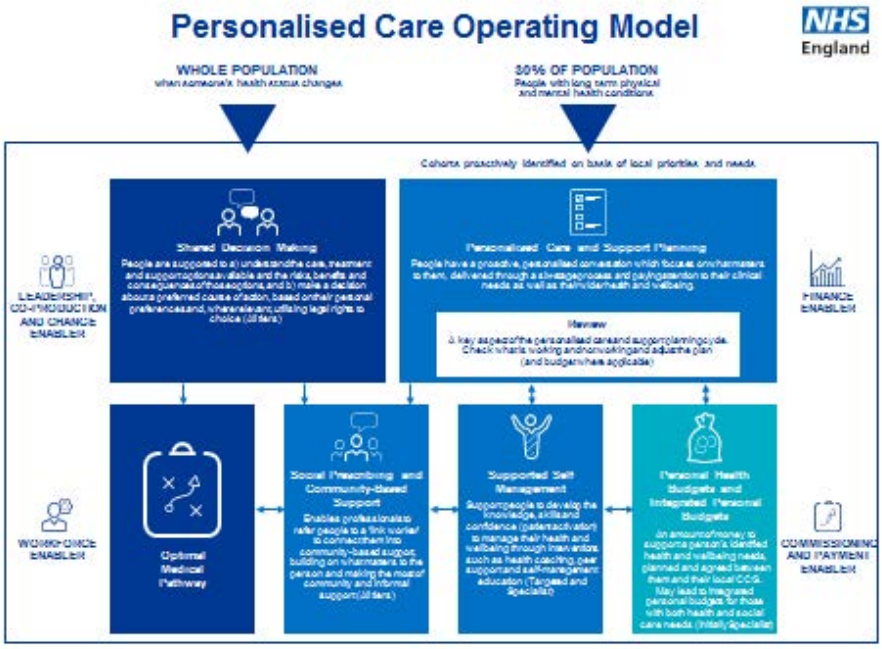
A person-centred approach puts people, families and communities at the heart of health, care and wellbeing. It means people feeling able to speak about what is important to them and the workforce listening and developing an understanding of *what matters to people*. It means working in a system in which people and staff feel in control, valued, motivated and supported.



Person-centred approaches are a more personalised approach to commissioning, contracting and payment which enables people to access services that are more appropriate for their specific needs. It does this by:

- Designing a health and care system driven by people and communities
- Encouraging and motivating commissioners and providers to shift their approaches to focus on people and the outcomes most important to them
- Incentivising commissioners and providers, including VCSE organisations, to develop personalised care packages for people with the most complex needs

- Successful implementation of IPC and personal health budgets[10]



This approach is fundamental to social care and the changes the NHS is seeking to make over the next few years. The result is better health and wellbeing for individuals, better quality and experience of care that is integrated and tailored around what really matters to them, and more sustainable health and social care services.

Being person-centred is about focusing care on the needs of the individual and empowering people to make informed choices about their health and social care decisions.

[10] https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Personalised-commissioning-and-payment_S8.pdf

Appendix Five: Greater Nottingham and Mid Nottinghamshire Delivery Plan

STP Implementation Plan v 1.5 - one plan.

Appendix Six: Memorandum of Understanding for Personalised Care Demonstration Sites between NHS England, Local Government Association and Nottingham and Nottinghamshire Sustainability and Transformation Partnership

Notts MOU.doc

Appendix Seven: Nottinghamshire STP Prevention, Person- and Community-Centred Approaches Workstream Strategic Overview and Key Areas for Development

Introduction

The Prevention, Self-care and Independence workstream is being re-designed to create a more unified and integrated work programme to increase efficiency and respond to an NHSE diagnostic suggesting closer working with personal health budget work. The new programme will also focus on place-based solutions to encourage local ownership tailored to differences in local needs.

The STP Leadership Board has confirmed that Healthy Life Expectancy remains a key performance metric for the STP and, as such, some of the early modelling used to establish this metric is being refreshed. This will bring aspects of primary and secondary prevention back into focus and strengthen delivery and oversight of system-wide actions. It will also allow us to weave prevention into the breadth of our work as well as identifying the additional actions needed in other workstreams to contribute to improving healthy life expectancy. Work on self-care and independence is well advanced with established NHSE targets but will also contribute to both reduced urgent care pressures as well as healthy life expectancy. Our work will also review the benefits to the system from reduced emergency and unplanned care as a consequence of a stronger focus on prevention, as clearly described in the Five Year Forward View.

Overarching outcome:

To improve Healthy Life Expectancy by three years from a baseline at 2015

Underpinning principles:

- A major challenge in prevention work is the training of clinical and care staff - especially around methods of engagement and empowerment and associated cultures. The Workforce group should be closely involved in this aspect of STP work.

- Prevention topics that arise in individual care conversations should be prioritised based on patient-led needs and may relate to prevention in the context of the

care and self-care advice, e.g. reducing falls, reducing risk factors for vascular dementia, and mental wellbeing.

Main topic areas

1. Primary prevention

- Modelling of behavioural change and assumptions required to deliver Health Life Expectancy targets
- Consider options for universal and stratified targeted work relative to maximising cost effective interventions linked between primary and secondary prevention at individual and community level
- The role of the Health and Wellbeing Boards as central to system wide efforts on primary prevention and this area of work should take its strategic advice from these established Leadership processes

2. Person and Community Centred Approaches

Person:

- Person centred approaches to increase numbers of personalised support plans and development of personal health budgets
- Joined up assessment and support planning for individuals in contact with health and care services
- Build appropriate prevention into individual contact work

Community**:**

- Building Community Connectivity models, rolling out use of Patient Activation Models that include prevention, and rolling out community signposting including social prescribing
- Develop community needs-driven prevention work at local level including local GP delivery or provision groups and NHS provider prevention plans

3. Secondary Prevention

MECC:

- Short term: In order to make a difference to NHS and social care demand and utilisation, it is proposed that we will focus initially on action on **smoking and alcohol:**
    - Smoking: maintaining current improvements in smoking prevalence, with a particular focus on groups and areas where prevalence remains high and demonstrates great inequality with population norms. Use brief and targeted intervention approaches
    - Alcohol: systematic work in healthcare settings to be developed across STP footprint with a particular emphasis on individuals or communities with high NHS or social care utilisation using brief and targeted intervention approaches

Specific existing programmes:

- Cardiovascular Disease and Stroke Prevention; existing programmes (HealthChecks and Rightcare Stroke Prevention) are firmly embedded in healthcare work and must continue to be strongly supported by the STP

Other MECC topics and longer-term work:

- Base future choices on evidence base and speed of effect of changes in behavioural factors, e.g. stronger evidence base developing for secondary prevention in obesity management and longer term need to see a step change in exercise levels
- Regularly consider NICE (Public Health Guidance) and Public Health England guidance to assess if new or revised prevention work should be prioritised

4. Prevention into other workstreams

We will identify, quantify and model benefits of specific prevention work in cancer, urgent care and planned care using MECC and supporting evidence-based aspects of care pathways. Other preventative work needs developing in strategies for overall wellbeing, children and young people, frailty, and mental illness, and we will work with the relevant workstreams to identify next steps.

5. Support within our workstream

- Communications: There is a strong level of support for prevention in all that health and social care does and this should be harnessed to encourage greater focus and enthusiasm for what can be achieved.
- Finance: Alongside epidemiological and health gain metrics, the return on investment and cost-effectiveness data can and does make strong strategic sense, and we need finance support to effectively present such data in a whole system way.
- Leadership: We have taken some steps to strengthen this, but additional actions to work more closely with Health and Wellbeing Boards may be needed.

6. Support from other workstreams

We will work with all major workstreams in the STP to identify specific actions that support the prevention, person and community centred agenda, and we will work with them to quantify and prioritise that effort. Other cross-linking themes are also important contributors such as workforce and cultural change, IT, evaluation and co-production and engagement.

7. Summary and next steps

The workstream will develop an action plan to strengthen prevention work across the STP footprint and provide decision-makers with quantified options to help prioritise this work as part of the overall activity of the health and care system. This will include a refresh of the current PIDs and identify remaining gaps to help risk assessment and management. Some of these can be filled with sufficient resource whilst some, especially relating more closely to longer term educational or derivation related outcomes, require an intergenerational approach. As such our action plan requires short-, medium- and longer-term components.

Chris Packham
STP Senior Responsible Officer for Prevention

Appendix Eight: Glossary of Terms

Term	Definition	Reference for further information
Accountable Care System (ACS)	An Accountable Care System sees NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They provide more joined-up and better coordinated care. In return, they get far more control and freedom over the total operations of the health system in their area and work closely with local government and other partners to keep people healthier for longer and out of hospital.	https://www.kingsfund.org.uk/publications/accountable-care-organisations-explained
Advanced Clinical Practice (ACP)	Advanced Clinical Practice is delivered by experienced registered healthcare practitioners. It is a level of practice characterized by a high level of autonomy and complex decision-making. This is underpinned by a master's level award or equivalent that encompasses the four pillars of clinical practice, management, leadership, education and research, with demonstration of core and area-specific clinical competence. Advanced Clinical Practice embodies the ability to manage complete clinical care in partnership with patients/carers. It includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance patient experience and improve outcomes. Within Nottinghamshire there has been work to develop the degree with Nottingham University.	https://www.hee.nhs.uk/our-work/developing-our-workforce/advanced-clinical-practice/advanced-clinical-practice-definition
Approved Mental Health Professionals (AMHP)	The Approved Mental Health Professional is authorised by the local authority, and they practice on their behalf, even though they may be employed by a Trust or another local authority. The AHMP provides a broad range of tasks under the Mental Health Act. What is important is that they are a counter balance to the medical model that can exist in mental health and bring a social or more holistic perspective. Their work involves the nearest relatives and carers, making sure service users are properly interviewed in an appropriate manner and ensuring they know	https://www.lancashirecare.nhs.uk/Approved-Mental-Health-Professional

	what their rights are if they are detained under the Mental Health Act 1983. The Approved Mental Health Professional is also the applicant in the majority of Mental Health Act application.	
Asset-Based Approaches	An asset-based approach to care and support is about supporting health care professionals to identify an individual's strengths and building care planning around their assets rather than their problems (or deficits). This model is designed to support the citizen to take control of their lives.	http://www.health.org.uk/publication/head-hands-and-heart-asset-based-approaches-health-care
Assistive Technology (AT)	AT is assistive, adaptive, and rehabilitative devices for people with disabilities. Assistive technology therefore promotes greater independence by enabling people to perform tasks that they were formerly unable to accomplish or had great difficulty accomplishing by providing enhancements to or changing methods of interacting with the technology needed to accomplish such tasks.	
Better Care Fund (BCF)	The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join up health and care services so people can manage their own health and wellbeing and live independently in their communities for as long as possible.	https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
Centene	Centene is an international organisation, now established in the UK, which works directly with health and care systems. It has a track record of transforming health care systems internationally both in the USA and through partnerships in Europe. Centene is not a healthcare provider. It is currently providing advice on how an Accountable Care System could be established in Nottinghamshire.	https://www.centene.com/who-we-are/about-us.html
Clinical Commissioning Groups (CCG)	Clinical Commission Groups (CCGs) are responsible for designing, commissioning and quality monitoring local health services. Within Nottingham & Nottinghamshire STP there are six CCGs: Nottingham City, Nottingham West, Mansfield and Ashfield, Newark and Sherwood, Rushcliffe and Nottingham North and East.	
Commissioning for Quality and Innovation (CQUIN)	The Commissioning for Quality and Innovation (CQUINs) payments framework encourages health care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare.	https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17/
Community and Voluntary sector	The community and voluntary sector (or third sector) is a group of voluntary organisations.	http://www.nottinghamcvs.co.uk/

(CVS)	The role of the CVS is vital when considering as asset based approach to care and heavily supports the self-care agenda, supporting individuals to help themselves. There are a number of services available to the public within the network of CVS that can offer individuals support and guidance on a number of issues.	
Community Education Provider Network (CEPN)	A CEPN brings together organisations who are involved with education and training in primary care. The CEPN delivers and co-ordinates education and training, promotes multi-professional training, supports local priorities and workforce needs, works collaboratively with health and social care, supports improvements in the quality of education, and utilises workforce data and provide continued professional development. The role of the CEPN is to help attract, recruit and retain staff in the region and help to develop a sustainable workforce.	https://www.england.nhs.uk/wp-content/uploads/2015/03/9-cquin-guid-2015-16.pdf
Connected Nottinghamshire	Connected Nottinghamshire is a transformation programme working to improve the way health information is shared to enhance service quality across health and social care services, support changes in the way health and social care services will be delivered in the future so that more care takes place in people's homes, closer to where they live and in hospitals, and improve collaborative working between IT service providers working in health and social care organisations. Their work supports health and social care staff to work together to provide a more efficient and effective service.	http://www.connectednottinghamshire.nhs.uk/
East Midlands Ambulance Service (EMAS)	EMAS provides emergency 999 care and clinical assessment services for a population of 4.8 million people across the entire east midlands. EMAS operates over the a number of STP areas.	http://www.emas.nhs.uk/
General Practitioner Forward View – GPFV	The GP Forward View's aim is to provide support to GP practices, including increases in funding. There have been agreed funding streams and innovations to tackle the challenges that are facing the general practice workforce.	https://www.england.nhs.uk/gp/gpfv/
Greater Nottingham Transformation Partnership	The Greater Nottingham Transformation Partnership is made up of all the organisations responsible for health and care in the greater Nottingham area. This includes 4 clinical commissioning groups, Nottingham North and East CCG, Nottingham West CCG, Nottingham City CCG and Rushcliffe CCG. Greater Nottingham Transformation	http://www.greaternottinghamtransformation.co.uk/

	Partnership also includes Nottinghamshire County Council and Nottingham City Council as well as Nottingham University hospitals, Nottinghamshire Healthcare Trust, CityCare Partnership and Circle Nottingham. The Greater Nottingham Partnership Board also has representatives from NCVS and Healthwatch.	
Health and Wellbeing Board	Health and wellbeing boards were established by local authorities to act as a forum for local commissioners across the NHS, social care, public health and other services. The boards intend to increase democratic input into strategic decisions about health and wellbeing services, strengthen working relationships between health and social care, and encourage integrated commissioning of health care services. Within Nottinghamshire there are two health and wellbeing boards (Greater Nottingham Transformation Partnership and Mid Notts Transformation Board) which both report into the STP leadership board.	
Health Education England (HEE)	Health Education England (HEE) is a national leadership organisation for education, training and workforce development in the health sector.	https://hee.nhs.uk/
Health Literacy	Health literacy is the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health. Health literacy means more than being able to read pamphlets and successfully make appointments. By improving people's access to health information and their capacity to use it effectively, health literacy is critical to empowerment.	http://www.who.int/healthpromotion/conferences/7gchp/track2/en/
Healthy life expectancy	Healthy life expectancy is the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury; it describes an improvement in the length of time that individuals are likely to live by keeping people healthier for longer.	http://www.who.int/healthinfo/statistics/indhale/en/
Healthy Living Pharmacies (HLP)	HLP is an organisational development framework underpinned by three enablers of: o Workforce development – a skilled team to pro-actively support and promote behaviour change, improving health and wellbeing o Premises that are fit for purpose o Engagement with the local community, other health professionals	http://psnc.org.uk/services-commissioning/locally-commissioned-services/healthy-living-pharmacies/

	(especially GPs), social care, public health professionals and local authorities The HLP concept provides a framework for commissioning public health services through three levels of increasing complexity and required expertise with pharmacies aspiring to go from one level to the next. o Level 1: Promotion – Promoting health, wellbeing and self-care (in July 2016, Level 1 changed from a commissioner-led process to a profession-led self-assessment process) o Level 2: Prevention – Providing services (commissioner-led) o Level 3: Protection – Providing treatment (commissioner-led)	
Healthwatch	Healthwatch are a patient experience group who provide support and guidance to patients and highlight any inadequacies. Healthwatch state on their website: Healthwatch are a listening ear to people, especially the most vulnerable, to understand their experiences and what matters most to them, influencing those who have the power to change services so that they better meet people's needs now and into the future, empowering and informing people to get the most from their health and social care services and encouraging other organisations to do the same, and working with the Healthwatch network to champion service improvement and to empower local people.	http://www.healthwatch.co.uk/
Holistic Worker	The holistic worker model is an integrated approach to delivering care to individuals. Health and social care workers are trained in disciplines other than their own to provide joined up care to individuals and ultimately work to avoid hospital admission.	http://www.nhsemployers.org/case-studies-and-resources/2015/03/new-ways-of-working-in-nottingham-the-holistic-worker-model
House of Care	The House of Care is a framework which has been developed out of a need to manage the way that long term conditions are treated differently.	https://www.england.nhs.uk/ourwork/ltc-op-eolc/ltc-eolc/house-of-care/
Improving Access to Psychological Therapies (IAPT)	The Improving Access to Psychological Therapies programme began in 2008. IAPT services provide evidence-based treatments for people with anxiety and depression. The priority areas for service development	https://www.england.nhs.uk/mental-health/adults/iapt/

	are to expand services so that at least 1.5 million adults access care each year by 2020/21, focus on individuals with long-term conditions, support people to find or stay in work and improve quality and people's experience of services.	
Integrated Personal Commissioning (IPC)	Integrated personal commissioning is an approach to person-centred health and social care. It aims to: join up health and social care services so people with complex needs, carers and families can shape care that is effective and meaningful to them in their lives, offer councils and NHS commissioners and provider's technical support, regulation and financial flexibility to address the barriers they may experience as they change their systems, and partner with the voluntary sector to design effective approaches to change, support individuals and drive the cultural changes needed. The IPC programme builds on and brings together work on implementing personal budgets in the NHS and the Better Care Fund.	http://www.ipcprogramme.org.uk/about-the-programme/
Integrated budget	Integrated budgets are an amount of money to support a person's identified care and support and health and wellbeing needs, planned and agreed between the person and their social care and health team.	
Learning Beyond Registration (LBR)	Health Education East Midlands have entered into contracts with local training providers to provide training to professionals post-registration (excluding dentists and doctors) in order to improve the skills, knowledge and competency of the workforce.	http://lbr.eastmidlands.nhs.uk/
Local Information Online Nottingham (LION)	Nottingham LION has been developed by Nottingham City Council and Nottingham City CCG as an online directory of services and agencies within the Nottingham area.	https://www.asklion.co.uk/kb5/nottingham/directory/home.page
Local Workforce Action Boards-LWAB	Local workforce action boards have been set up across the areas of the sustainability and transformation plan and are working closely with health and social care providers and commissioners around the workforce elements of the STP.	https://hee.nhs.uk/sites/default/files/documents/TV_PaulineBrown_presentation.pdf
Local Medical Committee (LMC)	LMCs are local representative committees of NHS GPs and represent their interests in their localities to the NHS health authorities. They interact and work with – and through – the General Practitioners Committee as well	https://www.bma.org.uk/about-us/how-we-work/local-representation/local-medical-committees

	as other branch of practice committees and local specialist medical committees in various ways, including conferences.	
Local Pharmaceutical Committee (LPC)	Local Pharmaceutical Committees (LPCs) represent all NHS pharmacy contractors in a defined locality. LPCs are recognized by local NHS Primary Care Organisations and are consulted on local matters affecting pharmacy contractors. Nottinghamshire LPC represents local pharmacies in Nottinghamshire, Nottingham City and Bassetlaw.	http://lpc-online.org.uk/
Make Every Contact Count (MECC)	Making Every Contact Count (MECC) is an approach to behavior change that utilizes day to day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing. MECC enables the opportunistic delivery of consistent and concise healthy lifestyle information and enables individuals to engage in conversations about their health at scale across organisations and populations. The MECC approach has been developed by public health and has been rolled out to front line staff.	https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources
Make Every Contact Count (MECC) Plus	It is recognised that partner organisations such as local authorities may adopt a broader definition of the MECC approach, referred to as MECC plus. This may include conversations to help people think about wider determinants such as: • Debt management • Housing • Welfare rights advice	
Mid Nottinghamshire Alliance Transformation Board	Nottingham Better Together Partnership (Mid-Nottinghamshire Alliance Board) is made up of Mansfield and Ashfield CCG, Newark and Sherwood CCG, Sherwood Forest Hospitals, Circle Nottingham, East Midlands Ambulance Service, Nottinghamshire County Council and Nottinghamshire Healthcare Trust.	http://www.bettertogethermidnotts.org.uk/vanguard/
Multispecialty, community based provider – MCP	MCPs were introduced as a new type of integrated provider, combining the delivery of primary care and community-based health and care services. MCPs are part of the New Models of Care vanguard programme.	https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf
New Care	There are 5 types of vanguard, which are	https://www.england.n

Models – Vanguard	new models of care: • Integrated Primary and Acute Care Systems (PACS) – joining up GP, hospital, community and mental health services • Multispecialty Community Providers (MCP) – moving specialist care out of hospitals into the community • Enhanced Health in Care Homes (EHCH) – offering older people better, joined up health, care and rehabilitation services • Urgent and Emergency Care (UEC) – new approaches to improve the coordination of services and reduce pressure on A&E departments • Acute Care Collaborations (ACC) – linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency. The New Models of care (Vanguards) are a key element to the delivery of the Five Year Forward View.	hs.uk/2015/01/models-of-care/
NHS Five Year Forward View	This is a key strategic document for the NHS published in October 2014. It outlines the answers to: a) Why will the NHS need to change? b) What will the future look like? (use of new care models) c) How can we get there? Next Steps for the Five Year Forward View was published in March 2017.	https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf
National Institute for Health and Care Excellence (NICE)	NICE provides national guidance and advice to improve health and social care.	https://www.nice.org.uk/
Notts Help Yourself	The Notts Help Yourself website is aimed at supporting local people for find services or agencies that can support with finding help and advice. Notts Help Yourself was developed by Nottinghamshire County Council.	http://www.nottshelpyourself.org.uk/kb5/nottinghamshire/directory/home.page
Nottinghamshire County and Nottingham City Declaration on Tobacco Control	The Nottinghamshire County and Nottingham City Declaration on Tobacco Control is an extension of the original Local Government Declaration on Tobacco Control developed by Newcastle City Council as a response to the enormous and ongoing damage smoking causes to our communities. This locally developed, innovative document will enable organisations across the whole of the county	http://www.nottinghamshire.gov.uk/care/health-and-wellbeing/declaration-on-tobacco-control

	and city to also sign up to the principles of the Local Authority Declaration and be supported to develop an action plan.	
Nottinghamshire Wellbeing @ Work programme	This is a local scheme that acts as an umbrella for a range of public health and wider health related priorities to be implemented across adult working age population and their wider families and peers. It encompasses a very effective community development model, whereby people in the workplace are trained to promote health and wellbeing in the workplace. The award scheme comprises five attainment levels across five themed areas with a tiered approach. The scheme brings together a large network of interested businesses and provides robust information on the importance of health and wellbeing, promoting local business as exemplary employers and improving their public image.	https://search3.openobjects.com/mediamanager/nottinghamshire/fsd/files/workplace_health_toolkit.pdf
Nurse Associates	The nursing associate role is a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. Following huge interest, some 2,000 people are now in training with providers across England. The new role is expected to work alongside care assistants and registered nurses to deliver hands-on care, focusing on ensuring patients continue to get the compassionate care they deserve. Its introduction has the potential to transform the nursing and care workforce with clear entry and career progression points. The new role will be regulated by the Nursing and Midwifery Council.	https://hee.nhs.uk/our-work/developing-our-workforce/nursing/nursing-associate-new-support-role-nursing
Person-Centred Approaches	The priorities of person-centered approaches are to tailor care planning to individuals. Skills for Health have produced a paper in relation to person-centered approaches which demonstrates the positive outcomes citizens have when they are supported with a person centered approach.	http://www.skillsforhealth.org.uk/services/item/575-person-centred-approaches-cstf-download
Personal budget	This is a budget that is funded by the local authority for individuals eligible for care and support under the Care Act.	
Personal health budget (PHB)	A PHB is an amount of money to support a person's identified health and wellbeing needs.	https://www.england.nhs.uk/personal-health-budgets/
Prevention	Prevention is the act of stopping something from happening or stopping someone from	http://www.redcross.org.uk/About-

	doing something. For the health and care system, this term refers to the general prevention of incidence and progression of ill health and wellbeing. The Care Act's triple definition of prevention: • Primary prevention is about minimising the risk of people developing needs. • Secondary prevention is about targeting people at high risk of developing needs and intervening early. • Tertiary prevention is about minimising deterioration and the loss of independence for people with established needs or preventing the reoccurrence of a health and social care crisis.	us/Advocacy/Health-and-social-care/Prevention-in-action-resources-for-local-decision-makers
Priority Areas	Within the Sustainability and Transformation plan (STP), there are five areas where the biggest impact on improving services and improving the health and wellbeing of the population can be made. These areas are referred to as High Impact Areas (HIAs) throughout the STP.	
Promoting independence / maximising opportunities	This describes an approach where people are encouraged to do as much as they can for themselves whilst offering a good level of advice, information and access to support that can assist. Maximising opportunities for independence starts with people at risk of needing health or social care services through to people with complex health conditions or disabilities.	
Reablement	Reablement is interventions that are provided to individuals to help them to learn or relearn tasks to support them to regain their independence.	
Self-Care	Self-care is used to describe any human function that is under the control of the individual themselves. In healthcare, it is often used to describe people managing their long-term condition needs, but we are applying it in a broader context to wellbeing.	
Self-Care Forum	At the Department of Health on 10 May 2011, Paul Burstow, Minister of State for Care Services, met with 17 members of the Self Care Campaign. The occasion marked the inaugural meeting of the Self Care Forum, whose purpose is to further the reach of self-care and embed it into everyday life. The Minister invited the Self Care Forum to take over the organisation of Self Care Week, a yearly campaign that was started by the Department of Health in 2009. At the	http://www.selfcareforum.org/

	inaugural meeting, the Self Care Forum also agreed nine aims within its terms of reference, including to widely disseminate excellent examples of self-care activities.	
Self-Management	Self-management is part of self-care. People with long-term conditions manage well when they understand and follow complex medical regimes and adopt necessary changes in lifestyle. This can often require support, whether in managing aspects of physical health, aspects of adapting everyday activities and roles, and/or dealing with the emotions arising from having a particular condition or number of conditions.	
Skills for Care	Skills for Care aims to support a better-led, skilled and well supported work force. Skills for Care support this by providing training for all individuals employed in the social care sector. Skills for Care were involved in the development of the Care Certificate.	http://www.skillsforcare.org.uk/Home.aspx
Social Care Institute for Excellence (SCIE)	Social Care Institute for excellence seeks to improve the lives of individuals who use care services by sharing information. This includes provision of training, consultancy and resources guides.	https://www.scie.org.uk/
Social Prescribing	Social prescribing, sometimes referred to as a community referral, is a means of enabling GPs, nurses and other primary care professionals to refer individuals to a range of non-clinical services. Social prescribing seeks to support individuals in a holistic way considering social, economic and environmental factors. There are many different models for social prescribing; most involve a link worker or navigator who works with people to access local sources of support.	https://www.kingsfund.org.uk/publications/social-prescribing
Sustainability Transformation Partnership	The Nottingham and Nottinghamshire Sustainability and Transformation Partnership is not a public body but a partnership of the six CCGs, two NHS Trusts and eight Local Authorities in Nottingham and Nottinghamshire who are now coming together to plan and deliver services across a wider geography and as an integrated health and care system. The footprint has a resident population of 1,001,600 citizens and has a total place-based spend across health and social care of £3.7 billion. A copy of the plan and supporting documents can be accessed on line at this address http://www.stpnotts.org.uk/	https://www.stpnotts.org.uk/media/116401/sustainabilitytransformationplansummaryguide.pdf http://www.smybndccgs.nhs.uk/application/files/9514/8041/4423/South_Yorkshire_and_Bassetlaw_STP_-_a_summary_.pdf
Three Tier Model	The three tier model has been developed to work with families, partners and communities	

	to help more people to have healthy and fulfilling lives. The goal is for all service users to have a positive experience of care and support. Support will be tailored to individual's strengths, personal outcomes and the assets in the community. The model is based on three tiers: firstly, that individuals are supported to help themselves utilising resources readily available to all citizens including online resources, secondly, that there is a focused on short term care when needed, a reablement model that provides intensive support to support individuals to regain their independence, and thirdly, that there is help to live your life. This is self-directed based on citizens having choice and control.	
Workforce Temperature Check	In order to effectively respond to emerging workforce issues, it is vital that we have access to real time workforce intelligence. Numerous workforce data capture tools are utilised by STP partners, some of which capture mandatory data returns and data for internal reporting, but not all of which are readily available. There is no one system to systematically collect real time data that we can utilise to inform our plans. Conversations are currently taking place to determine the most effective approach for gaining system wide intelligence through a one off workforce survey. The survey will provide a 'temperature check' of key workforce risks and issues, including: o Business critical vacancies o Workforce skills gaps o Recruitment and retention approaches and associated success rates o Temporary/flexible workforce and associated spend o Current workforce strategies o Known risks Analysis of this will help focus our limited resources and support the ongoing workforce modelling project. The LWAB are asked to support the roll out of this survey across STP organisations.	